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(f) SECRETARIAL OVERSIGHT.—The Secretary shall each year conduct a review of each State program to ensure compliance with the requirements of this section, including ensuring that the State program meets—

- (1) eligibility verification requirements for participation in the program;
- (2) the requirements for use of Federal funds received by the program; and
- (3) the quality and performance standards under this section.

(g) STANDARD HEALTH PLAN OFFERORS.—A State may provide that persons eligible to offer standard health plans under a basic health program established under this section may include a licensed health maintenance organization, a licensed health insurance insurer, or a network of health care providers established to offer services under the program.

(h) DEFINITIONS.—Any term used in this section which is also used in section 36B of the Internal Revenue Code of 1986 shall have the meaning given such term by such section.

SEC. 1332. WAIVER FOR STATE INNOVATION.

(a) APPLICATION.—

(1) IN GENERAL.—A State may apply to the Secretary for the waiver of all or any requirements described in paragraph (2) with respect to health insurance coverage within that State for plan years beginning on or after January 1, 2017. Such application shall—

- (A) be filed at such time and in such manner as the Secretary may require;
- (B) contain such information as the Secretary may require, including—

(i) a comprehensive description of the State legislation and program to implement a plan meeting the requirements for a waiver under this section; and

(ii) a 10-year budget plan for such plan that is budget neutral for the Federal Government; and

(C) provide an assurance that the State has enacted the law described in subsection (b)(2).

(2) REQUIREMENTS.—The requirements described in this paragraph with respect to health insurance coverage within the State for plan years beginning on or after January 1, 2014, are as follows:

- (A) Part I of subtitle D.
- (B) Part II of subtitle D.

(C) Section 1402.

(D) Sections 36B, 4980H, and 5000A of the Internal Revenue Code of 1986.

(3) PASS THROUGH OF FUNDING.—With respect to a State waiver under paragraph (1), under which, due to the structure of the State plan, individuals and small employers in the State would not qualify for the premium tax credits, cost-sharing reductions, or small business credits under sections 36B of the Internal Revenue Code of 1986 or under part I of subtitle E for which they would otherwise be eligible, the Secretary shall provide for an alternative means by which the aggregate amount of such credits or reductions that would have been paid on behalf of participants in the Exchanges established

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under this title had the State not received such waiver, shall be paid to the State for purposes of implementing the State plan under the waiver. Such amount shall be determined annually by the Secretary, taking into consideration the experience of other States with respect to participation in an Exchange and credits and reductions provided under such provisions to residents of the other States.

(4) WAIVER CONSIDERATION AND TRANSPARENCY.—

(A) IN GENERAL.—An application for a waiver under this section shall be considered by the Secretary in accordance with the regulations described in subparagraph (B).

(B) REGULATIONS.—Not later than 180 days after the date of enactment of this Act, the Secretary shall promulgate regulations relating to waivers under this section that provide—

(i) a process for public notice and comment at the State level, including public hearings, sufficient to ensure a meaningful level of public input;

(ii) a process for the submission of an application that ensures the disclosure of—

(I) the provisions of law that the State involved seeks to waive; and

(II) the specific plans of the State to ensure that the waiver will be in compliance with subsection (b);

(iii) a process for providing public notice and comment after the application is received by the Secretary, that is sufficient to ensure a meaningful level of public input and that does not impose requirements that are in addition to, or duplicative of, requirements imposed under the Administrative Procedures Act, or requirements that are unreasonable or unnecessarily burdensome with respect to State compliance;

(iv) a process for the submission to the Secretary of periodic reports by the State concerning the implementation of the program under the waiver; and

(v) a process for the periodic evaluation by the Secretary of the program under the waiver.

(C) REPORT.—The Secretary shall annually report to Congress concerning actions taken by the Secretary with respect to applications for waivers under this section.

(5) COORDINATED WAIVER PROCESS.—The Secretary shall develop a process for coordinating and consolidating the State waiver processes applicable under the provisions of this section, and the existing waiver processes applicable under titles XVIII, XIX, and XXI of the Social Security Act, and any other Federal law relating to the provision of health care items or services. Such process shall permit a State to submit a single application for a waiver under any or all of such provisions.

(6) DEFINITION.—In this section, the term “Secretary” means—

(A) the Secretary of Health and Human Services with respect to waivers relating to the provisions described in subparagraph (A) through (C) of paragraph (2); and

(B) the Secretary of the Treasury with respect to waivers relating to the provisions described in paragraph (2)(D).

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(b) GRANTING OF WAIVERS.—

(1) IN GENERAL.—The Secretary may grant a request for a waiver under subsection (a)(1) only if the Secretary determines that the State plan—

(A) will provide coverage that is at least as comprehensive as the coverage defined in section 1302(b) and offered through Exchanges established under this title as certified by Office of the Actuary of the Centers for Medicare & Medicaid Services based on sufficient data from the State and from comparable States about their experience with programs created by this Act and the provisions of this Act that would be waived;

(B) will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of this title would provide;

(C) will provide coverage to at least a comparable number of its residents as the provisions of this title would provide; and

(D) will not increase the Federal deficit.

(2) REQUIREMENT TO ENACT A LAW.—

(A) IN GENERAL.—A law described in this paragraph is a State law that provides for State actions under a waiver under this section, including the implementation of the State plan under subsection (a)(1)(B).

(B) TERMINATION OF OPT OUT.—A State may repeal a law described in subparagraph (A) and terminate the authority provided under the waiver with respect to the State.

(c) SCOPE OF WAIVER.—

(1) IN GENERAL.—The Secretary shall determine the scope of a waiver of a requirement described in subsection (a)(2) granted to a State under subsection (a)(1).

(2) LIMITATION.—The Secretary may not waive under this section any Federal law or requirement that is not within the authority of the Secretary.

(d) DETERMINATIONS BY SECRETARY.—

(1) TIME FOR DETERMINATION.—The Secretary shall make a determination under subsection (a)(1) not later than 180 days after the receipt of an application from a State under such subsection.

(2) EFFECT OF DETERMINATION.—

(A) GRANTING OF WAIVERS.—If the Secretary determines to grant a waiver under subsection (a)(1), the Secretary shall notify the State involved of such determination and the terms and effectiveness of such waiver.

(B) DENIAL OF WAIVER.—If the Secretary determines a waiver should not be granted under subsection (a)(1), the Secretary shall notify the State involved, and the appropriate committees of Congress of such determination and the reasons therefore.

(e) TERM OF WAIVER.—No waiver under this section may extend over a period of longer than 5 years unless the State requests continuation of such waiver, and such request shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in

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writing or informs the State in writing with respect to any additional information which is needed in order to make a final determination with respect to the request.

SEC. 1333. PROVISIONS RELATING TO OFFERING OF PLANS IN MORE THAN ONE STATE.

(a) **HEALTH CARE CHOICE COMPACTS.**—

(1) **IN GENERAL.**—Not later than July 1, 2013, the Secretary shall, in consultation with the National Association of Insurance Commissioners, issue regulations for the creation of health care choice compacts under which 2 or more States may enter into an agreement under which—

(A) 1 or more qualified health plans could be offered in the individual markets in all such States but, except as provided in subparagraph (B), only be subject to the laws and regulations of the State in which the plan was written or issued;

(B) the issuer of any qualified health plan to which the compact applies—

(i) would continue to be subject to market conduct, unfair trade practices, network adequacy, and consumer protection standards (including standards relating to rating), including addressing disputes as to the performance of the contract, of the State in which the purchaser resides;

(ii) would be required to be licensed in each State in which it offers the plan under the compact or to submit to the jurisdiction of each such State with regard to the standards described in clause (i) (including allowing access to records as if the insurer were licensed in the State); and

(iii) must clearly notify consumers that the policy may not be subject to all the laws and regulations of the State in which the purchaser resides.

(2) **STATE AUTHORITY.**—A State may not enter into an agreement under this subsection unless the State enacts a law after the date of the enactment of this title that specifically authorizes the State to enter into such agreements.

(3) **APPROVAL OF COMPACTS.**—The Secretary may approve interstate health care choice compacts under paragraph (1) only if the Secretary determines that such health care choice compact—

(A) will provide coverage that is at least as comprehensive as the coverage defined in section 1302(b) and offered through Exchanges established under this title;

(B) will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of this title would provide;

(C) will provide coverage to at least a comparable number of its residents as the provisions of this title would provide;

(D) will not increase the Federal deficit; and

(E) will not weaken enforcement of laws and regulations described in paragraph (1)(B)(i) in any State that is included in such compact.

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(c) PAYMENT OF PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS.—

(1) IN GENERAL.—The Secretary shall notify the Secretary of the Treasury and the Exchange through which the individual is enrolling of the advance determination under section 1411.

(2) PREMIUM TAX CREDIT.—

(A) IN GENERAL.—The Secretary of the Treasury shall make the advance payment under this section of any premium tax credit allowed under section 36B of the Internal Revenue Code of 1986 to the issuer of a qualified health plan on a monthly basis (or such other periodic basis as the Secretary may provide).

(B) ISSUER RESPONSIBILITIES.—An issuer of a qualified health plan receiving an advance payment with respect to an individual enrolled in the plan shall—

(i) reduce the premium charged the insured for any period by the amount of the advance payment for the period;

(ii) notify the Exchange and the Secretary of such reduction;

(iii) include with each billing statement the amount by which the premium for the plan has been reduced by reason of the advance payment; and

(iv) in the case of any nonpayment of premiums by the insured—

(I) notify the Secretary of such nonpayment; and

(II) allow a 3-month grace period for nonpayment of premiums before discontinuing coverage.

(3) COST-SHARING REDUCTIONS.—The Secretary shall also notify the Secretary of the Treasury and the Exchange under paragraph (1) if an advance payment of the cost-sharing reductions under section 1402 is to be made to the issuer of any qualified health plan with respect to any individual enrolled in the plan. The Secretary of the Treasury shall make such advance payment at such time and in such amount as the Secretary specifies in the notice.

(d) NO FEDERAL PAYMENTS FOR INDIVIDUALS NOT LAWFULLY PRESENT.—Nothing in this subtitle or the amendments made by this subtitle allows Federal payments, credits, or cost-sharing reductions for individuals who are not lawfully present in the United States.

(e) STATE FLEXIBILITY.—Nothing in this subtitle or the amendments made by this subtitle shall be construed to prohibit a State from making payments to or on behalf of an individual for coverage under a qualified health plan offered through an Exchange that are in addition to any credits or cost-sharing reductions allowable to the individual under this subtitle and such amendments.

SEC. 1413. STREAMLINING OF PROCEDURES FOR ENROLLMENT THROUGH AN EXCHANGE AND STATE MEDICAID, CHIP, AND HEALTH SUBSIDY PROGRAMS.

(a) IN GENERAL.—The Secretary shall establish a system meeting the requirements of this section under which residents of each State may apply for enrollment in, receive a determination of eligibility for participation in, and continue participation in,

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applicable State health subsidy programs. Such system shall ensure that if an individual applying to an Exchange is found through screening to be eligible for medical assistance under the State medicaid plan under title XIX, or eligible for enrollment under a State children's health insurance program (CHIP) under title XXI of such Act, the individual is enrolled for assistance under such plan or program.

(b) REQUIREMENTS RELATING TO FORMS AND NOTICE.—

(1) REQUIREMENTS RELATING TO FORMS.—

(A) IN GENERAL.—The Secretary shall develop and provide to each State a single, streamlined form that—

(i) may be used to apply for all applicable State health subsidy programs within the State;

(ii) may be filed online, in person, by mail, or by telephone;

(iii) may be filed with an Exchange or with State officials operating one of the other applicable State health subsidy programs; and

(iv) is structured to maximize an applicant's ability to complete the form satisfactorily, taking into account the characteristics of individuals who qualify for applicable State health subsidy programs.

(B) STATE AUTHORITY TO ESTABLISH FORM.—A State may develop and use its own single, streamlined form as an alternative to the form developed under subparagraph (A) if the alternative form is consistent with standards promulgated by the Secretary under this section.

(C) SUPPLEMENTAL ELIGIBILITY FORMS.—The Secretary may allow a State to use a supplemental or alternative form in the case of individuals who apply for eligibility that is not determined on the basis of the household income (as defined in section 36B of the Internal Revenue Code of 1986).

(2) NOTICE.—The Secretary shall provide that an applicant filing a form under paragraph (1) shall receive notice of eligibility for an applicable State health subsidy program without any need to provide additional information or paperwork unless such information or paperwork is specifically required by law when information provided on the form is inconsistent with data used for the electronic verification under paragraph (3) or is otherwise insufficient to determine eligibility.

(c) REQUIREMENTS RELATING TO ELIGIBILITY BASED ON DATA EXCHANGES.—

(1) DEVELOPMENT OF SECURE INTERFACES.—Each State shall develop for all applicable State health subsidy programs a secure, electronic interface allowing an exchange of data (including information contained in the application forms described in subsection (b)) that allows a determination of eligibility for all such programs based on a single application. Such interface shall be compatible with the method established for data verification under section 1411(c)(4).

(2) DATA MATCHING PROGRAM.—Each applicable State health subsidy program shall participate in a data matching arrangement for determining eligibility for participation in the program under paragraph (3) that—

(A) provides access to data described in paragraph (3);

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- (B) applies only to individuals who—
- (i) receive assistance from an applicable State health subsidy program; or
 - (ii) apply for such assistance—
 - (I) by filing a form described in subsection (b); or
 - (II) by requesting a determination of eligibility and authorizing disclosure of the information described in paragraph (3) to applicable State health coverage subsidy programs for purposes of determining and establishing eligibility; and

(C) consistent with standards promulgated by the Secretary, including the privacy and data security safeguards described in section 1942 of the Social Security Act or that are otherwise applicable to such programs.

(3) DETERMINATION OF ELIGIBILITY.—

(A) IN GENERAL.—Each applicable State health subsidy program shall, to the maximum extent practicable—

- (i) establish, verify, and update eligibility for participation in the program using the data matching arrangement under paragraph (2); and
- (ii) determine such eligibility on the basis of reliable, third party data, including information described in sections 1137, 453(i), and 1942(a) of the Social Security Act, obtained through such arrangement.

(B) EXCEPTION.—This paragraph shall not apply in circumstances with respect to which the Secretary determines that the administrative and other costs of use of the data matching arrangement under paragraph (2) outweigh its expected gains in accuracy, efficiency, and program participation.

(4) SECRETARIAL STANDARDS.—The Secretary shall, after consultation with persons in possession of the data to be matched and representatives of applicable State health subsidy programs, promulgate standards governing the timing, contents, and procedures for data matching described in this subsection. Such standards shall take into account administrative and other costs and the value of data matching to the establishment, verification, and updating of eligibility for applicable State health subsidy programs.

(d) ADMINISTRATIVE AUTHORITY.—

(1) AGREEMENTS.—Subject to section 1411 and section 6103(l)(21) of the Internal Revenue Code of 1986 and any other requirement providing safeguards of privacy and data integrity, the Secretary may establish model agreements, and enter into agreements, for the sharing of data under this section.

(2) AUTHORITY OF EXCHANGE TO CONTRACT OUT.—Nothing in this section shall be construed to—

- (A) prohibit contractual arrangements through which a State medicaid agency determines eligibility for all applicable State health subsidy programs, but only if such agency complies with the Secretary's requirements ensuring reduced administrative costs, eligibility errors, and disruptions in coverage; or

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(B) change any requirement under title XIX that eligibility for participation in a State's medicaid program must be determined by a public agency.

(e) APPLICABLE STATE HEALTH SUBSIDY PROGRAM.—In this section, the term “applicable State health subsidy program” means—

(1) the program under this title for the enrollment in qualified health plans offered through an Exchange, including the premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402;

(2) a State medicaid program under title XIX of the Social Security Act;

(3) a State children's health insurance program (CHIP) under title XXI of such Act; and

(4) a State program under section 1331 establishing qualified basic health plans.

SEC. 1414. DISCLOSURES TO CARRY OUT ELIGIBILITY REQUIREMENTS FOR CERTAIN PROGRAMS.

(a) DISCLOSURE OF TAXPAYER RETURN INFORMATION AND SOCIAL SECURITY NUMBERS.—

(1) TAXPAYER RETURN INFORMATION.—Subsection (1) of section 6103 of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

“(21) DISCLOSURE OF RETURN INFORMATION TO CARRY OUT ELIGIBILITY REQUIREMENTS FOR CERTAIN PROGRAMS.—

“(A) IN GENERAL.—The Secretary, upon written request from the Secretary of Health and Human Services, shall disclose to officers, employees, and contractors of the Department of Health and Human Services return information of any taxpayer whose income is relevant in determining any premium tax credit under section 36B or any cost-sharing reduction under section 1402 of the Patient Protection and Affordable Care Act or eligibility for participation in a State medicaid program under title XIX of the Social Security Act, a State's children's health insurance program under title XXI of the Social Security Act, or a basic health program under section 1331 of Patient Protection and Affordable Care Act. Such return information shall be limited to—

“(i) taxpayer identity information with respect to such taxpayer,

“(ii) the filing status of such taxpayer,

“(iii) the number of individuals for whom a deduction is allowed under section 151 with respect to the taxpayer (including the taxpayer and the taxpayer's spouse),

“(iv) the modified adjusted gross income (as defined in section 36B) of such taxpayer and each of the other individuals included under clause (iii) who are required to file a return of tax imposed by chapter 1 for the taxable year, *[As revised by section 1004(a)(1)(B) of HCERA]*

“(v) such other information as is prescribed by the Secretary by regulation as might indicate whether the taxpayer is eligible for such credit or reduction (and the amount thereof), and

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“(vi) the taxable year with respect to which the preceding information relates or, if applicable, the fact that such information is not available.

“(B) INFORMATION TO EXCHANGE AND STATE AGENCIES.—The Secretary of Health and Human Services may disclose to an Exchange established under the Patient Protection and Affordable Care Act or its contractors, or to a State agency administering a State program described in subparagraph (A) or its contractors, any inconsistency between the information provided by the Exchange or State agency to the Secretary and the information provided to the Secretary under subparagraph (A).

“(C) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under subparagraph (A) or (B) may be used by officers, employees, and contractors of the Department of Health and Human Services, an Exchange, or a State agency only for the purposes of, and to the extent necessary in—

“(i) establishing eligibility for participation in the Exchange, and verifying the appropriate amount of, any credit or reduction described in subparagraph (A),

“(ii) determining eligibility for participation in the State programs described in subparagraph (A).”.

(2) SOCIAL SECURITY NUMBERS.—Section 205(c)(2)(C) of the Social Security Act is amended by adding at the end the following new clause:

“(x) The Secretary of Health and Human Services, and the Exchanges established under section 1311 of the Patient Protection and Affordable Care Act, are authorized to collect and use the names and social security account numbers of individuals as required to administer the provisions of, and the amendments made by, the such Act.”.

(b) CONFIDENTIALITY AND DISCLOSURE.—Paragraph (3) of section 6103(a) of such Code is amended by striking “or (20)” and inserting “(20), or (21)”.

(c) PROCEDURES AND RECORDKEEPING RELATED TO DISCLOSURES.—Paragraph (4) of section 6103(p) of such Code is amended—

(1) by inserting “, or any entity described in subsection (1)(21),” after “or (20)” in the matter preceding subparagraph (A),

(2) by inserting “or any entity described in subsection (1)(21),” after “or (o)(1)(A)” in subparagraph (F)(ii), and

(3) by inserting “or any entity described in subsection (1)(21),” after “or (20)” both places it appears in the matter after subparagraph (F).

(d) UNAUTHORIZED DISCLOSURE OR INSPECTION.—Paragraph (2) of section 7213(a) of such Code is amended by striking “or (20)” and inserting “(20), or (21)”.

SEC. 1415. PREMIUM TAX CREDIT AND COST-SHARING REDUCTION PAYMENTS DISREGARDED FOR FEDERAL AND FEDERALLY-ASSISTED PROGRAMS.

For purposes of determining the eligibility of any individual for benefits or assistance, or the amount or extent of benefits or assistance, under any Federal program or under any State or local program financed in whole or in part with Federal funds—

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(1) any credit or refund allowed or made to any individual by reason of section 36B of the Internal Revenue Code of 1986 (as added by section 1401) shall not be taken into account as income and shall not be taken into account as resources for the month of receipt and the following 2 months; and

(2) any cost-sharing reduction payment or advance payment of the credit allowed under such section 36B that is made under section 1402 or 1412 shall be treated as made to the qualified health plan in which an individual is enrolled and not to that individual.

SEC. 1416. STUDY OF GEOGRAPHIC VARIATION IN APPLICATION OF FPL.

[Section added by section 10105(f)]

(a) **IN GENERAL.**—The Secretary shall conduct a study to examine the feasibility and implication of adjusting the application of the Federal poverty level under this subtitle (and the amendments made by this subtitle) for different geographic areas so as to reflect the variations in cost-of-living among different areas within the United States. If the Secretary determines that an adjustment is feasible, the study should include a methodology to make such an adjustment. Not later than January 1, 2013, the Secretary shall submit to Congress a report on such study and shall include such recommendations as the Secretary determines appropriate.

(b) **INCLUSION OF TERRITORIES.**—

(1) **IN GENERAL.**—The Secretary shall ensure that the study under subsection (a) covers the territories of the United States and that special attention is paid to the disparity that exists among poverty levels and the cost of living in such territories and to the impact of such disparity on efforts to expand health coverage and ensure health care.

(2) **TERRITORIES DEFINED.**—In this subsection, the term “territories of the United States” includes the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, the Northern Mariana Islands, and any other territory or possession of the United States.

PART II—SMALL BUSINESS TAX CREDIT

SEC. 1421. CREDIT FOR EMPLOYEE HEALTH INSURANCE EXPENSES OF SMALL BUSINESSES.

(a) **IN GENERAL.**—Subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to business-related credits) is amended by inserting after section 45Q the following:

“SEC. 45R. EMPLOYEE HEALTH INSURANCE EXPENSES OF SMALL EMPLOYERS.

“(a) **GENERAL RULE.**—For purposes of section 38, in the case of an eligible small employer, the small employer health insurance credit determined under this section for any taxable year in the credit period is the amount determined under subsection (b).

“(b) **HEALTH INSURANCE CREDIT AMOUNT.**—Subject to subsection (c), the amount determined under this subsection with respect to any eligible small employer is equal to 50 percent (35 percent in the case of a tax-exempt eligible small employer) of the lesser of—

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(b) **RULE OF CONSTRUCTION REGARDING HAWAII'S PREPAID HEALTH CARE ACT.**—Nothing in this title (or an amendment made by this title) shall be construed to modify or limit the application of the exemption for Hawaii's Prepaid Health Care Act (Haw. Rev. Stat. §§ 393–1 et seq.) as provided for under section 514(b)(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)(5)).

(c) **STUDENT HEALTH INSURANCE PLANS.**—Nothing in this title (or an amendment made by this title) shall be construed to prohibit an institution of higher education (as such term is defined for purposes of the Higher Education Act of 1965) from offering a student health insurance plan, to the extent that such requirement is otherwise permitted under applicable Federal, State or local law.

(d) **NO EFFECT ON EXISTING REQUIREMENTS.**—Nothing in this title (or an amendment made by this title, unless specified by direct statutory reference) shall be construed to modify any existing Federal requirement concerning the State agency responsible for determining eligibility for programs identified in section 1413.

SEC. 1561. HEALTH INFORMATION TECHNOLOGY ENROLLMENT STANDARDS AND PROTOCOLS.

Title XXX of the Public Health Service Act (42 U.S.C. 300jj et seq.) is amended by adding at the end the following:

“Subtitle C—Other Provisions

“SEC. 3021. HEALTH INFORMATION TECHNOLOGY ENROLLMENT STANDARDS AND PROTOCOLS.

“(a) IN GENERAL.—

“(1) STANDARDS AND PROTOCOLS.—Not later than 180 days after the date of enactment of this title, the Secretary, in consultation with the HIT Policy Committee and the HIT Standards Committee, shall develop interoperable and secure standards and protocols that facilitate enrollment of individuals in Federal and State health and human services programs, as determined by the Secretary.

“(2) METHODS.—The Secretary shall facilitate enrollment in such programs through methods determined appropriate by the Secretary, which shall include providing individuals and third parties authorized by such individuals and their designees notification of eligibility and verification of eligibility required under such programs.

“(b) CONTENT.—The standards and protocols for electronic enrollment in the Federal and State programs described in subsection (a) shall allow for the following:

“(1) Electronic matching against existing Federal and State data, including vital records, employment history, enrollment systems, tax records, and other data determined appropriate by the Secretary to serve as evidence of eligibility and in lieu of paper-based documentation.

“(2) Simplification and submission of electronic documentation, digitization of documents, and systems verification of eligibility.

“(3) Reuse of stored eligibility information (including documentation) to assist with retention of eligible individuals.

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“(4) Capability for individuals to apply, recertify and manage their eligibility information online, including at home, at points of service, and other community-based locations.

“(5) Ability to expand the enrollment system to integrate new programs, rules, and functionalities, to operate at increased volume, and to apply streamlined verification and eligibility processes to other Federal and State programs, as appropriate.

“(6) Notification of eligibility, recertification, and other needed communication regarding eligibility, which may include communication via email and cellular phones.

“(7) Other functionalities necessary to provide eligibles with streamlined enrollment process.

“(c) APPROVAL AND NOTIFICATION.—With respect to any standard or protocol developed under subsection (a) that has been approved by the HIT Policy Committee and the HIT Standards Committee, the Secretary—

“(1) shall notify States of such standards or protocols; and

“(2) may require, as a condition of receiving Federal funds for the health information technology investments, that States or other entities incorporate such standards and protocols into such investments.

“(d) GRANTS FOR IMPLEMENTATION OF APPROPRIATE ENROLLMENT HIT.—

“(1) IN GENERAL.—The Secretary shall award grant to eligible entities to develop new, and adapt existing, technology systems to implement the HIT enrollment standards and protocols developed under subsection (a) (referred to in this subsection as ‘appropriate HIT technology’).

“(2) ELIGIBLE ENTITIES.—To be eligible for a grant under this subsection, an entity shall—

“(A) be a State, political subdivision of a State, or a local governmental entity; and

“(B) submit to the Secretary an application at such time, in such manner, and containing—

“(i) a plan to adopt and implement appropriate enrollment technology that includes—

“(I) proposed reduction in maintenance costs of technology systems;

“(II) elimination or updating of legacy systems; and

“(III) demonstrated collaboration with other entities that may receive a grant under this section that are located in the same State, political subdivision, or locality;

“(ii) an assurance that the entity will share such appropriate enrollment technology in accordance with paragraph (4); and

“(iii) such other information as the Secretary may require.

“(3) SHARING.—

“(A) IN GENERAL.—The Secretary shall ensure that appropriate enrollment HIT adopted under grants under this subsection is made available to other qualified State, qualified political subdivisions of a State, or other appropriate qualified entities (as described in subparagraph (B)) at no cost.

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“(B) QUALIFIED ENTITIES.—The Secretary shall determine what entities are qualified to receive enrollment HIT under subparagraph (A), taking into consideration the recommendations of the HIT Policy Committee and the HIT Standards Committee.”.

SEC. 1562. GAO STUDY REGARDING THE RATE OF DENIAL OF COVERAGE AND ENROLLMENT BY HEALTH INSURANCE ISSUERS AND GROUP HEALTH PLANS.

【Section inserted by section 10107(b)(2)】

(a) IN GENERAL.—The Comptroller General of the United States (referred to in this section as the “Comptroller General”) shall conduct a study of the incidence of denials of coverage for medical services and denials of applications to enroll in health insurance plans, as described in subsection (b), by group health plans and health insurance issuers.

(b) DATA.—

(1) IN GENERAL.—In conducting the study described in subsection (a), the Comptroller General shall consider samples of data concerning the following:

(A)(i) denials of coverage for medical services to a plan enrollees, by the types of services for which such coverage was denied; and

(ii) the reasons such coverage was denied; and

(B)(i) incidents in which group health plans and health insurance issuers deny the application of an individual to enroll in a health insurance plan offered by such group health plan or issuer; and

(ii) the reasons such applications are denied.

(2) SCOPE OF DATA.—

(A) FAVORABLY RESOLVED DISPUTES.—The data that the Comptroller General considers under paragraph (1) shall include data concerning denials of coverage for medical services and denials of applications for enrollment in a plan by a group health plan or health insurance issuer, where such group health plan or health insurance issuer later approves such coverage or application.

(B) ALL HEALTH PLANS.—The study under this section shall consider data from varied group health plans and health insurance plans offered by health insurance issuers, including qualified health plans and health plans that are not qualified health plans.

(c) REPORT.—Not later than one year after the date of enactment of this Act, the Comptroller General shall submit to the Secretaries of Health and Human Services and Labor a report describing the results of the study conducted under this section.

(d) PUBLICATION OF REPORT.—The Secretaries of Health and Human Services and Labor shall make the report described in subsection (c) available to the public on an Internet website.

【The following section 1563 (relating to small business procurement) inserted by section 10107(b)(2)】

SEC. 1563. SMALL BUSINESS PROCUREMENT.

Part 19 of the Federal Acquisition Regulation, section 15 of the Small Business Act (15 U.S.C. 644), and any other applicable laws or regulations establishing procurement requirements relating to small business concerns (as defined in section 3 of the Small Business Act (15 U.S.C. 632)) may not be waived with respect

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(2) CBO projects this Act will continue to reduce budget deficits after 2019.

(3) Based on CBO estimates, this Act will extend the solvency of the Medicare HI Trust Fund.

(4) This Act will increase the surplus in the Social Security Trust Fund, which should be reserved to strengthen the finances of Social Security.

(5) The initial net savings generated by the Community Living Assistance Services and Supports (CLASS) program are necessary to ensure the long-term solvency of that program.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) the additional surplus in the Social Security Trust Fund generated by this Act should be reserved for Social Security and not spent in this Act for other purposes; and

(2) the net savings generated by the CLASS program should be reserved for the CLASS program and not spent in this Act for other purposes.

[Note section 10108, p. 793, provides for free choice vouchers]

TITLE II—ROLE OF PUBLIC PROGRAMS

Subtitle A—Improved Access to Medicaid

SEC. 2001. MEDICAID COVERAGE FOR THE LOWEST INCOME POPULATIONS.

(a) COVERAGE FOR INDIVIDUALS WITH INCOME AT OR BELOW 133 PERCENT OF THE POVERTY LINE.—

(1) BEGINNING 2014.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396a) is amended—

(A) by striking “or” at the end of subclause (VI);

(B) by adding “or” at the end of subclause (VII); and

(C) by inserting after subclause (VII) the following:

“(VIII) beginning January 1, 2014, who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII, and are not described in a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) does not exceed 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved, subject to subsection (k);”.

(2) PROVISION OF AT LEAST MINIMUM ESSENTIAL COVERAGE.—

(A) IN GENERAL.—Section 1902 of such Act (42 U.S.C. 1396a) is amended by inserting after subsection (j) the following:

“(k)(1) The medical assistance provided to an individual described in subclause (VIII) of subsection (a)(10)(A)(i) shall consist of benchmark coverage described in section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2). Such medical assistance shall be provided subject to the requirements of section 1937, without regard to whether a State otherwise has elected the option to provide medical assistance through coverage under that section, unless an individual described in subclause (VIII) of subsection (a)(10)(A)(i) is also an individual for whom, under

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subparagraph (B) of section 1937(a)(2), the State may not require enrollment in benchmark coverage described in subsection (b)(1) of section 1937 or benchmark equivalent coverage described in subsection (b)(2) of that section.”.

(B) CONFORMING AMENDMENT.—Section 1903(i) of the Social Security Act, as amended by section 6402(c), is amended—

- (i) in paragraph (24), by striking “or” at the end;
- (ii) in paragraph (25), by striking the period and inserting “; or”; and
- (iii) by adding at the end the following:

“(26) with respect to any amounts expended for medical assistance for individuals described in subclause (VIII) of subsection (a)(10)(A)(i) other than medical assistance provided through benchmark coverage described in section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2).”.

(3) FEDERAL FUNDING FOR COST OF COVERING NEWLY ELIGIBLE INDIVIDUALS.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), is amended—

(A) in subsection (b), in the first sentence, by inserting “subsection (y) and” before “section 1933(d)”; and

(B) by adding at the end the following new subsection:
“(y) INCREASED FMAP FOR MEDICAL ASSISTANCE FOR NEWLY ELIGIBLE MANDATORY INDIVIDUALS.—

“(1) AMOUNT OF INCREASE.—**[Replaced by section 1201(1)(B) of HCERA]** Notwithstanding subsection (b), the Federal medical assistance percentage for a State that is one of the 50 States or the District of Columbia, with respect to amounts expended by such State for medical assistance for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i), shall be equal to—

“(A) 100 percent for calendar quarters in 2014, 2015, and 2016;

“(B) 95 percent for calendar quarters in 2017;

“(C) 94 percent for calendar quarters in 2018;

“(D) 93 percent for calendar quarters in 2019; and

“(E) 90 percent for calendar quarters in 2020 and each year thereafter.

“(2) DEFINITIONS.—In this subsection:

“(A) NEWLY ELIGIBLE.—The term ‘newly eligible’ means, with respect to an individual described in subclause (VIII) of section 1902(a)(10)(A)(i), an individual who is not under 19 years of age (or such higher age as the State may have elected) and who, as of December 1, 2009, is not eligible under the State plan or under a waiver of the plan for full benefits or for benchmark coverage described in subparagraph (A), (B), or (C) of section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2) that has an aggregate actuarial value that is at least actuarially equivalent to benchmark coverage described in subparagraph (A), (B), or (C) of section 1937(b)(1), or is eligible but not enrolled (or is on a waiting list) for such benefits or coverage through a waiver under the plan that has a capped or limited enrollment that is full. **[As revised by section 10201(c)(3)(B)]**

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“(B) FULL BENEFITS.—The term ‘full benefits’ means, with respect to an individual, medical assistance for all services covered under the State plan under this title that is not less in amount, duration, or scope, or is determined by the Secretary to be substantially equivalent, to the medical assistance available for an individual described in section 1902(a)(10)(A)(i).

【Drafting note: subclause (II) of paragraph (1)(B)(ii), as originally added by section 2001(a)(3) and as amended by section 10201(c)(3)(A), was redesignated as paragraph (5) of subsection (z) and is shown in subsection (z), p. 797, as added by section 10201(c)(4)】

(4) STATE OPTIONS TO OFFER COVERAGE EARLIER AND PRESUMPTIVE ELIGIBILITY; CHILDREN REQUIRED TO HAVE COVERAGE FOR PARENTS TO BE ELIGIBLE.—

(A) IN GENERAL.—Subsection (k) of section 1902 of the Social Security Act (as added by paragraph (2)), is amended by inserting after paragraph (1) the following:

“(2) *【As revised by section 10201(b)】* Beginning with the first day of any fiscal year quarter that begins on or after April 1, 2010, and before January 1, 2014, a State may elect through a State plan amendment to provide medical assistance to individuals who would be described in subclause (VIII) of subsection (a)(10)(A)(i) if that subclause were effective before January 1, 2014. A State may elect to phase-in the extension of eligibility for medical assistance to such individuals based on income, so long as the State does not extend such eligibility to individuals described in such subclause with higher income before making individuals described in such subclause with lower income eligible for medical assistance.

“(3) If an individual described in subclause (VIII) of subsection (a)(10)(A)(i) is the parent of a child who is under 19 years of age (or such higher age as the State may have elected) who is eligible for medical assistance under the State plan or under a waiver of such plan (under that subclause or under a State plan amendment under paragraph (2), the individual may not be enrolled under the State plan unless the individual’s child is enrolled under the State plan or under a waiver of the plan or is enrolled in other health insurance coverage. For purposes of the preceding sentence, the term ‘parent’ includes an individual treated as a caretaker relative for purposes of carrying out section 1931.”

(B) PRESUMPTIVE ELIGIBILITY.—Section 1920 of the Social Security Act (42 U.S.C. 1396r–1) is amended by adding at the end the following:

“(e) If the State has elected the option to provide a presumptive eligibility period under this section or section 1920A, the State may elect to provide a presumptive eligibility period (as defined in subsection (b)(1)) for individuals who are eligible for medical assistance under clause (i)(VIII) of subsection (a)(10)(A) or section 1931 in the same manner as the State provides for such a period under this section or section 1920A, subject to such guidance as the Secretary shall establish.”

(5) CONFORMING AMENDMENTS.—

(A) Section 1902(a)(10) of such Act (42 U.S.C. 1396a(a)(10)) is amended in the matter following subparagraph (G), by striking “and (XIV)” and inserting “(XIV)” and by inserting “and (XV) the medical assistance made available to an individual described in subparagraph

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(A)(i)(VIII) shall be limited to medical assistance described in subsection (k)(1)” before the semicolon. **[Note that section 10201(a)(2) made an additional conforming amendment to reflect overlap with subparagraph (A)(i)(IX), added by section 2004(a)]**

(B) Section 1902(1)(2)(C) of such Act (42 U.S.C. 1396a(1)(2)(C)) is amended by striking “100” and inserting “133”.

(C) Section 1905(a) of such Act (42 U.S.C. 1396d(a)) is amended in the matter preceding paragraph (1)—

(i) by striking “or” at the end of clause (xii);

(ii) by inserting “or” at the end of clause (xiii);

and

(iii) by inserting after clause (xiii) the following:

“(xiv) individuals described in section 1902(a)(10)(A)(i)(VIII),”.

(D) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)) is amended by inserting “1902(a)(10)(A)(i)(VIII),” after “1902(a)(10)(A)(i)(VII),”.

(E) Section 1937(a)(1)(B) of such Act (42 U.S.C. 1396u–7(a)(1)(B)) is amended by inserting “subclause (VIII) of section 1902(a)(10)(A)(i) or under” after “eligible under”.

(b) MAINTENANCE OF MEDICAID INCOME ELIGIBILITY.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(1) in subsection (a)—

(A) by striking “and” at the end of paragraph (72);

(B) by striking the period at the end of paragraph (73) and inserting “; and”; and

(C) by inserting after paragraph (73) the following new paragraph:

“(74) provide for maintenance of effort under the State plan or under any waiver of the plan in accordance with subsection (gg).”; and

(2) by adding at the end the following new subsection: “(gg) MAINTENANCE OF EFFORT.—

“(1) GENERAL REQUIREMENT TO MAINTAIN ELIGIBILITY STANDARDS UNTIL STATE EXCHANGE IS FULLY OPERATIONAL.—Subject to the succeeding paragraphs of this subsection, during the period that begins on the date of enactment of the Patient Protection and Affordable Care Act and ends on the date on which the Secretary determines that an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act is fully operational, as a condition for receiving any Federal payments under section 1903(a) for calendar quarters occurring during such period, a State shall not have in effect eligibility standards, methodologies, or procedures under the State plan under this title or under any waiver of such plan that is in effect during that period, that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under the plan or waiver that are in effect on the date of enactment of the Patient Protection and Affordable Care Act.

“(2) CONTINUATION OF ELIGIBILITY STANDARDS FOR CHILDREN UNTIL OCTOBER 1, 2019.—The requirement under paragraph (1) shall continue to apply to a State through September 30, 2019, with respect to the eligibility standards, methodologies, and procedures under the State plan under this title

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or under any waiver of such plan that are applicable to determining the eligibility for medical assistance of any child who is under 19 years of age (or such higher age as the State may have elected).

“(3) NONAPPLICATION.—During the period that begins on January 1, 2011, and ends on December 31, 2013, the requirement under paragraph (1) shall not apply to a State with respect to nonpregnant, nondisabled adults who are eligible for medical assistance under the State plan or under a waiver of the plan at the option of the State and whose income exceeds 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved if, on or after December 31, 2010, the State certifies to the Secretary that, with respect to the State fiscal year during which the certification is made, the State has a budget deficit, or with respect to the succeeding State fiscal year, the State is projected to have a budget deficit. Upon submission of such a certification to the Secretary, the requirement under paragraph (1) shall not apply to the State with respect to any remaining portion of the period described in the preceding sentence.

“(4) DETERMINATION OF COMPLIANCE.—

“(A) STATES SHALL APPLY MODIFIED ADJUSTED GROSS INCOME.—A State’s determination of income in accordance with subsection (e)(14) shall not be considered to be eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act for purposes of determining compliance with the requirements of paragraph (1), (2), or (3). *[As revised by section 1004(b)(1)(B) of HCERA]*

“(B) STATES MAY EXPAND ELIGIBILITY OR MOVE WAIVERED POPULATIONS INTO COVERAGE UNDER THE STATE PLAN.—With respect to any period applicable under paragraph (1), (2), or (3), a State that applies eligibility standards, methodologies, or procedures under the State plan under this title or under any waiver of the plan that are less restrictive than the eligibility standards, methodologies, or procedures, applied under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act, or that makes individuals who, on such date of enactment, are eligible for medical assistance under a waiver of the State plan, after such date of enactment eligible for medical assistance through a State plan amendment with an income eligibility level that is not less than the income eligibility level that applied under the waiver, or as a result of the application of subclause (VIII) of section 1902(a)(10)(A)(i), shall not be considered to have in effect eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).”.

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(c) **MEDICAID BENCHMARK BENEFITS MUST CONSIST OF AT LEAST MINIMUM ESSENTIAL COVERAGE.**—Section 1937(b) of such Act (42 U.S.C. 1396u–7(b)) is amended—

(1) in paragraph (1), in the matter preceding subparagraph (A), by inserting “subject to paragraphs (5) and (6),” before “each”;

(2) in paragraph (2)—

(A) in the matter preceding subparagraph (A), by inserting “subject to paragraphs (5) and (6)” after “subsection (a)(1),”;

(B) in subparagraph (A)—

(i) by redesignating clauses (iv) and (v) as clauses (vi) and (vii), respectively; and

(ii) by inserting after clause (iii), the following:

“(iv) Coverage of prescription drugs.

“(v) Mental health services.”; and

(C) in subparagraph (C)—

(i) by striking clauses (i) and (ii); and

(ii) by redesignating clauses (iii) and (iv) as clauses

(i) and (ii), respectively; and

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

“(5) **MINIMUM STANDARDS.**—Effective January 1, 2014, any benchmark benefit package under paragraph (1) or benchmark equivalent coverage under paragraph (2) must provide at least essential health benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.

“(6) **MENTAL HEALTH SERVICES PARITY.**—

“(A) **IN GENERAL.**—In the case of any benchmark benefit package under paragraph (1) or benchmark equivalent coverage under paragraph (2) that is offered by an entity that is not a medicaid managed care organization and that provides both medical and surgical benefits and mental health or substance use disorder benefits, the entity shall ensure that the financial requirements and treatment limitations applicable to such mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

“(B) **DEEMED COMPLIANCE.**—Coverage provided with respect to an individual described in section 1905(a)(4)(B) and covered under the State plan under section 1902(a)(10)(A) of the services described in section 1905(a)(4)(B) (relating to early and periodic screening, diagnostic, and treatment services defined in section 1905(r)) and provided in accordance with section 1902(a)(43), shall be deemed to satisfy the requirements of subparagraph (A).”.

(d) **ANNUAL REPORTS ON MEDICAID ENROLLMENT.**—

(1) **STATE REPORTS.**—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by subsection (b), is amended—

(A) by striking “and” at the end of paragraph (73);

(B) by striking the period at the end of paragraph (74) and inserting “; and”;

(C) by inserting after paragraph (74) the following new paragraph:

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“(75) provide that, beginning January 2015, and annually thereafter, the State shall submit a report to the Secretary that contains—

“(A) the total number of enrolled and newly enrolled individuals in the State plan or under a waiver of the plan for the fiscal year ending on September 30 of the preceding calendar year, disaggregated by population, including children, parents, nonpregnant childless adults, disabled individuals, elderly individuals, and such other categories or sub-categories of individuals eligible for medical assistance under the State plan or under a waiver of the plan as the Secretary may require;

“(B) a description, which may be specified by population, of the outreach and enrollment processes used by the State during such fiscal year; and

“(C) any other data reporting determined necessary by the Secretary to monitor enrollment and retention of individuals eligible for medical assistance under the State plan or under a waiver of the plan.”.

(2) REPORTS TO CONGRESS.—Beginning April 2015, and annually thereafter, the Secretary of Health and Human Services shall submit a report to the appropriate committees of Congress on the total enrollment and new enrollment in Medicaid for the fiscal year ending on September 30 of the preceding calendar year on a national and State-by-State basis, and shall include in each such report such recommendations for administrative or legislative changes to improve enrollment in the Medicaid program as the Secretary determines appropriate.

(e) STATE OPTION FOR COVERAGE FOR INDIVIDUALS WITH INCOME THAT EXCEEDS 133 PERCENT OF THE POVERTY LINE.—

(1) COVERAGE AS OPTIONAL CATEGORICALLY NEEDY GROUP.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(A) in subsection (a)(10)(A)(ii)—

(i) in subclause (XVIII), by striking “or” at the end;

(ii) in subclause (XIX), by adding “or” at the end; and

(iii) by adding at the end the following new subclause:

“(XX) beginning January 1, 2014, who are under 65 years of age and are not described in or enrolled under a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) exceeds 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved but does not exceed the highest income eligibility level established under the State plan or under a waiver of the plan, subject to subsection (hh);” and

(B) by adding at the end the following new subsection:

“(hh)(1) A State may elect to phase-in the extension of eligibility for medical assistance to individuals described in subclause (XX) of subsection (a)(10)(A)(ii) based on the categorical group (including nonpregnant childless adults) or income, so long as the State does not extend such eligibility to individuals described in such subclause

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with higher income before making individuals described in such subclause with lower income eligible for medical assistance.

“(2) If an individual described in subclause (XX) of subsection (a)(10)(A)(ii) is the parent of a child who is under 19 years of age (or such higher age as the State may have elected) who is eligible for medical assistance under the State plan or under a waiver of such plan, the individual may not be enrolled under the State plan unless the individual’s child is enrolled under the State plan or under a waiver of the plan or is enrolled in other health insurance coverage. For purposes of the preceding sentence, the term ‘parent’ includes an individual treated as a caretaker relative for purposes of carrying out section 1931.”

(2) CONFORMING AMENDMENTS.—

(A) Section 1905(a) of such Act (42 U.S.C. 1396d(a)), as amended by subsection (a)(5)(C), is amended in the matter preceding paragraph (1)—

(i) by striking “or” at the end of clause (xiii);

(ii) by inserting “or” at the end of clause (xiv);

and

(iii) by inserting after clause (xiv) the following:

“(xv) individuals described in section 1902(a)(10)(A)(ii)(XX).”

(B) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)) is amended by inserting “1902(a)(10)(A)(ii)(XX),” after “1902(a)(10)(A)(ii)(XIX).”

(C) Section 1920(e) of such Act (42 U.S.C. 1396r-1(e)), as added by subsection (a)(4)(B), is amended by inserting “or clause (ii)(XX)” after “clause (i)(VIII).”

SEC. 2002. INCOME ELIGIBILITY FOR NONELDERLY DETERMINED USING MODIFIED GROSS INCOME.

(a) IN GENERAL.—Section 1902(e) of the Social Security Act (42 U.S.C. 1396a(e)) is amended by adding at the end the following:

“(14) INCOME DETERMINED USING MODIFIED ADJUSTED GROSS INCOME.—**[As revised by section 1004(b)(1)(A) & 1004(e) of HCERA]**

“(A) IN GENERAL.—Notwithstanding subsection (r) or any other provision of this title, except as provided in subparagraph (D), for purposes of determining income eligibility for medical assistance under the State plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required, including with respect to the imposition of premiums and cost-sharing, a State shall use the modified adjusted gross income of an individual and, in the case of an individual in a family greater than 1, the household income of such family. A State shall establish income eligibility thresholds for populations to be eligible for medical assistance under the State plan or a waiver of the plan using modified adjusted gross income and household income that are not less than the effective income eligibility levels that applied under the State plan or waiver on the date of enactment of the Patient Protection and Affordable Care Act. For purposes of complying with the maintenance of effort requirements under subsection (gg) during the transition to modified adjusted gross income and household income, a State shall,

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working with the Secretary, establish an equivalent income test that ensures individuals eligible for medical assistance under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act, do not lose coverage under the State plan or under a waiver of the plan. The Secretary may waive such provisions of this title and title XXI as are necessary to ensure that States establish income and eligibility determination systems that protect beneficiaries.

“(B) NO INCOME OR EXPENSE DISREGARDS.—Subject to subparagraph (I), no type of expense, block, or other income disregard shall be applied by a State to determine income eligibility for medical assistance under the State plan or under any waiver of such plan or for any other purpose applicable under the plan or waiver for which a determination of income is required.

“(C) NO ASSETS TEST.—A State shall not apply any assets or resources test for purposes of determining eligibility for medical assistance under the State plan or under a waiver of the plan.

“(D) EXCEPTIONS.—

“(i) INDIVIDUALS ELIGIBLE BECAUSE OF OTHER AID OR ASSISTANCE, ELDERLY INDIVIDUALS, MEDICALLY NEEDY INDIVIDUALS, AND INDIVIDUALS ELIGIBLE FOR MEDICARE COST-SHARING.—Subparagraphs (A), (B), and (C) shall not apply to the determination of eligibility under the State plan or under a waiver for medical assistance for the following:

“(I) Individuals who are eligible for medical assistance under the State plan or under a waiver of the plan on a basis that does not require a determination of income by the State agency administering the State plan or waiver, including as a result of eligibility for, or receipt of, other Federal or State aid or assistance, individuals who are eligible on the basis of receiving (or being treated as if receiving) supplemental security income benefits under title XVI, and individuals who are eligible as a result of being or being deemed to be a child in foster care under the responsibility of the State.

“(II) Individuals who have attained age 65.

“(III) Individuals who qualify for medical assistance under the State plan or under any waiver of such plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for supplemental security income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3).

“(IV) Individuals described in subsection (a)(10)(C).

“(V) Individuals described in any clause of subsection (a)(10)(E).

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“(ii) EXPRESS LANE AGENCY FINDINGS.—In the case of a State that elects the Express Lane option under paragraph (13), notwithstanding subparagraphs (A), (B), and (C), the State may rely on a finding made by an Express Lane agency in accordance with that paragraph relating to the income of an individual for purposes of determining the individual’s eligibility for medical assistance under the State plan or under a waiver of the plan.

“(iii) MEDICARE PRESCRIPTION DRUG SUBSIDIES DETERMINATIONS.—Subparagraphs (A), (B), and (C) shall not apply to any determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D–14 made by the State pursuant to section 1935(a)(2).

“(iv) LONG-TERM CARE.—Subparagraphs (A), (B), and (C) shall not apply to any determinations of eligibility of individuals for purposes of medical assistance for nursing facility services, a level of care in any institution equivalent to that of nursing facility services, home or community-based services furnished under a waiver or State plan amendment under section 1915 or a waiver under section 1115, and services described in section 1917(c)(1)(C)(ii).

“(v) GRANDFATHER OF CURRENT ENROLLEES UNTIL DATE OF NEXT REGULAR REDETERMINATION.—An individual who, on January 1, 2014, is enrolled in the State plan or under a waiver of the plan and who would be determined ineligible for medical assistance solely because of the application of the modified adjusted gross income or household income standard described in subparagraph (A), shall remain eligible for medical assistance under the State plan or waiver (and subject to the same premiums and cost-sharing as applied to the individual on that date) through March 31, 2014, or the date on which the individual’s next regularly scheduled redetermination of eligibility is to occur, whichever is later.

“(E) TRANSITION PLANNING AND OVERSIGHT.—Each State shall submit to the Secretary for the Secretary’s approval the income eligibility thresholds proposed to be established using modified adjusted gross income and household income, the methodologies and procedures to be used to determine income eligibility using modified adjusted gross income and household income and, if applicable, a State plan amendment establishing an optional eligibility category under subsection (a)(10)(A)(ii)(XX). To the extent practicable, the State shall use the same methodologies and procedures for purposes of making such determinations as the State used on the date of enactment of the Patient Protection and Affordable Care Act. The Secretary shall ensure that the income eligibility thresholds proposed to be established using modified adjusted gross income and household income, including under the eligibility category established under subsection (a)(10)(A)(ii)(XX), and the methodologies and procedures proposed to be used to determine income eligibility, will

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not result in children who would have been eligible for medical assistance under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act no longer being eligible for such assistance.

“(F) LIMITATION ON SECRETARIAL AUTHORITY.—The Secretary shall not waive compliance with the requirements of this paragraph except to the extent necessary to permit a State to coordinate eligibility requirements for dual eligible individuals (as defined in section 1915(h)(2)(B)) under the State plan or under a waiver of the plan and under title XVIII and individuals who require the level of care provided in a hospital, a nursing facility, or an intermediate care facility for the mentally retarded.

“(G) DEFINITIONS OF MODIFIED ADJUSTED GROSS INCOME AND HOUSEHOLD INCOME.—In this paragraph, the terms ‘modified adjusted gross income’ and ‘household income’ have the meanings given such terms in section 36B(d)(2) of the Internal Revenue Code of 1986.

“(H) CONTINUED APPLICATION OF MEDICAID RULES REGARDING POINT-IN-TIME INCOME AND SOURCES OF INCOME.—The requirement under this paragraph for States to use modified adjusted gross income and household income to determine income eligibility for medical assistance under the State plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required shall not be construed as affecting or limiting the application of—

“(i) the requirement under this title and under the State plan or a waiver of the plan to determine an individual’s income as of the point in time at which an application for medical assistance under the State plan or a waiver of the plan is processed; or

“(ii) any rules established under this title or under the State plan or a waiver of the plan regarding sources of countable income.

“(I) TREATMENT OF PORTION OF MODIFIED ADJUSTED GROSS INCOME.—[As added by section 1004(e)(2) of HCERA] For purposes of determining the income eligibility of an individual for medical assistance whose eligibility is determined based on the application of modified adjusted gross income under subparagraph (A), the State shall—

“(i) determine the dollar equivalent of the difference between the upper income limit on eligibility for such an individual (expressed as a percentage of the poverty line) and such upper income limit increased by 5 percentage points; and

“(ii) notwithstanding the requirement in subparagraph (A) with respect to use of modified adjusted gross income, utilize as the applicable income of such individual, in determining such income eligibility, an amount equal to the modified adjusted gross income applicable to such individual reduced by such dollar equivalent amount.”

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(b) CONFORMING AMENDMENT.—Section 1902(a)(17) of such Act (42 U.S.C. 1396a(a)(17)) is amended by inserting “(e)(14),” before “(1)(3)”.

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) take effect on January 1, 2014.

SEC. 2003. REQUIREMENT TO OFFER PREMIUM ASSISTANCE FOR EMPLOYER-SPONSORED INSURANCE.

(a) IN GENERAL.—Section 1906A of such Act (42 U.S.C. 1396e-1) is amended—

(1) in subsection (a)—

(A) by striking “may elect to” and inserting “shall”;

【*Subparagraph (B) of section 10203(b)(2), p. 805, provides: “This Act shall be applied without regard to subparagraph (A) of section 2003(a)(1) of this Act and that subparagraph and the amendment made by that subparagraph are hereby deemed null, void, and of no effect.”*】

(B) by striking “under age 19”; and

(C) by inserting “, in the case of an individual under age 19,” after “(and”;

(2) in subsection (c), in the first sentence, by striking “under age 19”; and

(3) in subsection (d)—

(A) in paragraph (2)—

(i) in the first sentence, by striking “under age 19”; and

(ii) by striking the third sentence and inserting “A State may not require, as a condition of an individual (or the individual’s parent) being or remaining eligible for medical assistance under this title, that the individual (or the individual’s parent) apply for enrollment in qualified employer-sponsored coverage under this section.”; and

(B) in paragraph (3), by striking “the parent of an individual under age 19” and inserting “an individual (or the parent of an individual”); and

(4) in subsection (e), by striking “under age 19” each place it appears.

(b) CONFORMING AMENDMENT.—The heading for section 1906A of such Act (42 U.S.C. 1396e-1) is amended by striking “OPTION FOR CHILDREN”.

(c) EFFECTIVE DATE.—The amendments made by this section take effect on January 1, 2014.

SEC. 2004. MEDICAID COVERAGE FOR FORMER FOSTER CARE CHILDREN.

(a) IN GENERAL.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396a), as amended by section 2001(a)(1), is amended—

(1) by striking “or” at the end of subclause (VII);

(2) by adding “or” at the end of subclause (VIII); and

(3) by inserting after subclause (VIII) the following:

“(IX) 【*Replaced by section 10201(a)(1)*】 who—

“(aa) are under 26 years of age;

“(bb) are not described in or enrolled under any of subclauses (I) through (VII) of this clause or are described in any of such subclauses but have income that exceeds the

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level of income applicable under the State plan for eligibility to enroll for medical assistance under such subclause;

“(cc) were in foster care under the responsibility of the State on the date of attaining 18 years of age or such higher age as the State has elected under section 475(8)(B)(iii); and

“(dd) were enrolled in the State plan under this title or under a waiver of the plan while in such foster care;”.

【Section 10201(a)(2), p. 797, provides a related amendment to section 1902(a)(10) of the SSA】

(b) **OPTION TO PROVIDE PRESUMPTIVE ELIGIBILITY.**—Section 1920(e) of such Act (42 U.S.C. 1396r–1(e)), as added by section 2001(a)(4)(B) and amended by section 2001(e)(2)(C), is amended by inserting “, clause (i)(IX),” after “clause (i)(VIII)”.

(c) **CONFORMING AMENDMENTS.**—

(1) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)), as amended by section 2001(a)(5)(D), is amended by inserting “1902(a)(10)(A)(i)(IX),” after “1902(a)(10)(A)(i)(VIII),”.

(2) Section 1937(a)(2)(B)(viii) of such Act (42 U.S.C. 1396u–7(a)(2)(B)(viii)) is amended by inserting “, or the individual qualifies for medical assistance on the basis of section 1902(a)(10)(A)(i)(IX)” before the period.

【Additional conforming amendments relating to section 1902(a)(10)(A)(i)(IX) are in section 10201(c)(1), p. 797】

(d) **EFFECTIVE DATE.**—The amendments made by this section take effect on January 1, 2014. **【As revised by section 10201(a)(3)】**

SEC. 2005. PAYMENTS TO TERRITORIES.

(a) **INCREASE IN LIMIT ON PAYMENTS.**—Section 1108(g) of the Social Security Act (42 U.S.C. 1308(g)) is amended—

(1) in paragraph (2), in the matter preceding subparagraph (A), by striking “paragraph (3)” and inserting “paragraphs (3) and (5)”;

(2) in paragraph (4), by striking “and (3)” and inserting “(3), and (4)”;

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

“(5) **ADDITIONAL INCREASE.**—**【Replaced by section 1204(b)(1)(B) of HCERA】** The Secretary shall increase the amounts otherwise determined under this subsection for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa (after the application of subsection (f) and the preceding paragraphs of this subsection) for the period beginning July 1, 2011, and ending on September 30, 2019, by such amounts that the total additional payments under title XIX to such territories equals \$6,300,000,000 for such period. The Secretary shall increase such amounts in proportion to the amounts applicable to such territories under this subsection and subsection (f) on the date of enactment of this paragraph.”.

【Subsection (b) repealed by section 1204(b)(2)(A) of HCERA】

(c) **INCREASED FMAP.**—

(1) **IN GENERAL.**—The first sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended by

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and Affordable Care Act, is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year after the application of only subsection (a) of section 5001 of Public Law 111-5 (if applicable to the preceding fiscal year) and without regard to this subsection, subsection (y), and subsections (b) and (c) of section 5001 of Public Law 111-5, by at least 3 percentage points; and

“(B) in the case of the second or any succeeding fiscal year for which this subsection applies to the State, the Federal medical assistance percentage determined for the State for the fiscal year without regard to this subsection, subsection (y), subsection (z), and section 10202 of the Patient Protection and Affordable Care Act, is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year under this subsection by at least 3 percentage points.

“(3) The Federal medical assistance percentage determined for a disaster-recovery FMAP adjustment State under paragraph (1) shall apply for purposes of this title (other than with respect to disproportionate share hospital payments described in section 1923 and payments under this title that are based on the enhanced FMAP described in 2105(b)) and shall not apply with respect to payments under title IV (other than under part E of title IV) or payments under title XXI.”

SEC. 2007. MEDICAID IMPROVEMENT FUND RESCISSION.

(a) RESCISSION.—Any amounts available to the Medicaid Improvement Fund established under section 1941 of the Social Security Act (42 U.S.C. 1396w-1) for any of fiscal years 2014 through 2018 that are available for expenditure from the Fund and that are not so obligated as of the date of the enactment of this Act are rescinded.

(b) CONFORMING AMENDMENTS.—Section 1941(b)(1) of the Social Security Act (42 U.S.C. 1396w-1(b)(1)) is amended—

(1) in subparagraph (A), by striking “\$100,000,000” and inserting “\$0”; and

(2) in subparagraph (B), by striking “\$150,000,000” and inserting “\$0”.

Subtitle B—Enhanced Support for the Children’s Health Insurance Program

SEC. 2101. ADDITIONAL FEDERAL FINANCIAL PARTICIPATION FOR CHIP.

(a) IN GENERAL.—Section 2105(b) of the Social Security Act (42 U.S.C. 1397ee(b)) is amended by adding at the end the following: **[As revised by section 10203(c)(1)]** “Notwithstanding the preceding sentence, during the period that begins on October 1, 2015, and ends on September 30, 2019, the enhanced FMAP determined for a State for a fiscal year (or for any portion of a fiscal year occurring during such period) shall be increased by 23 percentage points, but in no case shall exceed 100 percent. The increase in the enhanced FMAP under the preceding sentence shall not apply with respect to determining the payment to a State under subsection

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(a)(1) for expenditures described in subparagraph (D)(iv), paragraphs (8), (9), (11) of subsection (c), or clause (4) of the first sentence of section 1905(b).”.

(b) MAINTENANCE OF EFFORT.—

(1) IN GENERAL.—Section 2105(d) of the Social Security Act (42 U.S.C. 1397ee(d)) is amended by adding at the end the following:

“(3) CONTINUATION OF ELIGIBILITY STANDARDS FOR CHILDREN UNTIL OCTOBER 1, 2019.—

“(A) IN GENERAL.—*[As revised by section 10203(c)(2)(A)(i)]* During the period that begins on the date of enactment of the Patient Protection and Affordable Care Act and ends on September 30, 2019, as a condition of receiving payments under section 1903(a), a State shall not have in effect eligibility standards, methodologies, or procedures under its State child health plan (including any waiver under such plan) for children (including children provided medical assistance for which payment is made under section 2105(a)(1)(A)) that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) as in effect on the date of enactment of that Act. The preceding sentence shall not be construed as preventing a State during such period from—

“(i) applying eligibility standards, methodologies, or procedures for children under the State child health plan or under any waiver of the plan that are less restrictive than the eligibility standards, methodologies, or procedures, respectively, for children under the plan or waiver that are in effect on the date of enactment of such Act; *[As revised by section 10203(c)(2)(A)(ii)]*

“(ii) after September 30, 2015, enrolling children eligible to be targeted low-income children under the State child health plan in a qualified health plan that has been certified by the Secretary under subparagraph (C); or *[As added by section 10203(c)(2)(A)(iv)]*

“(iii) imposing a limitation described in section 2112(b)(7) for a fiscal year in order to limit expenditures under the State child health plan to those for which Federal financial participation is available under this section for the fiscal year.

“(B) ASSURANCE OF EXCHANGE COVERAGE FOR TARGETED LOW-INCOME CHILDREN UNABLE TO BE PROVIDED CHILD HEALTH ASSISTANCE AS A RESULT OF FUNDING SHORTFALLS.—In the event that allotments provided under section 2104 are insufficient to provide coverage to all children who are eligible to be targeted low-income children under the State child health plan under this title, a State shall establish procedures to ensure that such children are screened for eligibility for medical assistance under the State plan under title XIX or a waiver of that plan and, if found eligible, enrolled in such plan or a waiver. In the case of such children who, as a result of such screening, are determined to not be eligible for medical assistance under the State plan or a waiver under title XIX, the State shall establish procedures to ensure that the children

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are enrolled in a qualified health plan that has been certified by the Secretary under subparagraph (C) and is offered through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act. For purposes of eligibility for premium assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 and reduced cost-sharing under section 1402 of the Patient Protection and Affordable Care Act, children described in the preceding sentence shall be deemed to be ineligible for coverage under the State child health plan. **[As revised by sections 10201(g) and 10203(c)(2)(B)]**

“(C) CERTIFICATION OF COMPARABILITY OF PEDIATRIC COVERAGE OFFERED BY QUALIFIED HEALTH PLANS.—With respect to each State, the Secretary, not later than April 1, 2015, shall review the benefits offered for children and the cost-sharing imposed with respect to such benefits by qualified health plans offered through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act and shall certify those plans that offer benefits for children and impose cost-sharing with respect to such benefits that the Secretary determines are at least comparable to the benefits offered and cost-sharing protections provided under the State child health plan. **[As added by section 10203(c)(2)(C)]**”.

(2) CONFORMING AMENDMENT TO TITLE XXI MEDICAID MAINTENANCE OF EFFORT.—Section 2105(d)(1) of the Social Security Act (42 U.S.C. 1397ee(d)(1)) is amended by adding before the period “, except as required under section 1902(e)(14)”.

(c) NO ENROLLMENT BONUS PAYMENTS FOR CHILDREN ENROLLED AFTER FISCAL YEAR 2013.—Section 2105(a)(3)(F)(iii) of the Social Security Act (42 U.S.C. 1397ee(a)(3)(F)(iii)) is amended by inserting “or any children enrolled on or after October 1, 2013” before the period.

(d) INCOME ELIGIBILITY DETERMINED USING MODIFIED GROSS INCOME.—

(1) STATE PLAN REQUIREMENT.—Section 2102(b)(1)(B) of the Social Security Act (42 U.S.C. 1397bb(b)(1)(B)) is amended—

(A) in clause (iii), by striking “and” after the semicolon;

(B) in clause (iv), by striking the period and inserting “; and”; and

(C) by adding at the end the following: **[As revised by section 1004(b)(2)(A) of HCERA]**

“(v) shall, beginning January 1, 2014, use modified adjusted gross income and household income (as defined in section 36B(d)(2) of the Internal Revenue Code of 1986) to determine eligibility for child health assistance under the State child health plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required, including with respect to the imposition of premiums and cost-sharing, consistent with section 1902(e)(14).”

(2) CONFORMING AMENDMENT.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended—

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(A) by redesignating subparagraphs (E) through (L) as subparagraphs (F) through (M), respectively; and

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

“(E) Section 1902(e)(14) (relating to income determined using modified adjusted gross income and household income). **[As revised by section 1004(b)(2)(B) of HCERA]**”.

(e) APPLICATION OF STREAMLINED ENROLLMENT SYSTEM.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)), as amended by subsection (d)(2), is amended by adding at the end the following:

“(N) Section 1943(b) (relating to coordination with State Exchanges and the State Medicaid agency).”.

(f) CHIP ELIGIBILITY FOR CHILDREN INELIGIBLE FOR MEDICAID AS A RESULT OF ELIMINATION OF DISREGARDS.—Notwithstanding any other provision of law, a State shall treat any child who is determined to be ineligible for medical assistance under the State Medicaid plan or under a waiver of the plan as a result of the elimination of the application of an income disregard based on expense or type of income, as required under section 1902(e)(14) of the Social Security Act (as added by this Act), as a targeted low-income child under section 2110(b) (unless the child is excluded under paragraph (2) of that section) and shall provide child health assistance to the child under the State child health plan (whether implemented under title XIX or XXI, or both, of the Social Security Act).

[Additional CHIP amendments made by section 10203, p. 804]

SEC. 2102. TECHNICAL CORRECTIONS.

(a) CHIPRA.—Effective as if included in the enactment of the Children’s Health Insurance Program Reauthorization Act of 2009 (Public Law 111–3) (in this section referred to as “CHIPRA”):

(1) Section 2104(m) of the Social Security Act, as added by section 102 of CHIPRA, is amended—

(A) by redesignating paragraph (7) as paragraph (8); and

(B) by inserting after paragraph (6), the following:

“(7) ADJUSTMENT OF FISCAL YEAR 2010 ALLOTMENTS TO ACCOUNT FOR CHANGES IN PROJECTED SPENDING FOR CERTAIN PREVIOUSLY APPROVED EXPANSION PROGRAMS.—For purposes of recalculating the fiscal year 2010 allotment, in the case of one of the 50 States or the District of Columbia that has an approved State plan amendment effective January 1, 2006, to provide child health assistance through the provision of benefits under the State plan under title XIX for children from birth through age 5 whose family income does not exceed 200 percent of the poverty line, the Secretary shall increase the allotment by an amount that would be equal to the Federal share of expenditures that would have been claimed at the enhanced FMAP rate rather than the Federal medical assistance percentage matching rate for such population.”.

[Additional amendments to section 2104(m) of the SSA made by section 10203(d)(2), p. 805]

(2) Section 605 of CHIPRA is amended by striking “legal residents” and insert “lawfully residing in the United States”.

(3) Subclauses (I) and (II) of paragraph (3)(C)(i) of section 2105(a) of the Social Security Act (42 U.S.C. 1397ee(a)(3)(ii)),

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as added by section 104 of CHIPRA, are each amended by striking “, respectively”.

(4) Section 2105(a)(3)(E)(ii) of the Social Security Act (42 U.S.C. 1397ee(a)(3)(E)(ii)), as added by section 104 of CHIPRA, is amended by striking subclause (IV).

(5) Section 2105(c)(9)(B) of the Social Security Act (42 U.S.C. 1397e(c)(9)(B)), as added by section 211(c)(1) of CHIPRA, is amended by striking “section 1903(a)(3)(F)” and inserting “section 1903(a)(3)(G)”.

(6) Section 2109(b)(2)(B) of the Social Security Act (42 U.S.C. 1397ii(b)(2)(B)), as added by section 602 of CHIPRA, is amended by striking “the child population growth factor under section 2104(m)(5)(B)” and inserting “a high-performing State under section 2111(b)(3)(B)”.

(7) Section 2110(c)(9)(B)(v) of the Social Security Act (42 U.S.C. 1397jj(c)(9)(B)(v)), as added by section 505(b) of CHIPRA, is amended by striking “school or school system” and inserting “local educational agency (as defined under section 9101 of the Elementary and Secondary Education Act of 1965”.

(8) Section 211(a)(1)(B) of CHIPRA is amended—

(A) by striking “is amended” and all that follows through “adding” and inserting “is amended by adding”; and

(B) by redesignating the new subparagraph to be added by such section to section 1903(a)(3) of the Social Security Act as a new subparagraph (H).

(b) ARRA.—Effective as if included in the enactment of section 5006(a) of division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5), the second sentence of section 1916A(a)(1) of the Social Security Act (42 U.S.C. 1396o–1(a)(1)) is amended by striking “or (i)” and inserting “, (i), or (j)”.

Subtitle C—Medicaid and CHIP Enrollment Simplification

SEC. 2201. ENROLLMENT SIMPLIFICATION AND COORDINATION WITH STATE HEALTH INSURANCE EXCHANGES.

Title XIX of the Social Security Act (42 U.S.C. 1397aa et seq.) is amended by adding at the end the following:

“SEC. 1943. ENROLLMENT SIMPLIFICATION AND COORDINATION WITH STATE HEALTH INSURANCE EXCHANGES.

“(a) **CONDITION FOR PARTICIPATION IN MEDICAID.**—As a condition of the State plan under this title and receipt of any Federal financial assistance under section 1903(a) for calendar quarters beginning after January 1, 2014, a State shall ensure that the requirements of subsection (b) is met.

“(b) **ENROLLMENT SIMPLIFICATION AND COORDINATION WITH STATE HEALTH INSURANCE EXCHANGES AND CHIP.**—

“(1) **IN GENERAL.**—A State shall establish procedures for—

“(A) enabling individuals, through an Internet website that meets the requirements of paragraph (4), to apply for medical assistance under the State plan or under a waiver of the plan, to be enrolled in the State plan or waiver, to renew their enrollment in the plan or waiver,

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and to consent to enrollment or reenrollment in the State plan through electronic signature;

“(B) enrolling, without any further determination by the State and through such website, individuals who are identified by an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act as being eligible for—

“(i) medical assistance under the State plan or under a waiver of the plan; or

“(ii) child health assistance under the State child health plan under title XXI;

“(C) ensuring that individuals who apply for but are determined to be ineligible for medical assistance under the State plan or a waiver or ineligible for child health assistance under the State child health plan under title XXI, are screened for eligibility for enrollment in qualified health plans offered through such an Exchange and, if applicable, premium assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 (and, if applicable, advance payment of such assistance under section 1412 of the Patient Protection and Affordable Care Act), and, if eligible, enrolled in such a plan without having to submit an additional or separate application, and that such individuals receive information regarding reduced cost-sharing for eligible individuals under section 1402 of the Patient Protection and Affordable Care Act, and any other assistance or subsidies available for coverage obtained through the Exchange;

“(D) ensuring that the State agency responsible for administering the State plan under this title (in this section referred to as the ‘State Medicaid agency’), the State agency responsible for administering the State child health plan under title XXI (in this section referred to as the ‘State CHIP agency’) and an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act utilize a secure electronic interface sufficient to allow for a determination of an individual’s eligibility for such medical assistance, child health assistance, or premium assistance, and enrollment in the State plan under this title, title XXI, or a qualified health plan, as appropriate;

“(E) coordinating, for individuals who are enrolled in the State plan or under a waiver of the plan and who are also enrolled in a qualified health plan offered through such an Exchange, and for individuals who are enrolled in the State child health plan under title XXI and who are also enrolled in a qualified health plan, the provision of medical assistance or child health assistance to such individuals with the coverage provided under the qualified health plan in which they are enrolled, including services described in section 1905(a)(4)(B) (relating to early and periodic screening, diagnostic, and treatment services defined in section 1905(r)) and provided in accordance with the requirements of section 1902(a)(43); and

“(F) conducting outreach to and enrolling vulnerable and underserved populations eligible for medical assistance under this title XIX or for child health assistance under

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title XXI, including children, unaccompanied homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS.

“(2) AGREEMENTS WITH STATE HEALTH INSURANCE EXCHANGES.—The State Medicaid agency and the State CHIP agency may enter into an agreement with an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act under which the State Medicaid agency or State CHIP agency may determine whether a State resident is eligible for premium assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 (and, if applicable, advance payment of such assistance under section 1412 of the Patient Protection and Affordable Care Act), so long as the agreement meets such conditions and requirements as the Secretary of the Treasury may prescribe to reduce administrative costs and the likelihood of eligibility errors and disruptions in coverage.

“(3) STREAMLINED ENROLLMENT SYSTEM.—The State Medicaid agency and State CHIP agency shall participate in and comply with the requirements for the system established under section 1413 of the Patient Protection and Affordable Care Act (relating to streamlined procedures for enrollment through an Exchange, Medicaid, and CHIP).

“(4) ENROLLMENT WEBSITE REQUIREMENTS.—The procedures established by State under paragraph (1) shall include establishing and having in operation, not later than January 1, 2014, an Internet website that is linked to any website of an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act and to the State CHIP agency (if different from the State Medicaid agency) and allows an individual who is eligible for medical assistance under the State plan or under a waiver of the plan and who is eligible to receive premium credit assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 to compare the benefits, premiums, and cost-sharing applicable to the individual under the State plan or waiver with the benefits, premiums, and cost-sharing available to the individual under a qualified health plan offered through such an Exchange, including, in the case of a child, the coverage that would be provided for the child through the State plan or waiver with the coverage that would be provided to the child through enrollment in family coverage under that plan and as supplemental coverage by the State under the State plan or waiver.

“(5) CONTINUED NEED FOR ASSESSMENT FOR HOME AND COMMUNITY-BASED SERVICES.—Nothing in paragraph (1) shall limit or modify the requirement that the State assess an individual for purposes of providing home and community-based services under the State plan or under any waiver of such plan for individuals described in subsection (a)(10)(A)(ii)(VI).”.

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SEC. 2202. PERMITTING HOSPITALS TO MAKE PRESUMPTIVE ELIGIBILITY DETERMINATIONS FOR ALL MEDICAID ELIGIBLE POPULATIONS.

(a) IN GENERAL.—Section 1902(a)(47) of the Social Security Act (42 U.S.C. 1396a(a)(47)) is amended—

(1) by striking “at the option of the State, provide” and inserting “provide—

“(A) at the option of the State,”;

(2) by inserting “and” after the semicolon; and

(3) by adding at the end the following:

“(B) that any hospital that is a participating provider under the State plan may elect to be a qualified entity for purposes of determining, on the basis of preliminary information, whether any individual is eligible for medical assistance under the State plan or under a waiver of the plan for purposes of providing the individual with medical assistance during a presumptive eligibility period, in the same manner, and subject to the same requirements, as apply to the State options with respect to populations described in section 1920, 1920A, or 1920B (but without regard to whether the State has elected to provide for a presumptive eligibility period under any such sections), subject to such guidance as the Secretary shall establish;”.

(b) CONFORMING AMENDMENT.—Section 1903(u)(1)(D)(v) of such Act (42 U.S.C. 1396b(u)(1)(D)(v)) is amended—

(1) by striking “or for” and inserting “for”; and

(2) by inserting before the period at the end the following: “, or for medical assistance provided to an individual during a presumptive eligibility period resulting from a determination of presumptive eligibility made by a hospital that elects under section 1902(a)(47)(B) to be a qualified entity for such purpose”.

(c) EFFECTIVE DATE.—The amendments made by this section take effect on January 1, 2014, and apply to services furnished on or after that date.

Subtitle D—Improvements to Medicaid Services

SEC. 2301. COVERAGE FOR FREESTANDING BIRTH CENTER SERVICES.

(a) IN GENERAL.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), is amended—

(1) in subsection (a)—

(A) in paragraph (27), by striking “and” at the end;

(B) by redesignating paragraph (28) as paragraph (29);

and

(C) by inserting after paragraph (27) the following new paragraph:

“(28) freestanding birth center services (as defined in subsection (1)(3)(A)) and other ambulatory services that are offered by a freestanding birth center (as defined in subsection (1)(3)(B)) and that are otherwise included in the plan; and”;

(2) in subsection (1), by adding at the end the following new paragraph:

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“(3)(A) The term ‘freestanding birth center services’ means services furnished to an individual at a freestanding birth center (as defined in subparagraph (B)) at such center.

“(B) The term ‘freestanding birth center’ means a health facility—

“(i) that is not a hospital;

“(ii) where childbirth is planned to occur away from the pregnant woman’s residence;

“(iii) that is licensed or otherwise approved by the State to provide prenatal labor and delivery or postpartum care and other ambulatory services that are included in the plan; and

“(iv) that complies with such other requirements relating to the health and safety of individuals furnished services by the facility as the State shall establish.

“(C) A State shall provide separate payments to providers administering prenatal labor and delivery or postpartum care in a freestanding birth center (as defined in subparagraph (B)), such as nurse midwives and other providers of services such as birth attendants recognized under State law, as determined appropriate by the Secretary. For purposes of the preceding sentence, the term ‘birth attendant’ means an individual who is recognized or registered by the State involved to provide health care at childbirth and who provides such care within the scope of practice under which the individual is legally authorized to perform such care under State law (or the State regulatory mechanism provided by State law), regardless of whether the individual is under the supervision of, or associated with, a physician or other health care provider. Nothing in this subparagraph shall be construed as changing State law requirements applicable to a birth attendant.”.

(b) CONFORMING AMENDMENT.—Section 1902(a)(10)(A) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)), is amended in the matter preceding clause (i) by striking “and (21)” and inserting “, (21), and (28)”.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall take effect on the date of the enactment of this Act and shall apply to services furnished on or after such date.

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

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SEC. 2302. CONCURRENT CARE FOR CHILDREN.

(a) IN GENERAL.—Section 1905(o)(1) of the Social Security Act (42 U.S.C. 1396d(o)(1)) is amended—

(1) in subparagraph (A), by striking “subparagraph (B)” and inserting “subparagraphs (B) and (C)”; and

(2) by adding at the end the following new subparagraph:
 “(C) A voluntary election to have payment made for hospice care for a child (as defined by the State) shall not constitute a waiver of any rights of the child to be provided with, or to have payment made under this title for, services that are related to the treatment of the child’s condition for which a diagnosis of terminal illness has been made.”.

(b) APPLICATION TO CHIP.—Section 2110(a)(23) of the Social Security Act (42 U.S.C. 1397jj(a)(23)) is amended by inserting “(concurrent, in the case of an individual who is a child, with care related to the treatment of the child’s condition with respect to which a diagnosis of terminal illness has been made” after “hospice care”.

SEC. 2303. STATE ELIGIBILITY OPTION FOR FAMILY PLANNING SERVICES.

(a) COVERAGE AS OPTIONAL CATEGORICALLY NEEDY GROUP.—

(1) IN GENERAL.—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)), as amended by section 2001(e), is amended—

(A) in subclause (XIX), by striking “or” at the end;

(B) in subclause (XX), by adding “or” at the end; and

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

“(XXI) who are described in subsection (ii) (relating to individuals who meet certain income standards);”.

(2) GROUP DESCRIBED.—Section 1902 of such Act (42 U.S.C. 1396a), as amended by section 2001(d), is amended by adding at the end the following new subsection:

“(ii)(1) Individuals described in this subsection are individuals—

“(A) whose income does not exceed an income eligibility level established by the State that does not exceed the highest income eligibility level established under the State plan under this title (or under its State child health plan under title XXI) for pregnant women; and

“(B) who are not pregnant.

“(2) At the option of a State, individuals described in this subsection may include individuals who, had individuals applied on or before January 1, 2007, would have been made eligible pursuant to the standards and processes imposed by that State for benefits described in clause (XV) of the matter following subparagraph (G) of section subsection (a)(10) pursuant to a waiver granted under section 1115.

“(3) At the option of a State, for purposes of subsection (a)(17)(B), in determining eligibility for services under this subsection, the State may consider only the income of the applicant or recipient.”.

(3) LIMITATION ON BENEFITS.—Section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10)), as amended by section 2001(a)(5)(A), is amended in the matter following subparagraph (G)—

(A) by striking “and (XV)” and inserting “(XV)”; and

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(B) by inserting “, and (XVI) the medical assistance made available to an individual described in subsection (ii) shall be limited to family planning services and supplies described in section 1905(a)(4)(C) including medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting” before the semicolon.

(4) CONFORMING AMENDMENTS.—

(A) Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)), as amended by section 2001(e)(2)(A), is amended in the matter preceding paragraph (1)—

- (i) in clause (xiv), by striking “or” at the end;
- (ii) in clause (xv), by adding “or” at the end; and
- (iii) by inserting after clause (xv) the following: “(xvi) individuals described in section 1902(ii),”.

(B) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)), as amended by section 2001(e)(2)(B), is amended by inserting “1902(a)(10)(A)(ii)(XXI),” after “1902(a)(10)(A)(ii)(XX),”.

(b) PRESUMPTIVE ELIGIBILITY.—

(1) IN GENERAL.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by inserting after section 1920B the following:

“PRESUMPTIVE ELIGIBILITY FOR FAMILY PLANNING SERVICES

“SEC. 1920C. (a) STATE OPTION.—State plan approved under section 1902 may provide for making medical assistance available to an individual described in section 1902(ii) (relating to individuals who meet certain income eligibility standard) during a presumptive eligibility period. In the case of an individual described in section 1902(ii), such medical assistance shall be limited to family planning services and supplies described in 1905(a)(4)(C) and, at the State’s option, medical diagnosis and treatment services that are provided in conjunction with a family planning service in a family planning setting.

“(b) DEFINITIONS.—For purposes of this section:

“(1) PRESUMPTIVE ELIGIBILITY PERIOD.—The term ‘presumptive eligibility period’ means, with respect to an individual described in subsection (a), the period that—

“(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the individual is described in section 1902(ii); and

“(B) ends with (and includes) the earlier of—

“(i) the day on which a determination is made with respect to the eligibility of such individual for services under the State plan; or

“(ii) in the case of such an individual who does not file an application by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

“(2) QUALIFIED ENTITY.—

“(A) IN GENERAL.—Subject to subparagraph (B), the term ‘qualified entity’ means any entity that—

“(i) is eligible for payments under a State plan approved under this title; and

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“(ii) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A).

“(B) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing a State from limiting the classes of entities that may become qualified entities in order to prevent fraud and abuse.

“(c) ADMINISTRATION.—

“(1) IN GENERAL.—The State agency shall provide qualified entities with—

“(A) such forms as are necessary for an application to be made by an individual described in subsection (a) for medical assistance under the State plan; and

“(B) information on how to assist such individuals in completing and filing such forms.

“(2) NOTIFICATION REQUIREMENTS.—A qualified entity that determines under subsection (b)(1)(A) that an individual described in subsection (a) is presumptively eligible for medical assistance under a State plan shall—

“(A) notify the State agency of the determination within 5 working days after the date on which determination is made; and

“(B) inform such individual at the time the determination is made that an application for medical assistance is required to be made by not later than the last day of the month following the month during which the determination is made.

“(3) APPLICATION FOR MEDICAL ASSISTANCE.—In the case of an individual described in subsection (a) who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the individual shall apply for medical assistance by not later than the last day of the month following the month during which the determination is made.

“(d) PAYMENT.—Notwithstanding any other provision of law, medical assistance that—

“(1) is furnished to an individual described in subsection (a)—

“(A) during a presumptive eligibility period; and

“(B) by a entity that is eligible for payments under the State plan; and

“(2) is included in the care and services covered by the State plan, shall be treated as medical assistance provided by such plan for purposes of clause (4) of the first sentence of section 1905(b).”.

(2) CONFORMING AMENDMENTS.—

(A) Section 1902(a)(47) of the Social Security Act (42 U.S.C. 1396a(a)(47)), as amended by section 2202(a), is amended—

(i) in subparagraph (A), by inserting before the semicolon at the end the following: “and provide for making medical assistance available to individuals described in subsection (a) of section 1920C during a presumptive eligibility period in accordance with such section”; and

(ii) in subparagraph (B), by striking “or 1920B” and inserting “1920B, or 1920C”.

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(B) Section 1903(u)(1)(D)(v) of such Act (42 U.S.C. 1396b(u)(1)(D)(v)), as amended by section 2202(b), is amended by inserting “or for medical assistance provided to an individual described in subsection (a) of section 1920C during a presumptive eligibility period under such section,” after “1920B during a presumptive eligibility period under such section.”

(c) CLARIFICATION OF COVERAGE OF FAMILY PLANNING SERVICES AND SUPPLIES.—Section 1937(b) of the Social Security Act (42 U.S.C. 1396u–7(b)), as amended by section 2001(c), is amended by adding at the end the following:

“(7) COVERAGE OF FAMILY PLANNING SERVICES AND SUPPLIES.—Notwithstanding the previous provisions of this section, a State may not provide for medical assistance through enrollment of an individual with benchmark coverage or benchmark-equivalent coverage under this section unless such coverage includes for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.”

(d) EFFECTIVE DATE.—The amendments made by this section take effect on the date of the enactment of this Act and shall apply to items and services furnished on or after such date.

SEC. 2304. CLARIFICATION OF DEFINITION OF MEDICAL ASSISTANCE.

Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended by inserting “or the care and services themselves, or both” before “(if provided in or after”.

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

SEC. 2401. COMMUNITY FIRST CHOICE OPTION.

Section 1915 of the Social Security Act (42 U.S.C. 1396n) is amended by adding at the end the following:

“(k) STATE PLAN OPTION TO PROVIDE HOME AND COMMUNITY-BASED ATTENDANT SERVICES AND SUPPORTS.—

“(1) IN GENERAL.—*[As revised by section 1205 of HCERA]*

Subject to the succeeding provisions of this subsection, beginning October 1, 2011, a State may provide through a State plan amendment for the provision of medical assistance for home and community-based attendant services and supports for individuals who are eligible for medical assistance under the State plan whose income does not exceed 150 percent of the poverty line (as defined in section 2110(c)(5)) or, if greater, the income level applicable for an individual who has been determined to require an institutional level of care to be eligible for nursing facility services under the State plan and with respect to whom there has been a determination that, but for the provision of such services, the individuals would require the level of care provided in a hospital, a nursing facility, an intermediate care facility for the mentally retarded, or an institution for mental diseases, the cost of which could be reimbursed under the State plan, but only if the individual chooses to receive such home and community-based attendant services and supports, and only if the State meets the following requirements:

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“(A) AVAILABILITY.—The State shall make available home and community-based attendant services and supports to eligible individuals, as needed, to assist in accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks through hands-on assistance, supervision, or cueing—

“(i) under a person-centered plan of services and supports that is based on an assessment of functional need and that is agreed to in writing by the individual or, as appropriate, the individual’s representative;

“(ii) in a home or community setting, which does not include a nursing facility, institution for mental diseases, or an intermediate care facility for the mentally retarded;

“(iii) under an agency-provider model or other model (as defined in paragraph (6)(C)); and

“(iv) the furnishing of which—

“(I) is selected, managed, and dismissed by the individual, or, as appropriate, with assistance from the individual’s representative;

“(II) is controlled, to the maximum extent possible, by the individual or where appropriate, the individual’s representative, regardless of who may act as the employer of record; and

“(III) provided by an individual who is qualified to provide such services, including family members (as defined by the Secretary).

“(B) INCLUDED SERVICES AND SUPPORTS.—In addition to assistance in accomplishing activities of daily living, instrumental activities of daily living, and health related tasks, the home and community-based attendant services and supports made available include—

“(i) the acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish activities of daily living, instrumental activities of daily living, and health related tasks;

“(ii) back-up systems or mechanisms (such as the use of beepers or other electronic devices) to ensure continuity of services and supports; and

“(iii) voluntary training on how to select, manage, and dismiss attendants.

“(C) EXCLUDED SERVICES AND SUPPORTS.—Subject to subparagraph (D), the home and community-based attendant services and supports made available do not include—

“(i) room and board costs for the individual;

“(ii) special education and related services provided under the Individuals with Disabilities Education Act and vocational rehabilitation services provided under the Rehabilitation Act of 1973;

“(iii) assistive technology devices and assistive technology services other than those under (1)(B)(ii);

“(iv) medical supplies and equipment; or

“(v) home modifications.

“(D) PERMISSIBLE SERVICES AND SUPPORTS.—The home and community-based attendant services and supports may include—

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“(i) expenditures for transition costs such as rent and utility deposits, first month’s rent and utilities, bedding, basic kitchen supplies, and other necessities required for an individual to make the transition from a nursing facility, institution for mental diseases, or intermediate care facility for the mentally retarded to a community-based home setting where the individual resides; and

“(ii) expenditures relating to a need identified in an individual’s person-centered plan of services that increase independence or substitute for human assistance, to the extent that expenditures would otherwise be made for the human assistance.

“(2) INCREASED FEDERAL FINANCIAL PARTICIPATION.—For purposes of payments to a State under section 1903(a)(1), with respect to amounts expended by the State to provide medical assistance under the State plan for home and community-based attendant services and supports to eligible individuals in accordance with this subsection during a fiscal year quarter occurring during the period described in paragraph (1), the Federal medical assistance percentage applicable to the State (as determined under section 1905(b)) shall be increased by 6 percentage points.

“(3) STATE REQUIREMENTS.—In order for a State plan amendment to be approved under this subsection, the State shall—

“(A) develop and implement such amendment in collaboration with a Development and Implementation Council established by the State that includes a majority of members with disabilities, elderly individuals, and their representatives and consults and collaborates with such individuals;

“(B) provide consumer controlled home and community-based attendant services and supports to individuals on a statewide basis, in a manner that provides such services and supports in the most integrated setting appropriate to the individual’s needs, and without regard to the individual’s age, type or nature of disability, severity of disability, or the form of home and community-based attendant services and supports that the individual requires in order to lead an independent life;

“(C) with respect to expenditures during the first full fiscal year in which the State plan amendment is implemented, maintain or exceed the level of State expenditures for medical assistance that is provided under section 1905(a), section 1915, section 1115, or otherwise to individuals with disabilities or elderly individuals attributable to the preceding fiscal year;

“(D) establish and maintain a comprehensive, continuous quality assurance system with respect to community-based attendant services and supports that—

“(i) includes standards for agency-based and other delivery models with respect to training, appeals for denials and reconsideration procedures of an individual plan, and other factors as determined by the Secretary;

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“(ii) incorporates feedback from consumers and their representatives, disability organizations, providers, families of disabled or elderly individuals, members of the community, and others and maximizes consumer independence and consumer control;

“(iii) monitors the health and well-being of each individual who receives home and community-based attendant services and supports, including a process for the mandatory reporting, investigation, and resolution of allegations of neglect, abuse, or exploitation in connection with the provision of such services and supports; and

“(iv) provides information about the provisions of the quality assurance required under clauses (i) through (iii) to each individual receiving such services; and

“(E) collect and report information, as determined necessary by the Secretary, for the purposes of approving the State plan amendment, providing Federal oversight, and conducting an evaluation under paragraph (5)(A), including data regarding how the State provides home and community-based attendant services and supports and other home and community-based services, the cost of such services and supports, and how the State provides individuals with disabilities who otherwise qualify for institutional care under the State plan or under a waiver the choice to instead receive home and community-based services in lieu of institutional care.

“(4) COMPLIANCE WITH CERTAIN LAWS.—A State shall ensure that, regardless of whether the State uses an agency-provider model or other models to provide home and community-based attendant services and supports under a State plan amendment under this subsection, such services and supports are provided in accordance with the requirements of the Fair Labor Standards Act of 1938 and applicable Federal and State laws regarding—

“(A) withholding and payment of Federal and State income and payroll taxes;

“(B) the provision of unemployment and workers compensation insurance;

“(C) maintenance of general liability insurance; and

“(D) occupational health and safety.

“(5) EVALUATION, DATA COLLECTION, AND REPORT TO CONGRESS.—

“(A) EVALUATION.—The Secretary shall conduct an evaluation of the provision of home and community-based attendant services and supports under this subsection in order to determine the effectiveness of the provision of such services and supports in allowing the individuals receiving such services and supports to lead an independent life to the maximum extent possible; the impact on the physical and emotional health of the individuals who receive such services; and an comparative analysis of the costs of services provided under the State plan amendment under this subsection and those provided under institutional care in a nursing facility, institution for mental

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diseases, or an intermediate care facility for the mentally retarded.

“(B) DATA COLLECTION.—The State shall provide the Secretary with the following information regarding the provision of home and community-based attendant services and supports under this subsection for each fiscal year for which such services and supports are provided:

“(i) The number of individuals who are estimated to receive home and community-based attendant services and supports under this subsection during the fiscal year.

“(ii) The number of individuals that received such services and supports during the preceding fiscal year.

“(iii) The specific number of individuals served by type of disability, age, gender, education level, and employment status.

“(iv) Whether the specific individuals have been previously served under any other home and community based services program under the State plan or under a waiver.

“(C) REPORTS.—Not later than—

“(i) December 31, 2013, the Secretary shall submit to Congress and make available to the public an interim report on the findings of the evaluation under subparagraph (A); and

“(ii) December 31, 2015, the Secretary shall submit to Congress and make available to the public a final report on the findings of the evaluation under subparagraph (A).

“(6) DEFINITIONS.—In this subsection:

“(A) ACTIVITIES OF DAILY LIVING.—The term ‘activities of daily living’ includes tasks such as eating, toileting, grooming, dressing, bathing, and transferring.

“(B) CONSUMER CONTROLLED.—The term ‘consumer controlled’ means a method of selecting and providing services and supports that allow the individual, or where appropriate, the individual’s representative, maximum control of the home and community-based attendant services and supports, regardless of who acts as the employer of record.

“(C) DELIVERY MODELS.—

“(i) AGENCY-PROVIDER MODEL.—The term ‘agency-provider model’ means, with respect to the provision of home and community-based attendant services and supports for an individual, subject to paragraph (4), a method of providing consumer controlled services and supports under which entities contract for the provision of such services and supports.

“(ii) OTHER MODELS.—The term ‘other models’ means, subject to paragraph (4), methods, other than an agency-provider model, for the provision of consumer controlled services and supports. Such models may include the provision of vouchers, direct cash payments, or use of a fiscal agent to assist in obtaining services.

“(D) HEALTH-RELATED TASKS.—The term ‘health-related tasks’ means specific tasks related to the needs of an individual, which can be delegated or assigned by

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licensed health-care professionals under State law to be performed by an attendant.

“(E) INDIVIDUAL’S REPRESENTATIVE.—The term ‘individual’s representative’ means a parent, family member, guardian, advocate, or other authorized representative of an individual

“(F) INSTRUMENTAL ACTIVITIES OF DAILY LIVING.—The term ‘instrumental activities of daily living’ includes (but is not limited to) meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, and traveling around and participating in the community.”

[Note that section 10202, on p. 801, provides incentives for States to offer home and community -based services as long-term care alternative to nursing homes]

SEC. 2402. REMOVAL OF BARRIERS TO PROVIDING HOME AND COMMUNITY-BASED SERVICES.

(a) OVERSIGHT AND ASSESSMENT OF THE ADMINISTRATION OF HOME AND COMMUNITY-BASED SERVICES.—The Secretary of Health and Human Services shall promulgate regulations to ensure that all States develop service systems that are designed to—

(1) allocate resources for services in a manner that is responsive to the changing needs and choices of beneficiaries receiving non-institutionally-based long-term services and supports (including such services and supports that are provided under programs other than the State Medicaid program), and that provides strategies for beneficiaries receiving such services to maximize their independence, including through the use of client-employed providers;

(2) provide the support and coordination needed for a beneficiary in need of such services (and their family caregivers or representative, if applicable) to design an individualized, self-directed, community-supported life; and

(3) improve coordination among, and the regulation of, all providers of such services under federally and State-funded programs in order to—

(A) achieve a more consistent administration of policies and procedures across programs in relation to the provision of such services; and

(B) oversee and monitor all service system functions to assure—

(i) coordination of, and effectiveness of, eligibility determinations and individual assessments;

(ii) development and service monitoring of a complaint system, a management system, a system to qualify and monitor providers, and systems for role-setting and individual budget determinations; and

(iii) an adequate number of qualified direct care workers to provide self-directed personal assistance services.

(b) ADDITIONAL STATE OPTIONS.—Section 1915(i) of the Social Security Act (42 U.S.C. 1396n(i)) is amended by adding at the end the following new paragraphs:

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“(6) STATE OPTION TO PROVIDE HOME AND COMMUNITY-BASED SERVICES TO INDIVIDUALS ELIGIBLE FOR SERVICES UNDER A WAIVER.—

“(A) IN GENERAL.—A State that provides home and community-based services in accordance with this subsection to individuals who satisfy the needs-based criteria for the receipt of such services established under paragraph (1)(A) may, in addition to continuing to provide such services to such individuals, elect to provide home and community-based services in accordance with the requirements of this paragraph to individuals who are eligible for home and community-based services under a waiver approved for the State under subsection (c), (d), or (e) or under section 1115 to provide such services, but only for those individuals whose income does not exceed 300 percent of the supplemental security income benefit rate established by section 1611(b)(1).

“(B) APPLICATION OF SAME REQUIREMENTS FOR INDIVIDUALS SATISFYING NEEDS-BASED CRITERIA.—Subject to subparagraph (C), a State shall provide home and community-based services to individuals under this paragraph in the same manner and subject to the same requirements as apply under the other paragraphs of this subsection to the provision of home and community-based services to individuals who satisfy the needs-based criteria established under paragraph (1)(A).

“(C) AUTHORITY TO OFFER DIFFERENT TYPE, AMOUNT, DURATION, OR SCOPE OF HOME AND COMMUNITY-BASED SERVICES.—A State may offer home and community-based services to individuals under this paragraph that differ in type, amount, duration, or scope from the home and community-based services offered for individuals who satisfy the needs-based criteria established under paragraph (1)(A), so long as such services are within the scope of services described in paragraph (4)(B) of subsection (c) for which the Secretary has the authority to approve a waiver and do not include room or board.

“(7) STATE OPTION TO OFFER HOME AND COMMUNITY-BASED SERVICES TO SPECIFIC, TARGETED POPULATIONS.—

“(A) IN GENERAL.—A State may elect in a State plan amendment under this subsection to target the provision of home and community-based services under this subsection to specific populations and to differ the type, amount, duration, or scope of such services to such specific populations.

“(B) 5-YEAR TERM.—

“(i) IN GENERAL.—An election by a State under this paragraph shall be for a period of 5 years.

“(ii) PHASE-IN OF SERVICES AND ELIGIBILITY PERMITTED DURING INITIAL 5-YEAR PERIOD.—A State making an election under this paragraph may, during the first 5-year period for which the election is made, phase-in the enrollment of eligible individuals, or the provision of services to such individuals, or both, so long as all eligible individuals in the State for such services are enrolled, and all such services are provided, before the end of the initial 5-year period.

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“(C) RENEWAL.—An election by a State under this paragraph may be renewed for additional 5-year terms if the Secretary determines, prior to beginning of each such renewal period, that the State has—

“(i) adhered to the requirements of this subsection and paragraph in providing services under such an election; and

“(ii) met the State’s objectives with respect to quality improvement and beneficiary outcomes.”.

(c) REMOVAL OF LIMITATION ON SCOPE OF SERVICES.—Paragraph (1) of section 1915(i) of the Social Security Act (42 U.S.C. 1396n(i)), as amended by subsection (a), is amended by striking “or such other services requested by the State as the Secretary may approve”.

(d) OPTIONAL ELIGIBILITY CATEGORY TO PROVIDE FULL MEDICAID BENEFITS TO INDIVIDUALS RECEIVING HOME AND COMMUNITY-BASED SERVICES UNDER A STATE PLAN AMENDMENT.—

(1) IN GENERAL.—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)), as amended by section 2304(a)(1), is amended—

(A) in subclause (XX), by striking “or” at the end;

(B) in subclause (XXI), by adding “or” at the end;

and

(C) by inserting after subclause (XXI), the following new subclause:

“(XXII) who are eligible for home and community-based services under needs-based criteria established under paragraph (1)(A) of section 1915(i), or who are eligible for home and community-based services under paragraph (6) of such section, and who will receive home and community-based services pursuant to a State plan amendment under such subsection;”.

(2) CONFORMING AMENDMENTS.—

(A) Section 1903(f)(4) of the Social Security Act (42 U.S.C. 1396b(f)(4)), as amended by section 2304(a)(4)(B), is amended in the matter preceding subparagraph (A), by inserting “1902(a)(10)(A)(ii)(XXII),” after “1902(a)(10)(A)(ii)(XXI),”.

(B) Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)), as so amended, is amended in the matter preceding paragraph (1)—

(i) in clause (xv), by striking “or” at the end;

(ii) in clause (xvi), by adding “or” at the end;

and

(iii) by inserting after clause (xvi) the following new clause:

“(xvii) individuals who are eligible for home and community-based services under needs-based criteria established under paragraph (1)(A) of section 1915(i), or who are eligible for home and community-based services under paragraph (6) of such section, and who will receive home and community-based services pursuant to a State plan amendment under such subsection;”.

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(e) ELIMINATION OF OPTION TO LIMIT NUMBER OF ELIGIBLE INDIVIDUALS OR LENGTH OF PERIOD FOR GRANDFATHERED INDIVIDUALS IF ELIGIBILITY CRITERIA IS MODIFIED.—Paragraph (1) of section 1915(i) of such Act (42 U.S.C. 1396n(i)) is amended—

(1) by striking subparagraph (C) and inserting the following:

“(C) PROJECTION OF NUMBER OF INDIVIDUALS TO BE PROVIDED HOME AND COMMUNITY-BASED SERVICES.—The State submits to the Secretary, in such form and manner, and upon such frequency as the Secretary shall specify, the projected number of individuals to be provided home and community-based services.”; and

(2) in subclause (II) of subparagraph (D)(ii), by striking “to be eligible for such services for a period of at least 12 months beginning on the date the individual first received medical assistance for such services” and inserting “to continue to be eligible for such services after the effective date of the modification and until such time as the individual no longer meets the standard for receipt of such services under such pre-modified criteria”.

(f) ELIMINATION OF OPTION TO WAIVE STATEWIDENESS; ADDITION OF OPTION TO WAIVE COMPARABILITY.—Paragraph (3) of section 1915(i) of such Act (42 U.S.C. 1396n(3)) is amended by striking “1902(a)(1) (relating to statewideness)” and inserting “1902(a)(10)(B) (relating to comparability)”.

(g) EFFECTIVE DATE.—The amendments made by subsections (b) through (f) take effect on the first day of the first fiscal year quarter that begins after the date of enactment of this Act.

SEC. 2403. MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION.

(a) EXTENSION OF DEMONSTRATION.—

(1) IN GENERAL.—Section 6071(h) of the Deficit Reduction Act of 2005 (42 U.S.C. 1396a note) is amended—

(A) in paragraph (1)(E), by striking “fiscal year 2011” and inserting “each of fiscal years 2011 through 2016”; and

(B) in paragraph (2), by striking “2011” and inserting “2016”.

(2) EVALUATION.—Paragraphs (2) and (3) of section 6071(g) of such Act is amended are each amended by striking “2011” and inserting “2016”.

(b) REDUCTION OF INSTITUTIONAL RESIDENCY PERIOD.—

(1) IN GENERAL.—Section 6071(b)(2) of the Deficit Reduction Act of 2005 (42 U.S.C. 1396a note) is amended—

(A) in subparagraph (A)(i), by striking “, for a period of not less than 6 months or for such longer minimum period, not to exceed 2 years, as may be specified by the State” and inserting “for a period of not less than 90 consecutive days”; and

(B) by adding at the end the following:

“Any days that an individual resides in an institution on the basis of having been admitted solely for purposes of receiving short-term rehabilitative services for a period for which payment for such services is limited under title XVIII shall not be taken into account for purposes of determining the 90-day period required under subparagraph (A)(i).”.

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(2) EFFECTIVE DATE.—The amendments made by this subsection take effect 30 days after the date of enactment of this Act.

SEC. 2404. PROTECTION FOR RECIPIENTS OF HOME AND COMMUNITY-BASED SERVICES AGAINST SPOUSAL IMPOVERISHMENT.

During the 5-year period that begins on January 1, 2014, section 1924(h)(1)(A) of the Social Security Act (42 U.S.C. 1396r-5(h)(1)(A)) shall be applied as though “is eligible for medical assistance for home and community-based services provided under subsection (c), (d), or (i) of section 1915, under a waiver approved under section 1115, or who is eligible for such medical assistance by reason of being determined eligible under section 1902(a)(10)(C) or by reason of section 1902(f) or otherwise on the basis of a reduction of income based on costs incurred for medical or other remedial care, or who is eligible for medical assistance for home and community-based attendant services and supports under section 1915(k)” were substituted in such section for “(at the option of the State) is described in section 1902(a)(10)(A)(ii)(VI)”.

SEC. 2405. FUNDING TO EXPAND STATE AGING AND DISABILITY RESOURCE CENTERS.

Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary of Health and Human Services, acting through the Assistant Secretary for Aging, \$10,000,000 for each of fiscal years 2010 through 2014, to carry out subsections (a)(20)(B)(iii) and (b)(8) of section 202 of the Older Americans Act of 1965 (42 U.S.C. 3012).

SEC. 2406. SENSE OF THE SENATE REGARDING LONG-TERM CARE.

(a) FINDINGS.—The Senate makes the following findings:

(1) Nearly 2 decades have passed since Congress seriously considered long-term care reform. The United States Bipartisan Commission on Comprehensive Health Care, also known as the “Pepper Commission”, released its “Call for Action” blueprint for health reform in September 1990. In the 20 years since those recommendations were made, Congress has never acted on the report.

(2) In 1999, under the United States Supreme Court’s decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999), individuals with disabilities have the right to choose to receive their long-term services and supports in the community, rather than in an institutional setting.

(3) Despite the Pepper Commission and *Olmstead* decision, the long-term care provided to our Nation’s elderly and disabled has not improved. In fact, for many, it has gotten far worse.

(4) In 2007, 69 percent of Medicaid long-term care spending for elderly individuals and adults with physical disabilities paid for institutional services. Only 6 states spent 50 percent or more of their Medicaid long-term care dollars on home and community-based services for elderly individuals and adults with physical disabilities while ½ of the States spent less than 25 percent. This disparity continues even though, on average, it is estimated that Medicaid dollars can support nearly 3 elderly individuals and adults with physical disabilities in home and community-based services for every individual in a nursing home. Although every State has chosen to provide certain services under home and community-based waivers,

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these services are unevenly available within and across States, and reach a small percentage of eligible individuals.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) during the 111th session of Congress, Congress should address long-term services and supports in a comprehensive way that guarantees elderly and disabled individuals the care they need; and

(2) long term services and supports should be made available in the community in addition to in institutions.

Subtitle F—Medicaid Prescription Drug Coverage

SEC. 2501. PRESCRIPTION DRUG REBATES.

(a) INCREASE IN MINIMUM REBATE PERCENTAGE FOR SINGLE SOURCE DRUGS AND INNOVATOR MULTIPLE SOURCE DRUGS.—

(1) IN GENERAL.—Section 1927(c)(1)(B) of the Social Security Act (42 U.S.C. 1396r–8(c)(1)(B)) is amended—

(A) in clause (i)—

(i) in subclause (IV), by striking “and” at the end;

(ii) in subclause (V)—

(I) by inserting “and before January 1, 2010” after “December 31, 1995,”; and

(II) by striking the period at the end and inserting “; and”; and

(iii) by adding at the end the following new subclause:

“(VI) except as provided in clause (iii), after December 31, 2009, 23.1 percent.”; and

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

“(iii) MINIMUM REBATE PERCENTAGE FOR CERTAIN DRUGS.—

“(I) IN GENERAL.—In the case of a single source drug or an innovator multiple source drug described in subclause (II), the minimum rebate percentage for rebate periods specified in clause (i)(VI) is 17.1 percent.

“(II) DRUG DESCRIBED.—For purposes of subclause (I), a single source drug or an innovator multiple source drug described in this subclause is any of the following drugs:

“(aa) A clotting factor for which a separate furnishing payment is made under section 1842(o)(5) and which is included on a list of such factors specified and updated regularly by the Secretary.

“(bb) A drug approved by the Food and Drug Administration exclusively for pediatric indications.”.

(2) RECAPTURE OF TOTAL SAVINGS DUE TO INCREASE.—Section 1927(b)(1) of such Act (42 U.S.C. 1396r–8(b)(1)) is amended by adding at the end the following new subparagraph:

“(C) SPECIAL RULE FOR INCREASED MINIMUM REBATE PERCENTAGE.—

“(i) IN GENERAL.—In addition to the amounts applied as a reduction under subparagraph (B), for

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rebate periods beginning on or after January 1, 2010, during a fiscal year, the Secretary shall reduce payments to a State under section 1903(a) in the manner specified in clause (ii), in an amount equal to the product of—

“(I) 100 percent minus the Federal medical assistance percentage applicable to the rebate period for the State; and

“(II) the amounts received by the State under such subparagraph that are attributable (as estimated by the Secretary based on utilization and other data) to the increase in the minimum rebate percentage effected by the amendments made by subsections (a)(1), (b), and (d) of section 2501 of the Patient Protection and Affordable Care Act, taking into account the additional drugs included under the amendments made by subsection (c) of section 2501 of such Act.

The Secretary shall adjust such payment reduction for a calendar quarter to the extent the Secretary determines, based upon subsequent utilization and other data, that the reduction for such quarter was greater or less than the amount of payment reduction that should have been made.

“(ii) MANNER OF PAYMENT REDUCTION.—The amount of the payment reduction under clause (i) for a State for a quarter shall be deemed an overpayment to the State under this title to be disallowed against the State’s regular quarterly draw for all Medicaid spending under section 1903(d)(2). Such a disallowance is not subject to a reconsideration under section 1116(d).”.

(b) INCREASE IN REBATE FOR OTHER DRUGS.—Section 1927(c)(3)(B) of such Act (42 U.S.C. 1396r–8(c)(3)(B)) is amended—

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

(2) in clause (ii)—

(A) by inserting “and before January 1, 2010,” after “December 31, 1993,”; and

(B) by striking the period and inserting “; and”; and

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

“(iii) after December 31, 2009, is 13 percent.”.

(c) EXTENSION OF PRESCRIPTION DRUG DISCOUNTS TO ENROLLEES OF MEDICAID MANAGED CARE ORGANIZATIONS.—

(1) IN GENERAL.—Section 1903(m)(2)(A) of such Act (42 U.S.C. 1396b(m)(2)(A)) is amended—

(A) in clause (xi), by striking “and” at the end;

(B) in clause (xii), by striking the period at the end and inserting “; and”; and

(C) by adding at the end the following:

“(xiii) such contract provides that (I) covered out-patient drugs dispensed to individuals eligible for medical assistance who are enrolled with the entity shall be subject to the same rebate required by the agreement entered into under section 1927 as the State is subject to and that the State shall collect such rebates from manufacturers, (II) capitation rates paid to the entity shall be based on actual cost experience

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related to rebates and subject to the Federal regulations requiring actuarially sound rates, and (III) the entity shall report to the State, on such timely and periodic basis as specified by the Secretary in order to include in the information submitted by the State to a manufacturer and the Secretary under section 1927(b)(2)(A), information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed to individuals eligible for medical assistance who are enrolled with the entity and for which the entity is responsible for coverage of such drug under this subsection (other than covered outpatient drugs that under subsection (j)(1) of section 1927 are not subject to the requirements of that section) and such other data as the Secretary determines necessary to carry out this subsection.”.

(2) CONFORMING AMENDMENTS.—Section 1927 (42 U.S.C. 1396r–8) is amended—

(A) in subsection (b)—

(i) in paragraph (1)(A), in the first sentence, by inserting “, including such drugs dispensed to individuals enrolled with a medicaid managed care organization if the organization is responsible for coverage of such drugs” before the period; and

(ii) in paragraph (2)(A), by inserting “including such information reported by each medicaid managed care organization,” after “for which payment was made under the plan during the period.”; and

(B) in subsection (j), by striking paragraph (1) and inserting the following:

“(1) Covered outpatient drugs are not subject to the requirements of this section if such drugs are—

“(A) dispensed by health maintenance organizations, including Medicaid managed care organizations that contract under section 1903(m); and

“(B) subject to discounts under section 340B of the Public Health Service Act.”.

(d) ADDITIONAL REBATE FOR NEW FORMULATIONS OF EXISTING DRUGS.—

(1) IN GENERAL.—Section 1927(c)(2) of the Social Security Act (42 U.S.C. 1396r–8(c)(2)) is amended by adding at the end the following new subparagraph:

“(C) TREATMENT OF NEW FORMULATIONS.—~~Replaced by section 1206(a) of HCERA~~ In the case of a drug that is a line extension of a single source drug or an innovator multiple source drug that is an oral solid dosage form, the rebate obligation with respect to such drug under this section shall be the amount computed under this section for such new drug or, if greater, the product of—

“(i) the average manufacturer price of the line extension of a single source drug or an innovator multiple source drug that is an oral solid dosage form;

“(ii) the highest additional rebate (calculated as a percentage of average manufacturer price) under this section for any strength of the original single source drug or innovator multiple source drug; and

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“(iii) the total number of units of each dosage form and strength of the line extension product paid for under the State plan in the rebate period (as reported by the State).

In this subparagraph, the term ‘line extension’ means, with respect to a drug, a new formulation of the drug, such as an extended release formulation.”

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to drugs that are paid for by a State after December 31, 2009.

(e) MAXIMUM REBATE AMOUNT.—Section 1927(c)(2) of such Act (42 U.S.C. 1396r–8(c)(2)), as amended by subsection (d), is amended by adding at the end the following new subparagraph:

“(D) MAXIMUM REBATE AMOUNT.—In no case shall the sum of the amounts applied under paragraph (1)(A)(ii) and this paragraph with respect to each dosage form and strength of a single source drug or an innovator multiple source drug for a rebate period beginning after December 31, 2009, exceed 100 percent of the average manufacturer price of the drug.”

(f) CONFORMING AMENDMENTS.—

(1) IN GENERAL.—Section 340B of the Public Health Service Act (42 U.S.C. 256b) is amended—

(A) in subsection (a)(2)(B)(i), by striking “1927(c)(4)” and inserting “1927(c)(3)”; and

(B) by striking subsection (c); and

(C) redesignating subsection (d) as subsection (c).

(2) EFFECTIVE DATE.—The amendments made by this subsection take effect on January 1, 2010.

SEC. 2502. ELIMINATION OF EXCLUSION OF COVERAGE OF CERTAIN DRUGS.

(a) IN GENERAL.—Section 1927(d) of the Social Security Act (42 U.S.C. 1397r–8(d)) is amended—

(1) in paragraph (2)—

(A) by striking subparagraphs (E), (I), and (J), respectively; and

(B) by redesignating subparagraphs (F), (G), (H), and (K) as subparagraphs (E), (F), (G), and (H), respectively; and

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

“(7) NON-EXCLUDABLE DRUGS.—The following drugs or classes of drugs, or their medical uses, shall not be excluded from coverage:

“(A) Agents when used to promote smoking cessation, including agents approved by the Food and Drug Administration under the over-the-counter monograph process for purposes of promoting, and when used to promote, tobacco cessation.

“(B) Barbiturates.

“(C) Benzodiazepines.”

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2014.

SEC. 2503. PROVIDING ADEQUATE PHARMACY REIMBURSEMENT.

(a) PHARMACY REIMBURSEMENT LIMITS.—

(1) IN GENERAL.—Section 1927(e) of the Social Security Act (42 U.S.C. 1396r–8(e)) is amended—

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(A) in paragraph (4), by striking “(or, effective January 1, 2007, two or more)”; and

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

“(5) USE OF AMP IN UPPER PAYMENT LIMITS.—The Secretary shall calculate the Federal upper reimbursement limit established under paragraph (4) as no less than 175 percent of the weighted average (determined on the basis of utilization) of the most recently reported monthly average manufacturer prices for pharmaceutically and therapeutically equivalent multiple source drug products that are available for purchase by retail community pharmacies on a nationwide basis. The Secretary shall implement a smoothing process for average manufacturer prices. Such process shall be similar to the smoothing process used in determining the average sales price of a drug or biological under section 1847A.”

(2) DEFINITION OF AMP.—Section 1927(k)(1) of such Act (42 U.S.C. 1396r–8(k)(1)) is amended—

(A) in subparagraph (A), by striking “by” and all that follows through the period and inserting “by—

“(i) wholesalers for drugs distributed to retail community pharmacies; and

“(ii) retail community pharmacies that purchase drugs directly from the manufacturer.”; and

(B) by striking subparagraph (B) and inserting the following:

“(B) EXCLUSION OF CUSTOMARY PROMPT PAY DISCOUNTS AND OTHER PAYMENTS.—

“(i) IN GENERAL.—The average manufacturer price for a covered outpatient drug shall exclude—

“(I) customary prompt pay discounts extended to wholesalers;

“(II) bona fide service fees paid by manufacturers to wholesalers or retail community pharmacies, including (but not limited to) distribution service fees, inventory management fees, product stocking allowances, and fees associated with administrative services agreements and patient care programs (such as medication compliance programs and patient education programs);

“(III) reimbursement by manufacturers for recalled, damaged, expired, or otherwise unsalable returned goods, including (but not limited to) reimbursement for the cost of the goods and any reimbursement of costs associated with return goods handling and processing, reverse logistics, and drug destruction;

“(IV) payments received from, and rebates or discounts provided to, pharmacy benefit managers, managed care organizations, health maintenance organizations, insurers, hospitals, clinics, mail order pharmacies, long term care providers, manufacturers, or any other entity that does not conduct business as a wholesaler or a retail community pharmacy *[error in final punctuation—amendment made by section 1101(c)(2) of HCERA only struck period and did not insert ‘; and’]*

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“(V) discounts provided by manufacturers under section 1860D–14A. **[As added by section 1101(c)(3) of HCERA]**

“(ii) INCLUSION OF OTHER DISCOUNTS AND PAYMENTS.—Notwithstanding clause (i), any other discounts, rebates, payments, or other financial transactions that are received by, paid by, or passed through to, retail community pharmacies shall be included in the average manufacturer price for a covered outpatient drug.”; and

(C) in subparagraph (C), by striking “the retail pharmacy class of trade” and inserting “retail community pharmacies”.

(3) DEFINITION OF MULTIPLE SOURCE DRUG.—Section 1927(k)(7) of such Act (42 U.S.C. 1396r–8(k)(7)) is amended—

(A) in subparagraph (A)(i)(III), by striking “the State” and inserting “the United States”; and

(B) in subparagraph (C)—

(i) in clause (i), by inserting “and” after the semicolon;

(ii) in clause (ii), by striking “; and” and inserting a period; and

(iii) by striking clause (iii).

(4) DEFINITIONS OF RETAIL COMMUNITY PHARMACY; WHOLESALE.—Section 1927(k) of such Act (42 U.S.C. 1396r–8(k)) is amended by adding at the end the following new paragraphs:

“(10) RETAIL COMMUNITY PHARMACY.—The term ‘retail community pharmacy’ means an independent pharmacy, a chain pharmacy, a supermarket pharmacy, or a mass merchandiser pharmacy that is licensed as a pharmacy by the State and that dispenses medications to the general public at retail prices. Such term does not include a pharmacy that dispenses prescription medications to patients primarily through the mail, nursing home pharmacies, long-term care facility pharmacies, hospital pharmacies, clinics, charitable or not-for-profit pharmacies, government pharmacies, or pharmacy benefit managers.

“(11) WHOLESALER.—The term ‘wholesaler’ means a drug wholesaler that is engaged in wholesale distribution of prescription drugs to retail community pharmacies, including (but not limited to) manufacturers, repackers, distributors, own-label distributors, private-label distributors, jobbers, brokers, warehouses (including manufacturer’s and distributor’s warehouses, chain drug warehouses, and wholesale drug warehouses) independent wholesale drug traders, and retail community pharmacies that conduct wholesale distributions.”.

(b) DISCLOSURE OF PRICE INFORMATION TO THE PUBLIC.—Section 1927(b)(3) of such Act (42 U.S.C. 1396r–8(b)(3)) is amended—

(1) in subparagraph (A)—

(A) in the first sentence, by inserting after clause (iii) the following:

“(iv) not later than 30 days after the last day of each month of a rebate period under the agreement, on the manufacturer’s total number of units that are used to calculate the monthly average manufacturer price for each covered outpatient drug;” and

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(B) in the second sentence, by inserting “(relating to the weighted average of the most recently reported monthly average manufacturer prices)” after “(D)(v)”; and

(2) in subparagraph (D)(v), by striking “average manufacturer prices” and inserting “the weighted average of the most recently reported monthly average manufacturer prices and the average retail survey price determined for each multiple source drug in accordance with subsection (f)”.

(c) CLARIFICATION OF APPLICATION OF SURVEY OF RETAIL PRICES.—Section 1927(f)(1) of such Act (42 U.S.C. 1396r–8(b)(1)) is amended—

(1) in subparagraph (A)(i), by inserting “with respect to a retail community pharmacy,” before “the determination”; and

(2) in subparagraph (C)(ii), by striking “retail pharmacies” and inserting “retail community pharmacies”.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the first day of the first calendar year quarter that begins at least 180 days after the date of enactment of this Act, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

Subtitle G—Medicaid Disproportionate Share Hospital (DSH) Payments

SEC. 2551. DISPROPORTIONATE SHARE HOSPITAL PAYMENTS.

(a) IN GENERAL.—Section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)) is amended—

(1) in paragraph (1), by striking “and (3)” and inserting “, (3), and (7)”;

(2) in paragraph (3)(A), by striking “paragraph (6)” and inserting “paragraphs (6) and (7)”;

【Note: clause (v) added to paragraph (6)(A) of section 1923(f) by section 1203(b) of HCERA】

【Note: a clause (iii) is added to paragraph (6)(B) of section 1923(f) by section 10201(e)(1)(A)】

(3) by redesignating paragraph (7) as paragraph (8); and

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

“(7) MEDICAID DSH REDUCTIONS.—**【Replaced by section 1203(2) of HCERA; previously revised by section 10201(e)(1)(B)】**

“(A) REDUCTIONS.—

“(i) IN GENERAL.—For each of fiscal years 2014 through 2020 the Secretary shall effect the following reductions:

“(I) REDUCTION IN DSH ALLOTMENTS.—The Secretary shall reduce DSH allotments to States in the amount specified under the DSH health reform methodology under subparagraph (B) for the State for the fiscal year.

“(II) REDUCTIONS IN PAYMENTS.—The Secretary shall reduce payments to States under section 1903(a) for each calendar quarter in the fiscal year, in the manner specified in clause (iii), in an amount equal to $\frac{1}{4}$ of the DSH allotment reduction under subclause (I) for the State for the fiscal year.

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“(ii) AGGREGATE REDUCTIONS.—The aggregate reductions in DSH allotments for all States under clause (i)(I) shall be equal to—

- “(I) \$500,000,000 for fiscal year 2014;
- “(II) \$600,000,000 for fiscal year 2015;
- “(III) \$600,000,000 for fiscal year 2016;
- “(IV) \$1,800,000,000 for fiscal year 2017;
- “(V) \$5,000,000,000 for fiscal year 2018;
- “(VI) \$5,600,000,000 for fiscal year 2019; and
- “(VII) \$4,000,000,000 for fiscal year 2020.

The Secretary shall distribute such aggregate reductions among States in accordance with subparagraph (B).

“(iii) MANNER OF PAYMENT REDUCTION.—The amount of the payment reduction under clause (i)(II) for a State for a quarter shall be deemed an overpayment to the State under this title to be disallowed against the State’s regular quarterly draw for all spending under section 1903(d)(2). Such a disallowance is not subject to a reconsideration under subsections (d) and (e) of section 1116.

“(iv) DEFINITION.—In this paragraph, the term ‘State’ means the 50 States and the District of Columbia.

“(B) DSH HEALTH REFORM METHODOLOGY.—The Secretary shall carry out subparagraph (A) through use of a DSH Health Reform methodology that meets the following requirements:

“(i) The methodology imposes the largest percentage reductions on the States that—

“(I) have the lowest percentages of uninsured individuals (determined on the basis of data from the Bureau of the Census, audited hospital cost reports, and other information likely to yield accurate data) during the most recent year for which such data are available; or

“(II) do not target their DSH payments on—

“(aa) hospitals with high volumes of Medicaid inpatients (as defined in subsection (b)(1)(A)); and

“(bb) hospitals that have high levels of uncompensated care (excluding bad debt).

“(ii) The methodology imposes a smaller percentage reduction on low DSH States described in paragraph (5)(B).

“(iii) The methodology takes into account the extent to which the DSH allotment for a State was included in the budget neutrality calculation for a coverage expansion approved under section 1115 as of July 31, 2009.”.

【Subsection (b) stricken by section 10201(f)】

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(3) INSTITUTION FOR MENTAL DISEASES.—The term “institution for mental diseases” has the meaning given to that term in section 1905(i) of the Social Security Act (42 U.S.C. 1396d(i)).

(4) MEDICAL ASSISTANCE.—The term “medical assistance” has the meaning given that term in section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)).

(5) STABILIZED.—The term “stabilized” means, with respect to an individual, that the emergency medical condition no longer exists with respect to the individual and the individual is no longer dangerous to self or others.

(6) STATE.—The term “State” has the meaning given that term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

Subtitle II—Improvements to the Medicaid and CHIP Payment and Access Commission (MACPAC)

SEC. 2801. MACPAC ASSESSMENT OF POLICIES AFFECTING ALL MEDICAID BENEFICIARIES.

(a) IN GENERAL.—Section 1900 of the Social Security Act (42 U.S.C. 1396) is amended—

(1) in subsection (b)—

(A) in paragraph (1)—

(i) in the paragraph heading, by inserting “FOR ALL STATES” before “AND ANNUAL”; and

(ii) in subparagraph (A), by striking “children’s”;

(iii) in subparagraph (B), by inserting “, the Secretary, and States” after “Congress”;

(iv) in subparagraph (C), by striking “March 1” and inserting “March 15”; and

(v) in subparagraph (D), by striking “June 1” and inserting “June 15”;

(B) in paragraph (2)—

(i) in subparagraph (A)—

(I) in clause (i)—

(aa) by inserting “the efficient provision of” after “expenditures for”; and

(bb) by striking “hospital, skilled nursing facility, physician, Federally-qualified health center, rural health center, and other fees” and inserting “payments to medical, dental, and health professionals, hospitals, residential and long-term care providers, providers of home and community based services, Federally-qualified health centers and rural health clinics, managed care entities, and providers of other covered items and services”; and

(II) in clause (iii), by inserting “(including how such factors and methodologies enable such beneficiaries to obtain the services for which they are eligible, affect provider supply, and affect providers that serve a disproportionate share of low-income and other vulnerable populations)” after “beneficiaries”;

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(ii) by redesignating subparagraphs (B) and (C) as subparagraphs (F) and (H), respectively;

(iii) by inserting after subparagraph (A), the following:

“(B) ELIGIBILITY POLICIES.—Medicaid and CHIP eligibility policies, including a determination of the degree to which Federal and State policies provide health care coverage to needy populations.

“(C) ENROLLMENT AND RETENTION PROCESSES.—Medicaid and CHIP enrollment and retention processes, including a determination of the degree to which Federal and State policies encourage the enrollment of individuals who are eligible for such programs and screen out individuals who are ineligible, while minimizing the share of program expenses devoted to such processes.

“(D) COVERAGE POLICIES.—Medicaid and CHIP benefit and coverage policies, including a determination of the degree to which Federal and State policies provide access to the services enrollees require to improve and maintain their health and functional status.

“(E) QUALITY OF CARE.—Medicaid and CHIP policies as they relate to the quality of care provided under those programs, including a determination of the degree to which Federal and State policies achieve their stated goals and interact with similar goals established by other purchasers of health care services.”;

(iv) by inserting after subparagraph (F) (as redesignated by clause (ii) of this subparagraph), the following:

“(G) INTERACTIONS WITH MEDICARE AND MEDICAID.—Consistent with paragraph (11), the interaction of policies under Medicaid and the Medicare program under title XVIII, including with respect to how such interactions affect access to services, payments, and dual eligible individuals.” and

(v) in subparagraph (H) (as so redesignated), by inserting “and preventive, acute, and long-term services and supports” after “barriers”;

(C) by redesignating paragraphs (3) through (9) as paragraphs (4) through (10), respectively;

(D) by inserting after paragraph (2), the following new paragraph:

“(3) RECOMMENDATIONS AND REPORTS OF STATE-SPECIFIC DATA.—MACPAC shall—

“(A) review national and State-specific Medicaid and CHIP data; and

“(B) submit reports and recommendations to Congress, the Secretary, and States based on such reviews.”;

(E) in paragraph (4), as redesignated by subparagraph (C), by striking “or any other problems” and all that follows through the period and inserting “, as well as other factors that adversely affect, or have the potential to adversely affect, access to care by, or the health care status of, Medicaid and CHIP beneficiaries. MACPAC shall include in the annual report required under paragraph (1)(D) a description of all such areas or problems identified with respect to the period addressed in the report.”;

(F) in paragraph (5), as so redesignated,—

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(i) in the paragraph heading, by inserting “AND REGULATIONS” after “REPORTS”; and

(ii) by striking “If” and inserting the following: “(A) CERTAIN SECRETARIAL REPORTS.—If”; and

(iii) in the second sentence, by inserting “and the Secretary” after “appropriate committees of Congress”; and

(iv) by adding at the end the following:

“(B) REGULATIONS.—MACPAC shall review Medicaid and CHIP regulations and may comment through submission of a report to the appropriate committees of Congress and the Secretary, on any such regulations that affect access, quality, or efficiency of health care.”;

(G) in paragraph (10), as so redesignated, by inserting “, and shall submit with any recommendations, a report on the Federal and State-specific budget consequences of the recommendations” before the period; and

(H) by adding at the end the following:

“(11) CONSULTATION AND COORDINATION WITH MEDPAC.—

“(A) IN GENERAL.—MACPAC shall consult with the Medicare Payment Advisory Commission (in this paragraph referred to as ‘MedPAC’) established under section 1805 in carrying out its duties under this section, as appropriate and particularly with respect to the issues specified in paragraph (2) as they relate to those Medicaid beneficiaries who are dually eligible for Medicaid and the Medicare program under title XVIII, adult Medicaid beneficiaries (who are not dually eligible for Medicare), and beneficiaries under Medicare. Responsibility for analysis of and recommendations to change Medicare policy regarding Medicare beneficiaries, including Medicare beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with MedPAC.

“(B) INFORMATION SHARING.—MACPAC and MedPAC shall have access to deliberations and records of the other such entity, respectively, upon the request of the other such entity.

“(12) CONSULTATION WITH STATES.—MACPAC shall regularly consult with States in carrying out its duties under this section, including with respect to developing processes for carrying out such duties, and shall ensure that input from States is taken into account and represented in MACPAC’s recommendations and reports.

“(13) COORDINATE AND CONSULT WITH THE FEDERAL COORDINATED HEALTH CARE OFFICE.—MACPAC shall coordinate and consult with the Federal Coordinated Health Care Office established under section 2081 of the Patient Protection and Affordable Care Act before making any recommendations regarding dual eligible individuals.

“(14) PROGRAMMATIC OVERSIGHT VESTED IN THE SECRETARY.—MACPAC’s authority to make recommendations in accordance with this section shall not affect, or be considered to duplicate, the Secretary’s authority to carry out Federal responsibilities with respect to Medicaid and CHIP.”;

(2) in subsection (c)(2)—

(A) by striking subparagraphs (A) and (B) and inserting the following:

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“(A) IN GENERAL.—The membership of MACPAC shall include individuals who have had direct experience as enrollees or parents or caregivers of enrollees in Medicaid or CHIP and individuals with national recognition for their expertise in Federal safety net health programs, health finance and economics, actuarial science, health plans and integrated delivery systems, reimbursement for health care, health information technology, and other providers of health services, public health, and other related fields, who provide a mix of different professions, broad geographic representation, and a balance between urban and rural representation.

“(B) INCLUSION.—The membership of MACPAC shall include (but not be limited to) physicians, dentists, and other health professionals, employers, third-party payers, and individuals with expertise in the delivery of health services. Such membership shall also include representatives of children, pregnant women, the elderly, individuals with disabilities, caregivers, and dual eligible individuals, current or former representatives of State agencies responsible for administering Medicaid, and current or former representatives of State agencies responsible for administering CHIP.”.

(3) in subsection (d)(2), by inserting “and State” after “Federal”;

(4) in subsection (e)(1), in the first sentence, by inserting “and, as a condition for receiving payments under sections 1903(a) and 2105(a), from any State agency responsible for administering Medicaid or CHIP,” after “United States”; and

(5) in subsection (f)—

(A) in the subsection heading, by striking “AUTHORIZATION OF APPROPRIATIONS” and inserting “FUNDING”;

(B) in paragraph (1), by inserting “(other than for fiscal year 2010)” before “in the same manner”; and

(C) by adding at the end the following:

“(3) FUNDING FOR FISCAL YEAR 2010.—

“(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to MACPAC to carry out the provisions of this section for fiscal year 2010, \$9,000,000.

“(B) TRANSFER OF FUNDS.—Notwithstanding section 2104(a)(13), from the amounts appropriated in such section for fiscal year 2010, \$2,000,000 is hereby transferred and made available in such fiscal year to MACPAC to carry out the provisions of this section.

“(4) AVAILABILITY.—Amounts made available under paragraphs (2) and (3) to MACPAC to carry out the provisions of this section shall remain available until expended.”.

(b) CONFORMING MEDPAC AMENDMENTS.—Section 1805(b) of the Social Security Act (42 U.S.C. 1395b–6(b)), is amended—

(1) in paragraph (1)(C), by striking “March 1 of each year (beginning with 1998)” and inserting “March 15”;

(2) in paragraph (1)(D), by inserting “, and (beginning with 2012) containing an examination of the topics described in paragraph (9), to the extent feasible” before the period; and

(3) by adding at the end the following:

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“(9) REVIEW AND ANNUAL REPORT ON MEDICAID AND COMMERCIAL TRENDS.—The Commission shall review and report on aggregate trends in spending, utilization, and financial performance under the Medicaid program under title XIX and the private market for health care services with respect to providers for which, on an aggregate national basis, a significant portion of revenue or services is associated with the Medicaid program. Where appropriate, the Commission shall conduct such review in consultation with the Medicaid and CHIP Payment and Access Commission established under section 1900 (in this section referred to as ‘MACPAC’).

“(10) COORDINATE AND CONSULT WITH THE FEDERAL COORDINATED HEALTH CARE OFFICE.—The Commission shall coordinate and consult with the Federal Coordinated Health Care Office established under section 2081 of the Patient Protection and Affordable Care Act before making any recommendations regarding dual eligible individuals.

“(11) INTERACTION OF MEDICAID AND MEDICARE.—The Commission shall consult with MACPAC in carrying out its duties under this section, as appropriate. Responsibility for analysis of and recommendations to change Medicare policy regarding Medicare beneficiaries, including Medicare beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with the Commission. Responsibility for analysis of and recommendations to change Medicaid policy regarding Medicaid beneficiaries, including Medicaid beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with MACPAC.”.

Subtitle III—Protections for American Indians and Alaska Natives

SEC. 2901. SPECIAL RULES RELATING TO INDIANS.

(a) NO COST-SHARING FOR INDIANS WITH INCOME AT OR BELOW 300 PERCENT OF POVERTY ENROLLED IN COVERAGE THROUGH A STATE EXCHANGE.—For provisions prohibiting cost sharing for Indians enrolled in any qualified health plan in the individual market through an Exchange, see section 1402(d) of the Patient Protection and Affordable Care Act.

(b) PAYER OF LAST RESORT.—Health programs operated by the Indian Health Service, Indian tribes, tribal organizations, and Urban Indian organizations (as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)) shall be the payer of last resort for services provided by such Service, tribes, or organizations to individuals eligible for services through such programs, notwithstanding any Federal, State, or local law to the contrary.

(c) FACILITATING ENROLLMENT OF INDIANS UNDER THE EXPRESS LANE OPTION.—Section 1902(e)(13)(F)(ii) of the Social Security Act (42 U.S.C. 1396a(e)(13)(F)(ii)) is amended—

(1) in the clause heading, by inserting “AND INDIAN TRIBES AND TRIBAL ORGANIZATIONS” after “AGENCIES”; and

(2) by adding at the end the following:

“(IV) The Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (as defined in section 1139(c)).”.

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(d) **TECHNICAL CORRECTIONS.**—Section 1139(c) of the Social Security Act (42 U.S.C. 1320b–9(c)) is amended by striking “In this section” and inserting “For purposes of this section, title XIX, and title XXI”.

SEC. 2902. ELIMINATION OF SUNSET FOR REIMBURSEMENT FOR ALL MEDICARE PART B SERVICES FURNISHED BY CERTAIN INDIAN HOSPITALS AND CLINICS.

(a) **REIMBURSEMENT FOR ALL MEDICARE PART B SERVICES FURNISHED BY CERTAIN INDIAN HOSPITALS AND CLINICS.**—Section 1880(e)(1)(A) of the Social Security Act (42 U.S.C. 1395qq(e)(1)(A)) is amended by striking “during the 5-year period beginning on” and inserting “on or after”.

(b) **EFFECTIVE DATE.**—The amendments made by this section shall apply to items or services furnished on or after January 1, 2010.

Subtitle IV—Maternal and Child Health Services

SEC. 2951. MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAMS.

Title V of the Social Security Act (42 U.S.C. 701 et seq.) is amended by adding at the end the following new section:

“SEC. 511. MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAMS.

“(a) **PURPOSES.**—The purposes of this section are—

“(1) to strengthen and improve the programs and activities carried out under this title;

“(2) to improve coordination of services for at risk communities; and

“(3) to identify and provide comprehensive services to improve outcomes for families who reside in at risk communities.

“(b) **REQUIREMENT FOR ALL STATES TO ASSESS STATEWIDE NEEDS AND IDENTIFY AT RISK COMMUNITIES.**—

“(1) **IN GENERAL.**—Not later than 6 months after the date of enactment of this section, each State shall, as a condition of receiving payments from an allotment for the State under section 502 for fiscal year 2011, conduct a statewide needs assessment (which shall be separate from the statewide needs assessment required under section 505(a)) that identifies—

“(A) communities with concentrations of—

“(i) premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn, or child health;

“(ii) poverty;

“(iii) crime;

“(iv) domestic violence;

“(v) high rates of high-school drop-outs;

“(vi) substance abuse;

“(vii) unemployment; or

“(viii) child maltreatment;

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ages or age groups of children and adolescents, based on developing cognitive, emotional, and behavioral capacity typical for the age or age group.

“(2) **MEDICALLY ACCURATE AND COMPLETE.**—The term ‘medically accurate and complete’ means verified or supported by the weight of research conducted in compliance with accepted scientific methods and—

“(A) published in peer-reviewed journals, where applicable; or

“(B) comprising information that leading professional organizations and agencies with relevant expertise in the field recognize as accurate, objective, and complete.

“(3) **INDIAN TRIBES; TRIBAL ORGANIZATIONS.**—The terms ‘Indian tribe’ and ‘Tribal organization’ have the meanings given such terms in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)).

“(4) **YOUTH.**—The term ‘youth’ means an individual who has attained age 10 but has not attained age 20.

“(f) **APPROPRIATION.**—For the purpose of carrying out this section, there is appropriated, out of any money in the Treasury not otherwise appropriated, \$75,000,000 for each of fiscal years 2010 through 2014. Amounts appropriated under this subsection shall remain available until expended.”

SEC. 2954. RESTORATION OF FUNDING FOR ABSTINENCE EDUCATION.

Section 510 of the Social Security Act (42 U.S.C. 710) is amended—

(1) in subsection (a), by striking “fiscal year 1998 and each subsequent fiscal year” and inserting “each of fiscal years 2010 through 2014”; and

(2) in subsection (d)—

(A) in the first sentence, by striking “1998 through 2003” and inserting “2010 through 2014”; and

(B) in the second sentence, by inserting “(except that such appropriation shall be made on the date of enactment of the Patient Protection and Affordable Care Act in the case of fiscal year 2010)” before the period.

SEC. 2955. INCLUSION OF INFORMATION ABOUT THE IMPORTANCE OF HAVING A HEALTH CARE POWER OF ATTORNEY IN TRANSITION PLANNING FOR CHILDREN AGING OUT OF FOSTER CARE AND INDEPENDENT LIVING PROGRAMS.

(a) **TRANSITION PLANNING.**—Section 475(5)(H) of the Social Security Act (42 U.S.C. 675(5)(H)) is amended by inserting “includes information about the importance of designating another individual to make health care treatment decisions on behalf of the child if the child becomes unable to participate in such decisions and the child does not have, or does not want, a relative who would otherwise be authorized under State law to make such decisions, and provides the child with the option to execute a health care power of attorney, health care proxy, or other similar document recognized under State law,” after “employment services,”.

(b) **INDEPENDENT LIVING EDUCATION.**—Section 477(b)(3) of such Act (42 U.S.C. 677(b)(3)) is amended by adding at the end the following:

“(K) A certification by the chief executive officer of the State that the State will ensure that an adolescent

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participating in the program under this section are provided with education about the importance of designating another individual to make health care treatment decisions on behalf of the adolescent if the adolescent becomes unable to participate in such decisions and the adolescent does not have, or does not want, a relative who would otherwise be authorized under State law to make such decisions, whether a health care power of attorney, health care proxy, or other similar document is recognized under State law, and how to execute such a document if the adolescent wants to do so.”

(c) HEALTH OVERSIGHT AND COORDINATION PLAN.—Section 422(b)(15)(A) of such Act (42 U.S.C. 622(b)(15)(A)) is amended—

(1) in clause (v), by striking “and” at the end; and

(2) by adding at the end the following:

“(vii) steps to ensure that the components of the transition plan development process required under section 475(5)(H) that relate to the health care needs of children aging out of foster care, including the requirements to include options for health insurance, information about a health care power of attorney, health care proxy, or other similar document recognized under State law, and to provide the child with the option to execute such a document, are met; and”.

(d) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2010.

TITLE III—IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE

Subtitle A—Transforming the Health Care Delivery System

PART 1—LINKING PAYMENT TO QUALITY OUTCOMES UNDER THE MEDICARE PROGRAM

SEC. 3001. HOSPITAL VALUE-BASED PURCHASING PROGRAM.

(a) PROGRAM.—

(1) IN GENERAL.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by section 4102(a) of the HITECH Act (Public Law 111–5), is amended by adding at the end the following new subsection:

“(o) HOSPITAL VALUE-BASED PURCHASING PROGRAM.—

“(1) ESTABLISHMENT.—

“(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall establish a hospital value-based purchasing program (in this subsection referred to as the ‘Program’) under which value-based incentive payments are made in a fiscal year to hospitals that meet the performance standards under paragraph (3) for the performance period for such fiscal year (as established under paragraph (4)).

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than one such plan available, the Secretary shall enroll such an individual under the preceding sentence on a random basis among all such plans in the PDP region. Nothing in the previous sentence shall prevent such an individual from declining or changing such enrollment.”.

(c) **EFFECTIVE DATE.**—The amendments made by this subsection shall apply to premiums for months, and enrollments for plan years, beginning on or after January 1, 2011.

SEC. 3304. SPECIAL RULE FOR WIDOWS AND WIDOWERS REGARDING ELIGIBILITY FOR LOW-INCOME ASSISTANCE.

(a) **IN GENERAL.**—Section 1860D–14(a)(3)(B) of the Social Security Act (42 U.S.C. 1395w–114(a)(3)(B)) is amended by adding at the end the following new clause:

“(vi) **SPECIAL RULE FOR WIDOWS AND WIDOWERS.**—Notwithstanding the preceding provisions of this subparagraph, in the case of an individual whose spouse dies during the effective period for a determination or redetermination that has been made under this subparagraph, such effective period shall be extended through the date that is 1 year after the date on which the determination or redetermination would (but for the application of this clause) otherwise cease to be effective.”.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall take effect on January 1, 2011.

SEC. 3305. IMPROVED INFORMATION FOR SUBSIDY ELIGIBLE INDIVIDUALS REASSIGNED TO PRESCRIPTION DRUG PLANS AND MA-PD PLANS.

Section 1860D–14 of the Social Security Act (42 U.S.C. 1395w–114) is amended—

- (1) by redesignating subsection (d) as subsection (e); and
- (2) by inserting after subsection (c) the following new subsection:

“(d) **FACILITATION OF REASSIGNMENTS.**—Beginning not later than January 1, 2011, the Secretary shall, in the case of a subsidy eligible individual who is enrolled in one prescription drug plan and is subsequently reassigned by the Secretary to a new prescription drug plan, provide the individual, within 30 days of such reassignment, with—

“(1) information on formulary differences between the individual’s former plan and the plan to which the individual is reassigned with respect to the individual’s drug regimens; and

“(2) a description of the individual’s right to request a coverage determination, exception, or reconsideration under section 1860D–4(g), bring an appeal under section 1860D–4(h), or resolve a grievance under section 1860D–4(f).”.

SEC. 3306. FUNDING OUTREACH AND ASSISTANCE FOR LOW-INCOME PROGRAMS.

(a) **ADDITIONAL FUNDING FOR STATE HEALTH INSURANCE PROGRAMS.**—Subsection (a)(1)(B) of section 119 of the Medicare Improvements for Patients and Providers Act of 2008 (42 U.S.C. 1395b–3 note) is amended by striking “(42 U.S.C. 1395w–23(f))” and all that follows through the period at the end and inserting

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“(42 U.S.C. 1395w–23(f), to the Centers for Medicare & Medicaid Services Program Management Account—

- “(i) for fiscal year 2009, of \$7,500,000; and
- “(ii) for the period of fiscal years 2010 through 2012, of \$15,000,000.

Amounts appropriated under this subparagraph shall remain available until expended.”.

(b) ADDITIONAL FUNDING FOR AREA AGENCIES ON AGING.—Subsection (b)(1)(B) of such section 119 is amended by striking “(42 U.S.C. 1395w–23(f))” and all that follows through the period at the end and inserting “(42 U.S.C. 1395w–23(f), to the Administration on Aging—

- “(i) for fiscal year 2009, of \$7,500,000; and
- “(ii) for the period of fiscal years 2010 through 2012, of \$15,000,000.

Amounts appropriated under this subparagraph shall remain available until expended.”.

(c) ADDITIONAL FUNDING FOR AGING AND DISABILITY RESOURCE CENTERS.—Subsection (c)(1)(B) of such section 119 is amended by striking “(42 U.S.C. 1395w–23(f))” and all that follows through the period at the end and inserting “(42 U.S.C. 1395w–23(f), to the Administration on Aging—

- “(i) for fiscal year 2009, of \$5,000,000; and
- “(ii) for the period of fiscal years 2010 through 2012, of \$10,000,000.

Amounts appropriated under this subparagraph shall remain available until expended.”.

(d) ADDITIONAL FUNDING FOR CONTRACT WITH THE NATIONAL CENTER FOR BENEFITS AND OUTREACH ENROLLMENT.—Subsection (d)(2) of such section 119 is amended by striking “(42 U.S.C. 1395w–23(f))” and all that follows through the period at the end and inserting “(42 U.S.C. 1395w–23(f), to the Administration on Aging—

- “(i) for fiscal year 2009, of \$5,000,000; and
- “(ii) for the period of fiscal years 2010 through 2012, of \$5,000,000.

Amounts appropriated under this subparagraph shall remain available until expended.”.

(e) SECRETARIAL AUTHORITY TO ENLIST SUPPORT IN CONDUCTING CERTAIN OUTREACH ACTIVITIES.—Such section 119 is amended by adding at the end the following new subsection:

“(g) SECRETARIAL AUTHORITY TO ENLIST SUPPORT IN CONDUCTING CERTAIN OUTREACH ACTIVITIES.—The Secretary may request that an entity awarded a grant under this section support the conduct of outreach activities aimed at preventing disease and promoting wellness. Notwithstanding any other provision of this section, an entity may use a grant awarded under this subsection to support the conduct of activities described in the preceding sentence.”.

SEC. 3307. IMPROVING FORMULARY REQUIREMENTS FOR PRESCRIPTION DRUG PLANS AND MA-PD PLANS WITH RESPECT TO CERTAIN CATEGORIES OR CLASSES OF DRUGS.

(a) IMPROVING FORMULARY REQUIREMENTS.—Section 1860D–4(b)(3)(G) of the Social Security Act is amended to read as follows:

“(G) REQUIRED INCLUSION OF DRUGS IN CERTAIN CATEGORIES AND CLASSES.—

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(i) by striking “Return information” and inserting the following:

“(i) IN GENERAL.—Return information”;

(ii) by inserting “or increase under such section 1860D–13(a)(7)” before the period at the end;

(iii) as amended by clause (i), by inserting “or for the purpose of resolving taxpayer appeals with respect to any such premium adjustment or increase” before the period at the end; and

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

“(ii) DISCLOSURE TO OTHER AGENCIES.—Officers, employees, and contractors of the Social Security Administration may disclose—

“(I) the taxpayer identity information and the amount of the premium subsidy adjustment or premium increase with respect to a taxpayer described in subparagraph (A) to officers, employees, and contractors of the Centers for Medicare and Medicaid Services, to the extent that such disclosure is necessary for the collection of the premium subsidy amount or the increased premium amount,

“(II) the taxpayer identity information and the amount of the premium subsidy adjustment or the increased premium amount with respect to a taxpayer described in subparagraph (A) to officers and employees of the Office of Personnel Management and the Railroad Retirement Board, to the extent that such disclosure is necessary for the collection of the premium subsidy amount or the increased premium amount,

“(III) return information with respect to a taxpayer described in subparagraph (A) to officers and employees of the Department of Health and Human Services to the extent necessary to resolve administrative appeals of such premium subsidy adjustment or increased premium, and

“(IV) return information with respect to a taxpayer described in subparagraph (A) to officers and employees of the Department of Justice for use in judicial proceedings to the extent necessary to carry out the purposes described in clause (i).”.

SEC. 3309. ELIMINATION OF COST SHARING FOR CERTAIN DUAL ELIGIBLE INDIVIDUALS.

Section 1860D–14(a)(1)(D)(i) of the Social Security Act (42 U.S.C. 1395w–114(a)(1)(D)(i)) is amended by inserting “or, effective on a date specified by the Secretary (but in no case earlier than January 1, 2012), who would be such an institutionalized individual or couple, if the full-benefit dual eligible individual were not receiving services under a home and community-based waiver authorized for a State under section 1115 or subsection (c) or (d) of section 1915 or under a State plan amendment under subsection (i) of such section or services provided through enrollment in a medicaid managed care organization with a contract under section 1903(m) or under section 1932” after “1902(q)(1)(B))”.

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(2) by adding at the end the following new sentence: “Paragraph (1) of the first sentence of this subsection shall apply with respect to a colorectal cancer screening test regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as the screening test.”.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2011.

SEC. 4105. EVIDENCE-BASED COVERAGE OF PREVENTIVE SERVICES IN MEDICARE.

(a) AUTHORITY TO MODIFY OR ELIMINATE COVERAGE OF CERTAIN PREVENTIVE SERVICES.—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

“(n) AUTHORITY TO MODIFY OR ELIMINATE COVERAGE OF CERTAIN PREVENTIVE SERVICES.—Notwithstanding any other provision of this title, effective beginning on January 1, 2010, if the Secretary determines appropriate, the Secretary may—

“(1) modify—

“(A) the coverage of any preventive service described in subparagraph (A) of section 1861(ddd)(3) to the extent that such modification is consistent with the recommendations of the United States Preventive Services Task Force; and

“(B) the services included in the initial preventive physical examination described in subparagraph (B) of such section; and

“(2) provide that no payment shall be made under this title for a preventive service described in subparagraph (A) of such section that has not received a grade of A, B, C, or I by such Task Force.”.

(b) CONSTRUCTION.—Nothing in the amendment made by paragraph (1) shall be construed to affect the coverage of diagnostic or treatment services under title XVIII of the Social Security Act.

SEC. 4106. IMPROVING ACCESS TO PREVENTIVE SERVICES FOR ELIGIBLE ADULTS IN MEDICAID.

(a) CLARIFICATION OF INCLUSION OF SERVICES.—Section 1905(a)(13) of the Social Security Act (42 U.S.C. 1396d(a)(13)) is amended to read as follows:

“(13) other diagnostic, screening, preventive, and rehabilitative services, including—

“(A) any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force;

“(B) with respect to an adult individual, approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention) and their administration; and

“(C) any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within

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the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level;”.

(b) INCREASED FMAP.—Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), as amended by sections 2001(a)(3)(A) and 2004(c)(1), is amended in the first sentence—

(1) by striking “, and (4)” and inserting “, (4)”; and

(2) by inserting before the period the following: “, and (5) in the case of a State that provides medical assistance for services and vaccines described in subparagraphs (A) and (B) of subsection (a)(13), and prohibits cost-sharing for such services and vaccines, the Federal medical assistance percentage, as determined under this subsection and subsection (y) (without regard to paragraph (1)(C) of such subsection), shall be increased by 1 percentage point with respect to medical assistance for such services and vaccines and for items and services described in subsection (a)(4)(D)”.

(c) EFFECTIVE DATE.—The amendments made under this section shall take effect on January 1, 2013.

SEC. 4107. COVERAGE OF COMPREHENSIVE TOBACCO CESSATION SERVICES FOR PREGNANT WOMEN IN MEDICAID.

(a) REQUIRING COVERAGE OF COUNSELING AND PHARMACOTHERAPY FOR CESSATION OF TOBACCO USE BY PREGNANT WOMEN.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by sections 2001(a)(3)(B) and 2303, is further amended—

(1) in subsection (a)(4)—

(A) by striking “and” before “(C)”; and

(B) by inserting before the semicolon at the end the following new subparagraph: “; and (D) counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in subsection (bb))”; and

(2) by adding at the end the following:

“(bb)(1) For purposes of this title, the term ‘counseling and pharmacotherapy for cessation of tobacco use by pregnant women’ means diagnostic, therapy, and counseling services and pharmacotherapy (including the coverage of prescription and non-prescription tobacco cessation agents approved by the Food and Drug Administration) for cessation of tobacco use by pregnant women who use tobacco products or who are being treated for tobacco use that is furnished—

“(A) by or under the supervision of a physician; or

“(B) by any other health care professional who—

“(i) is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished; and

“(ii) is authorized to receive payment for other services under this title or is designated by the Secretary for this purpose.

“(2) Subject to paragraph (3), such term is limited to—

“(A) services recommended with respect to pregnant women in ‘Treating Tobacco Use and Dependence: 2008 Update: A Clinical Practice Guideline’, published by the Public Health

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Service in May 2008, or any subsequent modification of such Guideline; and

“(B) such other services that the Secretary recognizes to be effective for cessation of tobacco use by pregnant women.

“(3) Such term shall not include coverage for drugs or biologicals that are not otherwise covered under this title.”

(b) EXCEPTION FROM OPTIONAL RESTRICTION UNDER MEDICAID PRESCRIPTION DRUG COVERAGE.—Section 1927(d)(2)(F) of the Social Security Act (42 U.S.C. 1396r–8(d)(2)(F)), as redesignated by section 2502(a), is amended by inserting before the period at the end the following: “, except, in the case of pregnant women when recommended in accordance with the Guideline referred to in section 1905(bb)(2)(A), agents approved by the Food and Drug Administration under the over-the-counter monograph process for purposes of promoting, and when used to promote, tobacco cessation”.

(c) REMOVAL OF COST-SHARING FOR COUNSELING AND PHARMACOTHERAPY FOR CESSATION OF TOBACCO USE BY PREGNANT WOMEN.—

(1) GENERAL COST-SHARING LIMITATIONS.—Section 1916 of the Social Security Act (42 U.S.C. 1396o) is amended in each of subsections (a)(2)(B) and (b)(2)(B) by inserting “, and counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in section 1905(bb)) and covered outpatient drugs (as defined in subsection (k)(2) of section 1927 and including nonprescription drugs described in subsection (d)(2) of such section) that are prescribed for purposes of promoting, and when used to promote, tobacco cessation by pregnant women in accordance with the Guideline referred to in section 1905(bb)(2)(A)” after “complicate the pregnancy”.

(2) APPLICATION TO ALTERNATIVE COST-SHARING.—Section 1916A(b)(3)(B)(iii) of such Act (42 U.S.C. 1396o–1(b)(3)(B)(iii)) is amended by inserting “, and counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in section 1905(bb))” after “complicate the pregnancy”.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on October 1, 2010.

SEC. 4108. INCENTIVES FOR PREVENTION OF CHRONIC DISEASES IN MEDICAID.

(a) INITIATIVES.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The Secretary shall award grants to States to carry out initiatives to provide incentives to Medicaid beneficiaries who—

(i) successfully participate in a program described in paragraph (3); and

(ii) upon completion of such participation, demonstrate changes in health risk and outcomes, including the adoption and maintenance of healthy behaviors by meeting specific targets (as described in subsection (c)(2)).

(B) PURPOSE.—The purpose of the initiatives under this section is to test approaches that may encourage behavior modification and determine scalable solutions.

(2) DURATION.—

(A) INITIATION OF PROGRAM; RESOURCES.—The Secretary shall award grants to States beginning on January

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1, 2011, or beginning on the date on which the Secretary develops program criteria, whichever is earlier. The Secretary shall develop program criteria for initiatives under this section using relevant evidence-based research and resources, including the Guide to Community Preventive Services, the Guide to Clinical Preventive Services, and the National Registry of Evidence-Based Programs and Practices.

(B) DURATION OF PROGRAM.—A State awarded a grant to carry out initiatives under this section shall carry out such initiatives within the 5-year period beginning on January 1, 2011, or beginning on the date on which the Secretary develops program criteria, whichever is earlier. Initiatives under this section shall be carried out by a State for a period of not less than 3 years.

(3) PROGRAM DESCRIBED.—

(A) IN GENERAL.—A program described in this paragraph is a comprehensive, evidence-based, widely available, and easily accessible program, proposed by the State and approved by the Secretary, that is designed and uniquely suited to address the needs of Medicaid beneficiaries and has demonstrated success in helping individuals achieve one or more of the following:

- (i) Ceasing use of tobacco products.
- (ii) Controlling or reducing their weight.
- (iii) Lowering their cholesterol.
- (iv) Lowering their blood pressure.
- (v) Avoiding the onset of diabetes or, in the case of a diabetic, improving the management of that condition.

(B) CO-MORBIDITIES.—A program under this section may also address co-morbidities (including depression) that are related to any of the conditions described in subparagraph (A).

(C) WAIVER AUTHORITY.—The Secretary may waive the requirements of section 1902(a)(1) (relating to statewideness) of the Social Security Act for a State awarded a grant to conduct an initiative under this section and shall ensure that a State makes any program described in subparagraph (A) available and accessible to Medicaid beneficiaries.

(D) FLEXIBILITY IN IMPLEMENTATION.—A State may enter into arrangements with providers participating in Medicaid, community-based organizations, faith-based organizations, public-private partnerships, Indian tribes, or similar entities or organizations to carry out programs described in subparagraph (A).

(4) APPLICATION.—Following the development of program criteria by the Secretary, a State may submit an application, in such manner and containing such information as the Secretary may require, that shall include a proposal for programs described in paragraph (3)(A) and a plan to make Medicaid beneficiaries and providers participating in Medicaid who reside in the State aware and informed about such programs.

(b) EDUCATION AND OUTREACH CAMPAIGN.—

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(1) STATE AWARENESS.—The Secretary shall conduct an outreach and education campaign to make States aware of the grants under this section.

(2) PROVIDER AND BENEFICIARY EDUCATION.—A State awarded a grant to conduct an initiative under this section shall conduct an outreach and education campaign to make Medicaid beneficiaries and providers participating in Medicaid who reside in the State aware of the programs described in subsection (a)(3) that are to be carried out by the State under the grant.

(c) IMPACT.—A State awarded a grant to conduct an initiative under this section shall develop and implement a system to—

(1) track Medicaid beneficiary participation in the program and validate changes in health risk and outcomes with clinical data, including the adoption and maintenance of health behaviors by such beneficiaries;

(2) to the extent practicable, establish standards and health status targets for Medicaid beneficiaries participating in the program and measure the degree to which such standards and targets are met;

(3) evaluate the effectiveness of the program and provide the Secretary with such evaluations;

(4) report to the Secretary on processes that have been developed and lessons learned from the program; and

(5) report on preventive services as part of reporting on quality measures for Medicaid managed care programs.

(d) EVALUATIONS AND REPORTS.—

(1) INDEPENDENT ASSESSMENT.—The Secretary shall enter into a contract with an independent entity or organization to conduct an evaluation and assessment of the initiatives carried out by States under this section, for the purpose of determining—

(A) the effect of such initiatives on the use of health care services by Medicaid beneficiaries participating in the program;

(B) the extent to which special populations (including adults with disabilities, adults with chronic illnesses, and children with special health care needs) are able to participate in the program;

(C) the level of satisfaction of Medicaid beneficiaries with respect to the accessibility and quality of health care services provided through the program; and

(D) the administrative costs incurred by State agencies that are responsible for administration of the program.

(2) STATE REPORTING.—A State awarded a grant to carry out initiatives under this section shall submit reports to the Secretary, on a semi-annual basis, regarding the programs that are supported by the grant funds. Such report shall include information, as specified by the Secretary, regarding—

(A) the specific uses of the grant funds;

(B) an assessment of program implementation and lessons learned from the programs;

(C) an assessment of quality improvements and clinical outcomes under such programs; and

(D) estimates of cost savings resulting from such programs.

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(3) INITIAL REPORT.—Not later than January 1, 2014, the Secretary shall submit to Congress an initial report on such initiatives based on information provided by States through reports required under paragraph (2). The initial report shall include an interim evaluation of the effectiveness of the initiatives carried out with grants awarded under this section and a recommendation regarding whether funding for expanding or extending the initiatives should be extended beyond January 1, 2016.

(4) FINAL REPORT.—Not later than July 1, 2016, the Secretary shall submit to Congress a final report on the program that includes the results of the independent assessment required under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(e) NO EFFECT ON ELIGIBILITY FOR, OR AMOUNT OF, MEDICAID OR OTHER BENEFITS.—Any incentives provided to a Medicaid beneficiary participating in a program described in subsection (a)(3) shall not be taken into account for purposes of determining the beneficiary's eligibility for, or amount of, benefits under the Medicaid program or any program funded in whole or in part with Federal funds.

(f) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated for the 5-year period beginning on January 1, 2011, \$100,000,000 to the Secretary to carry out this section. Amounts appropriated under this subsection shall remain available until expended.

(g) DEFINITIONS.—In this section:

(1) MEDICAID BENEFICIARY.—The term “Medicaid beneficiary” means an individual who is eligible for medical assistance under a State plan or waiver under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) and is enrolled in such plan or waiver.

(2) STATE.—The term “State” has the meaning given that term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

Subtitle C—Creating Healthier Communities

SEC. 4201. COMMUNITY TRANSFORMATION GRANTS.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the “Secretary”), acting through the Director of the Centers for Disease Control and Prevention (referred to in this section as the “Director”), shall award competitive grants to State and local governmental agencies and community-based organizations for the implementation, evaluation, and dissemination of evidence-based community preventive health activities in order to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming, with not less than 20 percent of such grants being awarded to rural and frontier areas. *[As revised by section 10403(1)]*

(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity shall—

(1) be—

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“(1) IN GENERAL.—For cost reports submitted under this title for cost reporting periods beginning on or after the date that is 2 years after the date of the enactment of this subsection, skilled nursing facilities shall separately report expenditures for wages and benefits for direct care staff (breaking out (at a minimum) registered nurses, licensed professional nurses, certified nurse assistants, and other medical and therapy staff).

“(2) MODIFICATION OF FORM.—The Secretary, in consultation with private sector accountants experienced with Medicare and Medicaid nursing facility home cost reports, shall redesign such reports to meet the requirement of paragraph (1) not later than 1 year after the date of the enactment of this subsection.

“(3) CATEGORIZATION BY FUNCTIONAL ACCOUNTS.—Not later than 30 months after the date of the enactment of this subsection, the Secretary, working in consultation with the Medicare Payment Advisory Commission, the Medicaid and CHIP Payment and Access Commission, the Inspector General of the Department of Health and Human Services, and other expert parties the Secretary determines appropriate, shall take the expenditures listed on cost reports, as modified under paragraph (1), submitted by skilled nursing facilities and categorize such expenditures, regardless of any source of payment for such expenditures, for each skilled nursing facility into the following functional accounts on an annual basis:

“(A) Spending on direct care services (including nursing, therapy, and medical services).

“(B) Spending on indirect care (including housekeeping and dietary services).

“(C) Capital assets (including building and land costs).

“(D) Administrative services costs.

“(4) AVAILABILITY OF INFORMATION SUBMITTED.—The Secretary shall establish procedures to make information on expenditures submitted under this subsection readily available to interested parties upon request, subject to such requirements as the Secretary may specify under the procedures established under this paragraph.”.

SEC. 6105. STANDARDIZED COMPLAINT FORM.

(a) IN GENERAL.—Section 1128I of the Social Security Act, as added and amended by this Act, is amended by adding at the end the following new subsection:

“(f) STANDARDIZED COMPLAINT FORM.—

“(1) DEVELOPMENT BY THE SECRETARY.—The Secretary shall develop a standardized complaint form for use by a resident (or a person acting on the resident’s behalf) in filing a complaint with a State survey and certification agency and a State long-term care ombudsman program with respect to a facility.

“(2) COMPLAINT FORMS AND RESOLUTION PROCESSES.—

“(A) COMPLAINT FORMS.—The State must make the standardized complaint form developed under paragraph (1) available upon request to—

“(i) a resident of a facility; and

“(ii) any person acting on the resident’s behalf.

“(B) COMPLAINT RESOLUTION PROCESS.—The State must establish a complaint resolution process in order to ensure that the legal representative of a resident of a facility

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or other responsible party is not denied access to such resident or otherwise retaliated against if they have complained about the quality of care provided by the facility or other issues relating to the facility. Such complaint resolution process shall include—

“(i) procedures to assure accurate tracking of complaints received, including notification to the complainant that a complaint has been received;

“(ii) procedures to determine the likely severity of a complaint and for the investigation of the complaint; and

“(iii) deadlines for responding to a complaint and for notifying the complainant of the outcome of the investigation.

“(3) **RULE OF CONSTRUCTION.**—Nothing in this subsection shall be construed as preventing a resident of a facility (or a person acting on the resident’s behalf) from submitting a complaint in a manner or format other than by using the standardized complaint form developed under paragraph (1) (including submitting a complaint orally).”

(b) **EFFECTIVE DATE.**—The amendment made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 6106. ENSURING STAFFING ACCOUNTABILITY.

Section 1128I of the Social Security Act, as added and amended by this Act, is amended by adding at the end the following new subsection:

“(g) **SUBMISSION OF STAFFING INFORMATION BASED ON PAYROLL DATA IN A UNIFORM FORMAT.**—Beginning not later than 2 years after the date of the enactment of this subsection, and after consulting with State long-term care ombudsman programs, consumer advocacy groups, provider stakeholder groups, employees and their representatives, and other parties the Secretary deems appropriate, the Secretary shall require a facility to electronically submit to the Secretary direct care staffing information (including information with respect to agency and contract staff) based on payroll and other verifiable and auditable data in a uniform format (according to specifications established by the Secretary in consultation with such programs, groups, and parties). Such specifications shall require that the information submitted under the preceding sentence—

“(1) specify the category of work a certified employee performs (such as whether the employee is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other medical personnel);

“(2) include resident census data and information on resident case mix;

“(3) include a regular reporting schedule; and

“(4) include information on employee turnover and tenure and on the hours of care provided by each category of certified employees referenced in paragraph (1) per resident per day. Nothing in this subsection shall be construed as preventing the Secretary from requiring submission of such information with respect to specific categories, such as nursing staff, before other categories of certified employees. Information under this subsection

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(2) CLARIFICATION OF DEFINITION OF NURSE AIDE.—Section 1919(b)(5)(F) of the Social Security Act (42 U.S.C. 1396r(b)(5)(F)) is amended by adding at the end the following flush sentence:

“Such term includes an individual who provides such services through an agency or under a contract with the facility.”.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

Subtitle C—Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-term Care Facilities and Providers

SEC. 6201. NATIONWIDE PROGRAM FOR NATIONAL AND STATE BACKGROUND CHECKS ON DIRECT PATIENT ACCESS EMPLOYEES OF LONG-TERM CARE FACILITIES AND PROVIDERS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the “Secretary”), shall establish a program to identify efficient, effective, and economical procedures for long term care facilities or providers to conduct background checks on prospective direct patient access employees on a nationwide basis (in this subsection, such program shall be referred to as the “nationwide program”). Except for the following modifications, the Secretary shall carry out the nationwide program under similar terms and conditions as the pilot program under section 307 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2257), including the prohibition on hiring abusive workers and the authorization of the imposition of penalties by a participating State under subsection (b)(3)(A) and (b)(6), respectively, of such section 307:

(1) AGREEMENTS.—

(A) NEWLY PARTICIPATING STATES.—The Secretary shall enter into agreements with each State—

(i) that the Secretary has not entered into an agreement with under subsection (c)(1) of such section 307;

(ii) that agrees to conduct background checks under the nationwide program on a Statewide basis; and

(iii) that submits an application to the Secretary containing such information and at such time as the Secretary may specify.

(B) CERTAIN PREVIOUSLY PARTICIPATING STATES.—The Secretary shall enter into agreements with each State—

(i) that the Secretary has entered into an agreement with under such subsection (c)(1), but only in the case where such agreement did not require the State to conduct background checks under the program

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established under subsection (a) of such section 307 on a Statewide basis;

(ii) that agrees to conduct background checks under the nationwide program on a Statewide basis; and

(iii) that submits an application to the Secretary containing such information and at such time as the Secretary may specify.

(2) NONAPPLICATION OF SELECTION CRITERIA.—The selection criteria required under subsection (c)(3)(B) of such section 307 shall not apply.

(3) REQUIRED FINGERPRINT CHECK AS PART OF CRIMINAL HISTORY BACKGROUND CHECK.—The procedures established under subsection (b)(1) of such section 307 shall—

(A) require that the long-term care facility or provider (or the designated agent of the long-term care facility or provider) obtain State and national criminal history background checks on the prospective employee through such means as the Secretary determines appropriate, efficient, and effective that utilize a search of State-based abuse and neglect registries and databases, including the abuse and neglect registries of another State in the case where a prospective employee previously resided in that State, State criminal history records, the records of any proceedings in the State that may contain disqualifying information about prospective employees (such as proceedings conducted by State professional licensing and disciplinary boards and State Medicaid Fraud Control Units), and Federal criminal history records, including a fingerprint check using the Integrated Automated Fingerprint Identification System of the Federal Bureau of Investigation;

(B) require States to describe and test methods that reduce duplicative fingerprinting, including providing for the development of “rap back” capability by the State such that, if a direct patient access employee of a long-term care facility or provider is convicted of a crime following the initial criminal history background check conducted with respect to such employee, and the employee’s fingerprints match the prints on file with the State law enforcement department, the department will immediately inform the State and the State will immediately inform the long-term care facility or provider which employs the direct patient access employee of such conviction; and

(C) require that criminal history background checks conducted under the nationwide program remain valid for a period of time specified by the Secretary.

(4) STATE REQUIREMENTS.—An agreement entered into under paragraph (1) shall require that a participating State—

(A) be responsible for monitoring compliance with the requirements of the nationwide program;

(B) have procedures in place to—

(i) conduct screening and criminal history background checks under the nationwide program in accordance with the requirements of this section;

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(ii) monitor compliance by long-term care facilities and providers with the procedures and requirements of the nationwide program;

(iii) as appropriate, provide for a provisional period of employment by a long-term care facility or provider of a direct patient access employee, not to exceed 60 days, pending completion of the required criminal history background check and, in the case where the employee has appealed the results of such background check, pending completion of the appeals process, during which the employee shall be subject to direct on-site supervision (in accordance with procedures established by the State to ensure that a long-term care facility or provider furnishes such direct on-site supervision);

(iv) provide an independent process by which a provisional employee or an employee may appeal or dispute the accuracy of the information obtained in a background check performed under the nationwide program, including the specification of criteria for appeals for direct patient access employees found to have disqualifying information which shall include consideration of the passage of time, extenuating circumstances, demonstration of rehabilitation, and relevancy of the particular disqualifying information with respect to the current employment of the individual;

(v) provide for the designation of a single State agency as responsible for—

(I) overseeing the coordination of any State and national criminal history background checks requested by a long-term care facility or provider (or the designated agent of the long-term care facility or provider) utilizing a search of State and Federal criminal history records, including a fingerprint check of such records;

(II) overseeing the design of appropriate privacy and security safeguards for use in the review of the results of any State or national criminal history background checks conducted regarding a prospective direct patient access employee to determine whether the employee has any conviction for a relevant crime;

(III) immediately reporting to the long-term care facility or provider that requested the criminal history background check the results of such review; and

(IV) in the case of an employee with a conviction for a relevant crime that is subject to reporting under section 1128E of the Social Security Act (42 U.S.C. 1320a-7e), reporting the existence of such conviction to the database established under that section;

(vi) determine which individuals are direct patient access employees (as defined in paragraph (6)(B)) for purposes of the nationwide program;

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(vii) as appropriate, specify offenses, including convictions for violent crimes, for purposes of the nationwide program; and

(viii) describe and test methods that reduce duplicative fingerprinting, including providing for the development of “rap back” capability such that, if a direct patient access employee of a long-term care facility or provider is convicted of a crime following the initial criminal history background check conducted with respect to such employee, and the employee’s fingerprints match the prints on file with the State law enforcement department—

(I) the department will immediately inform the State agency designated under clause (v) and such agency will immediately inform the facility or provider which employs the direct patient access employee of such conviction; and

(II) the State will provide, or will require the facility to provide, to the employee a copy of the results of the criminal history background check conducted with respect to the employee at no charge in the case where the individual requests such a copy.

(5) PAYMENTS.—

(A) NEWLY PARTICIPATING STATES.—

(i) IN GENERAL.—As part of the application submitted by a State under paragraph (1)(A)(iii), the State shall guarantee, with respect to the costs to be incurred by the State in carrying out the nationwide program, that the State will make available (directly or through donations from public or private entities) a particular amount of non-Federal contributions, as a condition of receiving the Federal match under clause (ii).

(ii) FEDERAL MATCH.—The payment amount to each State that the Secretary enters into an agreement with under paragraph (1)(A) shall be 3 times the amount that the State guarantees to make available under clause (i), except that in no case may the payment amount exceed \$3,000,000.

(B) PREVIOUSLY PARTICIPATING STATES.—

(i) IN GENERAL.—As part of the application submitted by a State under paragraph (1)(B)(iii), the State shall guarantee, with respect to the costs to be incurred by the State in carrying out the nationwide program, that the State will make available (directly or through donations from public or private entities) a particular amount of non-Federal contributions, as a condition of receiving the Federal match under clause (ii).

(ii) FEDERAL MATCH.—The payment amount to each State that the Secretary enters into an agreement with under paragraph (1)(B) shall be 3 times the amount that the State guarantees to make available under clause (i), except that in no case may the payment amount exceed \$1,500,000.

(6) DEFINITIONS.—Under the nationwide program:

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(A) CONVICTION FOR A RELEVANT CRIME.—The term “conviction for a relevant crime” means any Federal or State criminal conviction for—

(i) any offense described in section 1128(a) of the Social Security Act (42 U.S.C. 1320a–7); or

(ii) such other types of offenses as a participating State may specify for purposes of conducting the program in such State.

(B) DISQUALIFYING INFORMATION.—The term “disqualifying information” means a conviction for a relevant crime or a finding of patient or resident abuse.

(C) FINDING OF PATIENT OR RESIDENT ABUSE.—The term “finding of patient or resident abuse” means any substantiated finding by a State agency under section 1819(g)(1)(C) or 1919(g)(1)(C) of the Social Security Act (42 U.S.C. 1395i–3(g)(1)(C), 1396r(g)(1)(C)) or a Federal agency that a direct patient access employee has committed—

(i) an act of patient or resident abuse or neglect or a misappropriation of patient or resident property; or

(ii) such other types of acts as a participating State may specify for purposes of conducting the program in such State.

(D) DIRECT PATIENT ACCESS EMPLOYEE.—The term “direct patient access employee” means any individual who has access to a patient or resident of a long-term care facility or provider through employment or through a contract with such facility or provider and has duties that involve (or may involve) one-on-one contact with a patient or resident of the facility or provider, as determined by the State for purposes of the nationwide program. Such term does not include a volunteer unless the volunteer has duties that are equivalent to the duties of a direct patient access employee and those duties involve (or may involve) one-on-one contact with a patient or resident of the long-term care facility or provider.

(E) LONG-TERM CARE FACILITY OR PROVIDER.—The term “long-term care facility or provider” means the following facilities or providers which receive payment for services under title XVIII or XIX of the Social Security Act:

(i) A skilled nursing facility (as defined in section 1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a))).

(ii) A nursing facility (as defined in section 1919(a) of such Act (42 U.S.C. 1396r(a))).

(iii) A home health agency.

(iv) A provider of hospice care (as defined in section 1861(dd)(1) of such Act (42 U.S.C. 1395x(dd)(1))).

(v) A long-term care hospital (as described in section 1886(d)(1)(B)(iv) of such Act (42 U.S.C. 1395ww(d)(1)(B)(iv))).

(vi) A provider of personal care services.

(vii) A provider of adult day care.

(viii) A residential care provider that arranges for, or directly provides, long-term care services, including

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an assisted living facility that provides a level of care established by the Secretary.

(ix) An intermediate care facility for the mentally retarded (as defined in section 1905(d) of such Act (42 U.S.C. 1396d(d))).

(x) Any other facility or provider of long-term care services under such titles as the participating State determines appropriate.

(7) EVALUATION AND REPORT.—

(A) EVALUATION.—

(i) IN GENERAL.—The Inspector General of the Department of Health and Human Services shall conduct an evaluation of the nationwide program.

(ii) INCLUSION OF SPECIFIC TOPICS.—The evaluation conducted under clause (i) shall include the following:

(I) A review of the various procedures implemented by participating States for long-term care facilities or providers, including staffing agencies, to conduct background checks of direct patient access employees under the nationwide program and identification of the most appropriate, efficient, and effective procedures for conducting such background checks.

(II) An assessment of the costs of conducting such background checks (including start up and administrative costs).

(III) A determination of the extent to which conducting such background checks leads to any unintended consequences, including a reduction in the available workforce for long-term care facilities or providers.

(IV) An assessment of the impact of the nationwide program on reducing the number of incidents of neglect, abuse, and misappropriation of resident property to the extent practicable.

(V) An evaluation of other aspects of the nationwide program, as determined appropriate by the Secretary.

(B) REPORT.—Not later than 180 days after the completion of the nationwide program, the Inspector General of the Department of Health and Human Services shall submit a report to Congress containing the results of the evaluation conducted under subparagraph (A).

(b) FUNDING.—

(1) NOTIFICATION.—The Secretary of Health and Human Services shall notify the Secretary of the Treasury of the amount necessary to carry out the nationwide program under this section for the period of fiscal years 2010 through 2012, except that in no case shall such amount exceed \$160,000,000.

(2) TRANSFER OF FUNDS.—

(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, the Secretary of the Treasury shall provide for the transfer to the Secretary of Health and Human Services of the amount specified as necessary to carry out the nationwide program under paragraph (1). Such amount shall remain available until expended.

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(B) RESERVATION OF FUNDS FOR CONDUCT OF EVALUATION.—The Secretary may reserve not more than \$3,000,000 of the amount transferred under subparagraph (A) to provide for the conduct of the evaluation under subsection (a)(7)(A).

Subtitle D—Patient-Centered Outcomes Research

SEC. 6301. PATIENT-CENTERED OUTCOMES RESEARCH.

(a) IN GENERAL.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end the following new part:

“PART D—COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH

“COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH

“SEC. 1181. (a) DEFINITIONS.—In this section:

“(1) BOARD.—The term ‘Board’ means the Board of Governors established under subsection (f).

“(2) COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH; RESEARCH.—

“(A) IN GENERAL.—The terms ‘comparative clinical effectiveness research’ and ‘research’ mean research evaluating and comparing health outcomes and the clinical effectiveness, risks, and benefits of 2 or more medical treatments, services, and items described in subparagraph (B).

“(B) MEDICAL TREATMENTS, SERVICES, AND ITEMS DESCRIBED.—The medical treatments, services, and items described in this subparagraph are health care interventions, protocols for treatment, care management, and delivery, procedures, medical devices, diagnostic tools, pharmaceuticals (including drugs and biologicals), integrative health practices, and any other strategies or items being used in the treatment, management, and diagnosis of, or prevention of illness or injury in, individuals.

“(3) CONFLICT OF INTEREST.—The term ‘conflict of interest’ means an association, including a financial or personal association, that have the potential to bias or have the appearance of biasing an individual’s decisions in matters related to the Institute or the conduct of activities under this section.

“(4) REAL CONFLICT OF INTEREST.—The term ‘real conflict of interest’ means any instance where a member of the Board, the methodology committee established under subsection (d)(6), or an advisory panel appointed under subsection (d)(4), or a close relative of such member, has received or could receive either of the following:

“(A) A direct financial benefit of any amount deriving from the result or findings of a study conducted under this section.

“(B) A financial benefit from individuals or companies that own or manufacture medical treatments, services, or items to be studied under this section that in the aggregate exceeds \$10,000 per year. For purposes of the preceding sentence, a financial benefit includes honoraria, fees, stock,

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(b) CONFORMING AMENDMENT.—The table of sections for part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as amended by section 6604, is further amended by adding at the end the following:

“Sec. 521. Administrative summary cease and desist orders and summary seizure orders against health plans in financially hazardous condition.”.

SEC. 6606. MEWA PLAN REGISTRATION WITH DEPARTMENT OF LABOR.

Section 101(g) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1021(g)) is amended—

(1) by striking “Secretary may” and inserting “Secretary shall”; and

(2) by inserting “to register with the Secretary prior to operating in a State and may, by regulation, require such multiple employer welfare arrangements” after “not group health plans”.

SEC. 6607. PERMITTING EVIDENTIARY PRIVILEGE AND CONFIDENTIAL COMMUNICATIONS.

Section 504 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1134) is amended by adding at the end the following:

“(d) The Secretary may promulgate a regulation that provides an evidentiary privilege for, and provides for the confidentiality of communications between or among, any of the following entities or their agents, consultants, or employees:

“(1) A State insurance department.

“(2) A State attorney general.

“(3) The National Association of Insurance Commissioners.

“(4) The Department of Labor.

“(5) The Department of the Treasury.

“(6) The Department of Justice.

“(7) The Department of Health and Human Services.

“(8) Any other Federal or State authority that the Secretary determines is appropriate for the purposes of enforcing the provisions of this title.

“(e) The privilege established under subsection (d) shall apply to communications related to any investigation, audit, examination, or inquiry conducted or coordinated by any of the agencies. A communication that is privileged under subsection (d) shall not waive any privilege otherwise available to the communicating agency or to any person who provided the information that is communicated.”.

Subtitle H—Elder Justice Act**SEC. 6701. SHORT TITLE OF SUBTITLE.**

This subtitle may be cited as the “Elder Justice Act of 2009”.

SEC. 6702. DEFINITIONS.

Except as otherwise specifically provided, any term that is defined in section 2011 of the Social Security Act (as added by section 6703(a)) and is used in this subtitle has the meaning given such term by such section.

SEC. 6703. ELDER JUSTICE.

(a) ELDER JUSTICE.—

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(1) IN GENERAL.—Title XX of the Social Security Act (42 U.S.C. 1397 et seq.) is amended—

(A) in the heading, by inserting “**AND ELDER JUSTICE**” after “**SOCIAL SERVICES**”;

(B) by inserting before section 2001 the following:

**“Subtitle A—Block Grants to States for
Social Services”;**

and

(C) by adding at the end the following:

“Subtitle B—Elder Justice

“SEC. 2011. DEFINITIONS.

“In this subtitle:

“(1) ABUSE.—The term ‘abuse’ means the knowing infliction of physical or psychological harm or the knowing deprivation of goods or services that are necessary to meet essential needs or to avoid physical or psychological harm.

“(2) ADULT PROTECTIVE SERVICES.—The term ‘adult protective services’ means such services provided to adults as the Secretary may specify and includes services such as—

“(A) receiving reports of adult abuse, neglect, or exploitation;

“(B) investigating the reports described in subparagraph (A);

“(C) case planning, monitoring, evaluation, and other case work and services; and

“(D) providing, arranging for, or facilitating the provision of medical, social service, economic, legal, housing, law enforcement, or other protective, emergency, or support services.

“(3) CAREGIVER.—The term ‘caregiver’ means an individual who has the responsibility for the care of an elder, either voluntarily, by contract, by receipt of payment for care, or as a result of the operation of law, and means a family member or other individual who provides (on behalf of such individual or of a public or private agency, organization, or institution) compensated or uncompensated care to an elder who needs supportive services in any setting.

“(4) DIRECT CARE.—The term ‘direct care’ means care by an employee or contractor who provides assistance or long-term care services to a recipient.

“(5) ELDER.—The term ‘elder’ means an individual age 60 or older.

“(6) ELDER JUSTICE.—The term ‘elder justice’ means—

“(A) from a societal perspective, efforts to—

“(i) prevent, detect, treat, intervene in, and prosecute elder abuse, neglect, and exploitation; and

“(ii) protect elders with diminished capacity while maximizing their autonomy; and

“(B) from an individual perspective, the recognition of an elder’s rights, including the right to be free of abuse, neglect, and exploitation.

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“(7) ELIGIBLE ENTITY.—The term ‘eligible entity’ means a State or local government agency, Indian tribe or tribal organization, or any other public or private entity that is engaged in and has expertise in issues relating to elder justice or in a field necessary to promote elder justice efforts.

“(8) EXPLOITATION.—The term ‘exploitation’ means the fraudulent or otherwise illegal, unauthorized, or improper act or process of an individual, including a caregiver or fiduciary, that uses the resources of an elder for monetary or personal benefit, profit, or gain, or that results in depriving an elder of rightful access to, or use of, benefits, resources, belongings, or assets.

“(9) FIDUCIARY.—The term ‘fiduciary’—

“(A) means a person or entity with the legal responsibility—

“(i) to make decisions on behalf of and for the benefit of another person; and

“(ii) to act in good faith and with fairness; and

“(B) includes a trustee, a guardian, a conservator, an executor, an agent under a financial power of attorney or health care power of attorney, or a representative payee.

“(10) GRANT.—The term ‘grant’ includes a contract, cooperative agreement, or other mechanism for providing financial assistance.

“(11) GUARDIANSHIP.—The term ‘guardianship’ means—

“(A) the process by which a State court determines that an adult individual lacks capacity to make decisions about self-care or property, and appoints another individual or entity known as a guardian, as a conservator, or by a similar term, as a surrogate decisionmaker;

“(B) the manner in which the court-appointed surrogate decisionmaker carries out duties to the individual and the court; or

“(C) the manner in which the court exercises oversight of the surrogate decisionmaker.

“(12) INDIAN TRIBE.—

“(A) IN GENERAL.—The term ‘Indian tribe’ has the meaning given such term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b).

“(B) INCLUSION OF PUEBLO AND RANCHERIA.—The term ‘Indian tribe’ includes any Pueblo or Rancheria.

“(13) LAW ENFORCEMENT.—The term ‘law enforcement’ means the full range of potential responders to elder abuse, neglect, and exploitation including—

“(A) police, sheriffs, detectives, public safety officers, and corrections personnel;

“(B) prosecutors;

“(C) medical examiners;

“(D) investigators; and

“(E) coroners.

“(14) LONG-TERM CARE.—

“(A) IN GENERAL.—The term ‘long-term care’ means supportive and health services specified by the Secretary for individuals who need assistance because the individuals have a loss of capacity for self-care due to illness, disability, or vulnerability.

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“(B) LOSS OF CAPACITY FOR SELF-CARE.—For purposes of subparagraph (A), the term ‘loss of capacity for self-care’ means an inability to engage in 1 or more activities of daily living, including eating, dressing, bathing, management of one’s financial affairs, and other activities the Secretary determines appropriate.

“(15) LONG-TERM CARE FACILITY.—The term ‘long-term care facility’ means a residential care provider that arranges for, or directly provides, long-term care.

“(16) NEGLECT.—The term ‘neglect’ means—

“(A) the failure of a caregiver or fiduciary to provide the goods or services that are necessary to maintain the health or safety of an elder; or

“(B) self-neglect.

“(17) NURSING FACILITY.—

“(A) IN GENERAL.—The term ‘nursing facility’ has the meaning given such term under section 1919(a).

“(B) INCLUSION OF SKILLED NURSING FACILITY.—The term ‘nursing facility’ includes a skilled nursing facility (as defined in section 1819(a)).

“(18) SELF-NEGLECT.—The term ‘self-neglect’ means an adult’s inability, due to physical or mental impairment or diminished capacity, to perform essential self-care tasks including—

“(A) obtaining essential food, clothing, shelter, and medical care;

“(B) obtaining goods and services necessary to maintain physical health, mental health, or general safety; or

“(C) managing one’s own financial affairs.

“(19) SERIOUS BODILY INJURY.—

“(A) IN GENERAL.—The term ‘serious bodily injury’ means an injury—

“(i) involving extreme physical pain;

“(ii) involving substantial risk of death;

“(iii) involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; or

“(iv) requiring medical intervention such as surgery, hospitalization, or physical rehabilitation.

“(B) CRIMINAL SEXUAL ABUSE.—Serious bodily injury shall be considered to have occurred if the conduct causing the injury is conduct described in section 2241 (relating to aggravated sexual abuse) or 2242 (relating to sexual abuse) of title 18, United States Code, or any similar offense under State law.

“(20) SOCIAL.—The term ‘social’, when used with respect to a service, includes adult protective services.

“(21) STATE LEGAL ASSISTANCE DEVELOPER.—The term ‘State legal assistance developer’ means an individual described in section 731 of the Older Americans Act of 1965.

“(22) STATE LONG-TERM CARE OMBUDSMAN.—The term ‘State Long-Term Care Ombudsman’ means the State Long-Term Care Ombudsman described in section 712(a)(2) of the Older Americans Act of 1965.

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“SEC. 2012. GENERAL PROVISIONS.

“(a) PROTECTION OF PRIVACY.—In pursuing activities under this subtitle, the Secretary shall ensure the protection of individual health privacy consistent with the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 and applicable State and local privacy regulations.

“(b) RULE OF CONSTRUCTION.—Nothing in this subtitle shall be construed to interfere with or abridge an elder’s right to practice his or her religion through reliance on prayer alone for healing when this choice—

“(1) is contemporaneously expressed, either orally or in writing, with respect to a specific illness or injury which the elder has at the time of the decision by an elder who is competent at the time of the decision;

“(2) is previously set forth in a living will, health care proxy, or other advance directive document that is validly executed and applied under State law; or

“(3) may be unambiguously deduced from the elder’s life history.

**“PART I—NATIONAL COORDINATION OF
ELDER JUSTICE ACTIVITIES AND RESEARCH**

**“Subpart A—Elder Justice Coordinating Council
and Advisory Board on Elder Abuse, Neglect,
and Exploitation**

“SEC. 2021. ELDER JUSTICE COORDINATING COUNCIL.

“(a) ESTABLISHMENT.—There is established within the Office of the Secretary an Elder Justice Coordinating Council (in this section referred to as the ‘Council’).

“(b) MEMBERSHIP.—

“(1) IN GENERAL.—The Council shall be composed of the following members:

“(A) The Secretary (or the Secretary’s designee).

“(B) The Attorney General (or the Attorney General’s designee).

“(C) The head of each Federal department or agency or other governmental entity identified by the Chair referred to in subsection (d) as having responsibilities, or administering programs, relating to elder abuse, neglect, and exploitation.

“(2) REQUIREMENT.—Each member of the Council shall be an officer or employee of the Federal Government.

“(c) VACANCIES.—Any vacancy in the Council shall not affect its powers, but shall be filled in the same manner as the original appointment was made.

“(d) CHAIR.—The member described in subsection (b)(1)(A) shall be Chair of the Council.

“(e) MEETINGS.—The Council shall meet at least 2 times per year, as determined by the Chair.

“(f) DUTIES.—

“(1) IN GENERAL.—The Council shall make recommendations to the Secretary for the coordination of activities of the Department of Health and Human Services, the Department of Justice, and other relevant Federal, State, local, and private

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agencies and entities, relating to elder abuse, neglect, and exploitation and other crimes against elders.

“(2) REPORT.—Not later than the date that is 2 years after the date of enactment of the Elder Justice Act of 2009 and every 2 years thereafter, the Council shall submit to the Committee on Finance of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report that—

“(A) describes the activities and accomplishments of, and challenges faced by—

“(i) the Council; and

“(ii) the entities represented on the Council; and

“(B) makes such recommendations for legislation, model laws, or other action as the Council determines to be appropriate.

“(g) POWERS OF THE COUNCIL.—

“(1) INFORMATION FROM FEDERAL AGENCIES.—Subject to the requirements of section 2012(a), the Council may secure directly from any Federal department or agency such information as the Council considers necessary to carry out this section. Upon request of the Chair of the Council, the head of such department or agency shall furnish such information to the Council.

“(2) POSTAL SERVICES.—The Council may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

“(h) TRAVEL EXPENSES.—The members of the Council shall not receive compensation for the performance of services for the Council. The members shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Council. Notwithstanding section 1342 of title 31, United States Code, the Secretary may accept the voluntary and uncompensated services of the members of the Council.

“(i) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Council without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

“(j) STATUS AS PERMANENT COUNCIL.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Council.

“(k) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.

“SEC. 2022. ADVISORY BOARD ON ELDER ABUSE, NEGLECT, AND EXPLOITATION.

“(a) ESTABLISHMENT.—There is established a board to be known as the ‘Advisory Board on Elder Abuse, Neglect, and Exploitation’ (in this section referred to as the ‘Advisory Board’) to create short- and long-term multidisciplinary strategic plans for the development of the field of elder justice and to make recommendations to the Elder Justice Coordinating Council established under section 2021.

“(b) COMPOSITION.—The Advisory Board shall be composed of 27 members appointed by the Secretary from among members of the general public who are individuals with experience and expertise

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in elder abuse, neglect, and exploitation prevention, detection, treatment, intervention, or prosecution.

“(c) SOLICITATION OF NOMINATIONS.—The Secretary shall publish a notice in the Federal Register soliciting nominations for the appointment of members of the Advisory Board under subsection (b).

“(d) TERMS.—

“(1) IN GENERAL.—Each member of the Advisory Board shall be appointed for a term of 3 years, except that, of the members first appointed—

“(A) 9 shall be appointed for a term of 3 years;

“(B) 9 shall be appointed for a term of 2 years; and

“(C) 9 shall be appointed for a term of 1 year.

“(2) VACANCIES.—

“(A) IN GENERAL.—Any vacancy on the Advisory Board shall not affect its powers, but shall be filled in the same manner as the original appointment was made.

“(B) FILLING UNEXPIRED TERM.—An individual chosen to fill a vacancy shall be appointed for the unexpired term of the member replaced.

“(3) EXPIRATION OF TERMS.—The term of any member shall not expire before the date on which the member’s successor takes office.

“(e) ELECTION OF OFFICERS.—The Advisory Board shall elect a Chair and Vice Chair from among its members. The Advisory Board shall elect its initial Chair and Vice Chair at its initial meeting.

“(f) DUTIES.—

“(1) ENHANCE COMMUNICATION ON PROMOTING QUALITY OF, AND PREVENTING ABUSE, NEGLECT, AND EXPLOITATION IN, LONG-TERM CARE.—The Advisory Board shall develop collaborative and innovative approaches to improve the quality of, including preventing abuse, neglect, and exploitation in, long-term care.

“(2) COLLABORATIVE EFFORTS TO DEVELOP CONSENSUS AROUND THE MANAGEMENT OF CERTAIN QUALITY-RELATED FACTORS.—

“(A) IN GENERAL.—The Advisory Board shall establish multidisciplinary panels to address, and develop consensus on, subjects relating to improving the quality of long-term care. At least 1 such panel shall address, and develop consensus on, methods for managing resident-to-resident abuse in long-term care.

“(B) ACTIVITIES CONDUCTED.—The multidisciplinary panels established under subparagraph (A) shall examine relevant research and data, identify best practices with respect to the subject of the panel, determine the best way to carry out those best practices in a practical and feasible manner, and determine an effective manner of distributing information on such subject.

“(3) REPORT.—Not later than the date that is 18 months after the date of enactment of the Elder Justice Act of 2009, and annually thereafter, the Advisory Board shall prepare and submit to the Elder Justice Coordinating Council, the Committee on Finance of the Senate, and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report containing—

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“(A) information on the status of Federal, State, and local public and private elder justice activities;

“(B) recommendations (including recommended priorities) regarding—

“(i) elder justice programs, research, training, services, practice, enforcement, and coordination;

“(ii) coordination between entities pursuing elder justice efforts and those involved in related areas that may inform or overlap with elder justice efforts, such as activities to combat violence against women and child abuse and neglect; and

“(iii) activities relating to adult fiduciary systems, including guardianship and other fiduciary arrangements;

“(C) recommendations for specific modifications needed in Federal and State laws (including regulations) or for programs, research, and training to enhance prevention, detection, and treatment (including diagnosis) of, intervention in (including investigation of), and prosecution of elder abuse, neglect, and exploitation;

“(D) recommendations on methods for the most effective coordinated national data collection with respect to elder justice, and elder abuse, neglect, and exploitation; and

“(E) recommendations for a multidisciplinary strategic plan to guide the effective and efficient development of the field of elder justice.

“(g) POWERS OF THE ADVISORY BOARD.—

“(1) INFORMATION FROM FEDERAL AGENCIES.—Subject to the requirements of section 2012(a), the Advisory Board may secure directly from any Federal department or agency such information as the Advisory Board considers necessary to carry out this section. Upon request of the Chair of the Advisory Board, the head of such department or agency shall furnish such information to the Advisory Board.

“(2) SHARING OF DATA AND REPORTS.—The Advisory Board may request from any entity pursuing elder justice activities under the Elder Justice Act of 2009 or an amendment made by that Act, any data, reports, or recommendations generated in connection with such activities.

“(3) POSTAL SERVICES.—The Advisory Board may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

“(h) TRAVEL EXPENSES.—The members of the Advisory Board shall not receive compensation for the performance of services for the Advisory Board. The members shall be allowed travel expenses for up to 4 meetings per year, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Advisory Board. Notwithstanding section 1342 of title 31, United States Code, the Secretary may accept the voluntary and uncompensated services of the members of the Advisory Board.

“(i) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Advisory Board without

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reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

“(j) STATUS AS PERMANENT ADVISORY COMMITTEE.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the advisory board.

“(k) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.

“SEC. 2023. RESEARCH PROTECTIONS.

“(a) GUIDELINES.—The Secretary shall promulgate guidelines to assist researchers working in the area of elder abuse, neglect, and exploitation, with issues relating to human subject protections.

“(b) DEFINITION OF LEGALLY AUTHORIZED REPRESENTATIVE FOR APPLICATION OF REGULATIONS.—For purposes of the application of subpart A of part 46 of title 45, Code of Federal Regulations, to research conducted under this subpart, the term ‘legally authorized representative’ means, unless otherwise provided by law, the individual or judicial or other body authorized under the applicable law to consent to medical treatment on behalf of another person.

“SEC. 2024. AUTHORIZATION OF APPROPRIATIONS.

“There are authorized to be appropriated to carry out this subpart—

“(1) for fiscal year 2011, \$6,500,000; and

“(2) for each of fiscal years 2012 through 2014, \$7,000,000.

**“Subpart B—Elder Abuse, Neglect, and
Exploitation Forensic Centers**

**“SEC. 2031. ESTABLISHMENT AND SUPPORT OF ELDER ABUSE,
NEGLECT, AND EXPLOITATION FORENSIC CENTERS.**

“(a) IN GENERAL.—The Secretary, in consultation with the Attorney General, shall make grants to eligible entities to establish and operate stationary and mobile forensic centers, to develop forensic expertise regarding, and provide services relating to, elder abuse, neglect, and exploitation.

“(b) STATIONARY FORENSIC CENTERS.—The Secretary shall make 4 of the grants described in subsection (a) to institutions of higher education with demonstrated expertise in forensics or commitment to preventing or treating elder abuse, neglect, or exploitation, to establish and operate stationary forensic centers.

“(c) MOBILE CENTERS.—The Secretary shall make 6 of the grants described in subsection (a) to appropriate entities to establish and operate mobile forensic centers.

“(d) AUTHORIZED ACTIVITIES.—

“(1) DEVELOPMENT OF FORENSIC MARKERS AND METHODOLOGIES.—An eligible entity that receives a grant under this section shall use funds made available through the grant to assist in determining whether abuse, neglect, or exploitation occurred and whether a crime was committed and to conduct research to describe and disseminate information on—

“(A) forensic markers that indicate a case in which elder abuse, neglect, or exploitation may have occurred; and

“(B) methodologies for determining, in such a case, when and how health care, emergency service, social and

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protective services, and legal service providers should intervene and when the providers should report the case to law enforcement authorities.

“(2) DEVELOPMENT OF FORENSIC EXPERTISE.—An eligible entity that receives a grant under this section shall use funds made available through the grant to develop forensic expertise regarding elder abuse, neglect, and exploitation in order to provide medical and forensic evaluation, therapeutic intervention, victim support and advocacy, case review, and case tracking.

“(3) COLLECTION OF EVIDENCE.—The Secretary, in coordination with the Attorney General, shall use data made available by grant recipients under this section to develop the capacity of geriatric health care professionals and law enforcement to collect forensic evidence, including collecting forensic evidence relating to a potential determination of elder abuse, neglect, or exploitation.

“(e) APPLICATION.—To be eligible to receive a grant under this section, an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

“(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

“(1) for fiscal year 2011, \$4,000,000;

“(2) for fiscal year 2012, \$6,000,000; and

“(3) for each of fiscal years 2013 and 2014, \$8,000,000.

“PART II—PROGRAMS TO PROMOTE ELDER JUSTICE

“SEC. 2041. ENHANCEMENT OF LONG-TERM CARE.

“(a) GRANTS AND INCENTIVES FOR LONG-TERM CARE STAFFING.—

“(1) IN GENERAL.—The Secretary shall carry out activities, including activities described in paragraphs (2) and (3), to provide incentives for individuals to train for, seek, and maintain employment providing direct care in long-term care.

“(2) SPECIFIC PROGRAMS TO ENHANCE TRAINING, RECRUITMENT, AND RETENTION OF STAFF.—

“(A) COORDINATION WITH SECRETARY OF LABOR TO RECRUIT AND TRAIN LONG-TERM CARE STAFF.—The Secretary shall coordinate activities under this subsection with the Secretary of Labor in order to provide incentives for individuals to train for and seek employment providing direct care in long-term care.

“(B) CAREER LADDERS AND WAGE OR BENEFIT INCREASES TO INCREASE STAFFING IN LONG-TERM CARE.—

“(i) IN GENERAL.—The Secretary shall make grants to eligible entities to carry out programs through which the entities—

“(I) offer, to employees who provide direct care to residents of an eligible entity or individuals receiving community-based long-term care from an eligible entity, continuing training and varying levels of certification, based on observed clinical care practices and the amount of time the employees spend providing direct care; and

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“(II) provide, or make arrangements to provide, bonuses or other increased compensation or benefits to employees who achieve certification under such a program.

“(ii) APPLICATION.—To be eligible to receive a grant under this subparagraph, an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require (which may include evidence of consultation with the State in which the eligible entity is located with respect to carrying out activities funded under the grant).

“(iii) AUTHORITY TO LIMIT NUMBER OF APPLICANTS.—Nothing in this subparagraph shall be construed as prohibiting the Secretary from limiting the number of applicants for a grant under this subparagraph.

“(3) SPECIFIC PROGRAMS TO IMPROVE MANAGEMENT PRACTICES.—

“(A) IN GENERAL.—The Secretary shall make grants to eligible entities to enable the entities to provide training and technical assistance.

“(B) AUTHORIZED ACTIVITIES.—An eligible entity that receives a grant under subparagraph (A) shall use funds made available through the grant to provide training and technical assistance regarding management practices using methods that are demonstrated to promote retention of individuals who provide direct care, such as—

“(i) the establishment of standard human resource policies that reward high performance, including policies that provide for improved wages and benefits on the basis of job reviews;

“(ii) the establishment of motivational and thoughtful work organization practices;

“(iii) the creation of a workplace culture that respects and values caregivers and their needs;

“(iv) the promotion of a workplace culture that respects the rights of residents of an eligible entity or individuals receiving community-based long-term care from an eligible entity and results in improved care for the residents or the individuals; and

“(v) the establishment of other programs that promote the provision of high quality care, such as a continuing education program that provides additional hours of training, including on-the-job training, for employees who are certified nurse aides.

“(C) APPLICATION.—To be eligible to receive a grant under this paragraph, an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require (which may include evidence of consultation with the State in which the eligible entity is located with respect to carrying out activities funded under the grant).

“(D) AUTHORITY TO LIMIT NUMBER OF APPLICANTS.—Nothing in this paragraph shall be construed as prohibiting the Secretary from limiting the number of applicants for a grant under this paragraph.

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“(4) ACCOUNTABILITY MEASURES.—The Secretary shall develop accountability measures to ensure that the activities conducted using funds made available under this subsection benefit individuals who provide direct care and increase the stability of the long-term care workforce.

“(5) DEFINITIONS.—In this subsection:

“(A) COMMUNITY-BASED LONG-TERM CARE.—The term ‘community-based long-term care’ has the meaning given such term by the Secretary.

“(B) ELIGIBLE ENTITY.—The term ‘eligible entity’ means the following:

“(i) A long-term care facility.

“(ii) A community-based long-term care entity (as defined by the Secretary).

“(b) CERTIFIED EHR TECHNOLOGY GRANT PROGRAM.—

“(1) GRANTS AUTHORIZED.—The Secretary is authorized to make grants to long-term care facilities for the purpose of assisting such entities in offsetting the costs related to purchasing, leasing, developing, and implementing certified EHR technology (as defined in section 1848(o)(4)) designed to improve patient safety and reduce adverse events and health care complications resulting from medication errors.

“(2) USE OF GRANT FUNDS.—Funds provided under grants under this subsection may be used for any of the following:

“(A) Purchasing, leasing, and installing computer software and hardware, including handheld computer technologies.

“(B) Making improvements to existing computer software and hardware.

“(C) Making upgrades and other improvements to existing computer software and hardware to enable e-prescribing.

“(D) Providing education and training to eligible long-term care facility staff on the use of such technology to implement the electronic transmission of prescription and patient information.

“(3) APPLICATION.—

“(A) IN GENERAL.—To be eligible to receive a grant under this subsection, a long-term care facility shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require (which may include evidence of consultation with the State in which the long-term care facility is located with respect to carrying out activities funded under the grant).

“(B) AUTHORITY TO LIMIT NUMBER OF APPLICANTS.—Nothing in this subsection shall be construed as prohibiting the Secretary from limiting the number of applicants for a grant under this subsection.

“(4) PARTICIPATION IN STATE HEALTH EXCHANGES.—A long-term care facility that receives a grant under this subsection shall, where available, participate in activities conducted by a State or a qualified State-designated entity (as defined in section 3013(f) of the Public Health Service Act) under a grant under section 3013 of the Public Health Service Act to coordinate care and for other purposes determined appropriate by the Secretary.

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“(5) ACCOUNTABILITY MEASURES.—The Secretary shall develop accountability measures to ensure that the activities conducted using funds made available under this subsection help improve patient safety and reduce adverse events and health care complications resulting from medication errors.

“(c) ADOPTION OF STANDARDS FOR TRANSACTIONS INVOLVING CLINICAL DATA BY LONG-TERM CARE FACILITIES.—

“(1) STANDARDS AND COMPATIBILITY.—The Secretary shall adopt electronic standards for the exchange of clinical data by long-term care facilities, including, where available, standards for messaging and nomenclature. Standards adopted by the Secretary under the preceding sentence shall be compatible with standards established under part C of title XI, standards established under subsections (b)(2)(B)(i) and (e)(4) of section 1860D–4, standards adopted under section 3004 of the Public Health Service Act, and general health information technology standards.

“(2) ELECTRONIC SUBMISSION OF DATA TO THE SECRETARY.—

“(A) IN GENERAL.—Not later than 10 years after the date of enactment of the Elder Justice Act of 2009, the Secretary shall have procedures in place to accept the optional electronic submission of clinical data by long-term care facilities pursuant to the standards adopted under paragraph (1).

“(B) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to require a long-term care facility to submit clinical data electronically to the Secretary.

“(3) REGULATIONS.—The Secretary shall promulgate regulations to carry out this subsection. Such regulations shall require a State, as a condition of the receipt of funds under this part, to conduct such data collection and reporting as the Secretary determines are necessary to satisfy the requirements of this subsection.

“(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

“(1) for fiscal year 2011, \$20,000,000;

“(2) for fiscal year 2012, \$17,500,000; and

“(3) for each of fiscal years 2013 and 2014, \$15,000,000.

“SEC. 2042. ADULT PROTECTIVE SERVICES FUNCTIONS AND GRANT PROGRAMS.

“(a) SECRETARIAL RESPONSIBILITIES.—

“(1) IN GENERAL.—The Secretary shall ensure that the Department of Health and Human Services—

“(A) provides funding authorized by this part to State and local adult protective services offices that investigate reports of the abuse, neglect, and exploitation of elders;

“(B) collects and disseminates data annually relating to the abuse, exploitation, and neglect of elders in coordination with the Department of Justice;

“(C) develops and disseminates information on best practices regarding, and provides training on, carrying out adult protective services;

“(D) conducts research related to the provision of adult protective services; and

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“(E) provides technical assistance to States and other entities that provide or fund the provision of adult protective services, including through grants made under subsections (b) and (c).

“(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, \$3,000,000 for fiscal year 2011 and \$4,000,000 for each of fiscal years 2012 through 2014.

“(b) GRANTS TO ENHANCE THE PROVISION OF ADULT PROTECTIVE SERVICES.—

“(1) ESTABLISHMENT.—There is established an adult protective services grant program under which the Secretary shall annually award grants to States in the amounts calculated under paragraph (2) for the purposes of enhancing adult protective services provided by States and local units of government.

“(2) AMOUNT OF PAYMENT.—

“(A) IN GENERAL.—Subject to the availability of appropriations and subparagraphs (B) and (C), the amount paid to a State for a fiscal year under the program under this subsection shall equal the amount appropriated for that year to carry out this subsection multiplied by the percentage of the total number of elders who reside in the United States who reside in that State.

“(B) GUARANTEED MINIMUM PAYMENT AMOUNT.—

“(i) 50 STATES.—Subject to clause (ii), if the amount determined under subparagraph (A) for a State for a fiscal year is less than 0.75 percent of the amount appropriated for such year, the Secretary shall increase such determined amount so that the total amount paid under this subsection to the State for the year is equal to 0.75 percent of the amount so appropriated.

“(ii) TERRITORIES.—In the case of a State other than 1 of the 50 States, clause (i) shall be applied as if each reference to ‘0.75’ were a reference to ‘0.1’.

“(C) PRO RATA REDUCTIONS.—The Secretary shall make such pro rata reductions to the amounts described in subparagraph (A) as are necessary to comply with the requirements of subparagraph (B).

“(3) AUTHORIZED ACTIVITIES.—

“(A) ADULT PROTECTIVE SERVICES.—Funds made available pursuant to this subsection may only be used by States and local units of government to provide adult protective services and may not be used for any other purpose.

“(B) USE BY AGENCY.—Each State receiving funds pursuant to this subsection shall provide such funds to the agency or unit of State government having legal responsibility for providing adult protective services within the State.

“(C) SUPPLEMENT NOT SUPPLANT.—Each State or local unit of government shall use funds made available pursuant to this subsection to supplement and not supplant other Federal, State, and local public funds expended to provide adult protective services in the State.

“(4) STATE REPORTS.—Each State receiving funds under this subsection shall submit to the Secretary, at such time and in such manner as the Secretary may require, a report

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on the number of elders served by the grants awarded under this subsection.

“(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, \$100,000,000 for each of fiscal years 2011 through 2014.

“(c) STATE DEMONSTRATION PROGRAMS.—

“(1) ESTABLISHMENT.—The Secretary shall award grants to States for the purposes of conducting demonstration programs in accordance with paragraph (2).

“(2) DEMONSTRATION PROGRAMS.—Funds made available pursuant to this subsection may be used by States and local units of government to conduct demonstration programs that test—

“(A) training modules developed for the purpose of detecting or preventing elder abuse;

“(B) methods to detect or prevent financial exploitation of elders;

“(C) methods to detect elder abuse;

“(D) whether training on elder abuse forensics enhances the detection of elder abuse by employees of the State or local unit of government; or

“(E) other matters relating to the detection or prevention of elder abuse.

“(3) APPLICATION.—To be eligible to receive a grant under this subsection, a State shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

“(4) STATE REPORTS.—Each State that receives funds under this subsection shall submit to the Secretary a report at such time, in such manner, and containing such information as the Secretary may require on the results of the demonstration program conducted by the State using funds made available under this subsection.

“(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, \$25,000,000 for each of fiscal years 2011 through 2014.

“SEC. 2043. LONG-TERM CARE OMBUDSMAN PROGRAM GRANTS AND TRAINING.

“(a) GRANTS TO SUPPORT THE LONG-TERM CARE OMBUDSMAN PROGRAM.—

“(1) IN GENERAL.—The Secretary shall make grants to eligible entities with relevant expertise and experience in abuse and neglect in long-term care facilities or long-term care ombudsman programs and responsibilities, for the purpose of—

“(A) improving the capacity of State long-term care ombudsman programs to respond to and resolve complaints about abuse and neglect;

“(B) conducting pilot programs with State long-term care ombudsman offices or local ombudsman entities; and

“(C) providing support for such State long-term care ombudsman programs and such pilot programs (such as through the establishment of a national long-term care ombudsman resource center).

“(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection—

“(A) for fiscal year 2011, \$5,000,000;

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“(B) for fiscal year 2012, \$7,500,000; and

“(C) for each of fiscal years 2013 and 2014, \$10,000,000.

“(b) OMBUDSMAN TRAINING PROGRAMS.—

“(1) IN GENERAL.—The Secretary shall establish programs to provide and improve ombudsman training with respect to elder abuse, neglect, and exploitation for national organizations and State long-term care ombudsman programs.

“(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, for each of fiscal years 2011 through 2014, \$10,000,000.

“SEC. 2044. PROVISION OF INFORMATION REGARDING, AND EVALUATIONS OF, ELDER JUSTICE PROGRAMS.

“(a) PROVISION OF INFORMATION.—To be eligible to receive a grant under this part, an applicant shall agree—

“(1) except as provided in paragraph (2), to provide the eligible entity conducting an evaluation under subsection (b) of the activities funded through the grant with such information as the eligible entity may require in order to conduct such evaluation; or

“(2) in the case of an applicant for a grant under section 2041(b), to provide the Secretary with such information as the Secretary may require to conduct an evaluation or audit under subsection (c).

“(b) USE OF ELIGIBLE ENTITIES TO CONDUCT EVALUATIONS.—

“(1) EVALUATIONS REQUIRED.—Except as provided in paragraph (2), the Secretary shall—

“(A) reserve a portion (not less than 2 percent) of the funds appropriated with respect to each program carried out under this part; and

“(B) use the funds reserved under subparagraph (A) to provide assistance to eligible entities to conduct evaluations of the activities funded under each program carried out under this part.

“(2) CERTIFIED EHR TECHNOLOGY GRANT PROGRAM NOT INCLUDED.—The provisions of this subsection shall not apply to the certified EHR technology grant program under section 2041(b).

“(3) AUTHORIZED ACTIVITIES.—A recipient of assistance described in paragraph (1)(B) shall use the funds made available through the assistance to conduct a validated evaluation of the effectiveness of the activities funded under a program carried out under this part.

“(4) APPLICATIONS.—To be eligible to receive assistance under paragraph (1)(B), an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a proposal for the evaluation.

“(5) REPORTS.—Not later than a date specified by the Secretary, an eligible entity receiving assistance under paragraph (1)(B) shall submit to the Secretary, the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives, and the Committee on Finance of the Senate a report containing the results of the evaluation conducted using such assistance together with such recommendations as the entity determines to be appropriate.

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“(c) EVALUATIONS AND AUDITS OF CERTIFIED EHR TECHNOLOGY GRANT PROGRAM BY THE SECRETARY.—

“(1) EVALUATIONS.—The Secretary shall conduct an evaluation of the activities funded under the certified EHR technology grant program under section 2041(b). Such evaluation shall include an evaluation of whether the funding provided under the grant is expended only for the purposes for which it is made.

“(2) AUDITS.—The Secretary shall conduct appropriate audits of grants made under section 2041(b).

“SEC. 2045. REPORT.

“Not later than October 1, 2014, the Secretary shall submit to the Elder Justice Coordinating Council established under section 2021, the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives, and the Committee on Finance of the Senate a report—

“(1) compiling, summarizing, and analyzing the information contained in the State reports submitted under subsections (b)(4) and (c)(4) of section 2042; and

“(2) containing such recommendations for legislative or administrative action as the Secretary determines to be appropriate.

“SEC. 2046. RULE OF CONSTRUCTION.

“Nothing in this subtitle shall be construed as—

“(1) limiting any cause of action or other relief related to obligations under this subtitle that is available under the law of any State, or political subdivision thereof; or

“(2) creating a private cause of action for a violation of this subtitle.”.

(2) OPTION FOR STATE PLAN UNDER PROGRAM FOR TEMPORARY ASSISTANCE FOR NEEDY FAMILIES.—

(A) IN GENERAL.—Section 402(a)(1)(B) of the Social Security Act (42 U.S.C. 602(a)(1)(B)) is amended by adding at the end the following new clause:

“(v) The document shall indicate whether the State intends to assist individuals to train for, seek, and maintain employment—

“(I) providing direct care in a long-term care facility (as such terms are defined under section 2011); or

“(II) in other occupations related to elder care determined appropriate by the State for which the State identifies an unmet need for service personnel,

and, if so, shall include an overview of such assistance.”.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall take effect on January 1, 2011.

(b) PROTECTING RESIDENTS OF LONG-TERM CARE FACILITIES.—**(1) NATIONAL TRAINING INSTITUTE FOR SURVEYORS.—**

(A) IN GENERAL.—The Secretary of Health and Human Services shall enter into a contract with an entity for the purpose of establishing and operating a National Training Institute for Federal and State surveyors. Such Institute shall provide and improve the training of surveyors with respect to investigating allegations of abuse,

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neglect, and misappropriation of property in programs and long-term care facilities that receive payments under title XVIII or XIX of the Social Security Act.

(B) ACTIVITIES CARRIED OUT BY THE INSTITUTE.—The contract entered into under subparagraph (A) shall require the Institute established and operated under such contract to carry out the following activities:

(i) Assess the extent to which State agencies use specialized surveyors for the investigation of reported allegations of abuse, neglect, and misappropriation of property in such programs and long-term care facilities.

(ii) Evaluate how the competencies of surveyors may be improved to more effectively investigate reported allegations of such abuse, neglect, and misappropriation of property, and provide feedback to Federal and State agencies on the evaluations conducted.

(iii) Provide a national program of training, tools, and technical assistance to Federal and State surveyors on investigating reports of such abuse, neglect, and misappropriation of property.

(iv) Develop and disseminate information on best practices for the investigation of such abuse, neglect, and misappropriation of property.

(v) Assess the performance of State complaint intake systems, in order to ensure that the intake of complaints occurs 24 hours per day, 7 days a week (including holidays).

(vi) To the extent approved by the Secretary of Health and Human Services, provide a national 24 hours per day, 7 days a week (including holidays), back-up system to State complaint intake systems in order to ensure optimum national responsiveness to complaints of such abuse, neglect, and misappropriation of property.

(vii) Analyze and report annually on the following:

(I) The total number and sources of complaints of such abuse, neglect, and misappropriation of property.

(II) The extent to which such complaints are referred to law enforcement agencies.

(III) General results of Federal and State investigations of such complaints.

(viii) Conduct a national study of the cost to State agencies of conducting complaint investigations of skilled nursing facilities and nursing facilities under sections 1819 and 1919, respectively, of the Social Security Act (42 U.S.C. 1395i-3; 1396r), and making recommendations to the Secretary of Health and Human Services with respect to options to increase the efficiency and cost-effectiveness of such investigations.

(C) AUTHORIZATION.—There are authorized to be appropriated to carry out this paragraph, for the period of fiscal years 2011 through 2014, \$12,000,000.

(2) GRANTS TO STATE SURVEY AGENCIES.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall make grants to State agencies that perform surveys of skilled nursing facilities or nursing facilities

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under sections 1819 or 1919, respectively, of the Social Security Act (42 U.S.C. 1395i-3; 1395r).

(B) USE OF FUNDS.—A grant awarded under subparagraph (A) shall be used for the purpose of designing and implementing complaint investigations systems that—

(i) promptly prioritize complaints in order to ensure a rapid response to the most serious and urgent complaints;

(ii) respond to complaints with optimum effectiveness and timeliness; and

(iii) optimize the collaboration between local authorities, consumers, and providers, including—

(I) such State agency;

(II) the State Long-Term Care Ombudsman;

(III) local law enforcement agencies;

(IV) advocacy and consumer organizations;

(V) State aging units;

(VI) Area Agencies on Aging; and

(VII) other appropriate entities.

(C) AUTHORIZATION.—There are authorized to be appropriated to carry out this paragraph, for each of fiscal years 2011 through 2014, \$5,000,000.

(3) REPORTING OF CRIMES IN FEDERALLY FUNDED LONG-TERM CARE FACILITIES.—Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by section 6005, is amended by inserting after section 1150A the following new section:

“REPORTING TO LAW ENFORCEMENT OF CRIMES OCCURRING IN
FEDERALLY FUNDED LONG-TERM CARE FACILITIES

“SEC. 1150B. (a) DETERMINATION AND NOTIFICATION.—

“(1) DETERMINATION.—The owner or operator of each long-term care facility that receives Federal funds under this Act shall annually determine whether the facility received at least \$10,000 in such Federal funds during the preceding year.

“(2) NOTIFICATION.—If the owner or operator determines under paragraph (1) that the facility received at least \$10,000 in such Federal funds during the preceding year, such owner or operator shall annually notify each covered individual (as defined in paragraph (3)) of that individual’s obligation to comply with the reporting requirements described in subsection (b).

“(3) COVERED INDIVIDUAL DEFINED.—In this section, the term ‘covered individual’ means each individual who is an owner, operator, employee, manager, agent, or contractor of a long-term care facility that is the subject of a determination described in paragraph (1).

“(b) REPORTING REQUIREMENTS.—

“(1) IN GENERAL.—Each covered individual shall report to the Secretary and 1 or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime (as defined by the law of the applicable political subdivision) against any individual who is a resident of, or is receiving care from, the facility.

“(2) TIMING.—If the events that cause the suspicion—

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“(A) result in serious bodily injury, the individual shall report the suspicion immediately, but not later than 2 hours after forming the suspicion; and

“(B) do not result in serious bodily injury, the individual shall report the suspicion not later than 24 hours after forming the suspicion.

“(c) PENALTIES.—

“(1) IN GENERAL.—If a covered individual violates subsection (b)—

“(A) the covered individual shall be subject to a civil money penalty of not more than \$200,000; and

“(B) the Secretary may make a determination in the same proceeding to exclude the covered individual from participation in any Federal health care program (as defined in section 1128B(f)).

“(2) INCREASED HARM.—If a covered individual violates subsection (b) and the violation exacerbates the harm to the victim of the crime or results in harm to another individual—

“(A) the covered individual shall be subject to a civil money penalty of not more than \$300,000; and

“(B) the Secretary may make a determination in the same proceeding to exclude the covered individual from participation in any Federal health care program (as defined in section 1128B(f)).

“(3) EXCLUDED INDIVIDUAL.—During any period for which a covered individual is classified as an excluded individual under paragraph (1)(B) or (2)(B), a long-term care facility that employs such individual shall be ineligible to receive Federal funds under this Act.

“(4) EXTENUATING CIRCUMSTANCES.—

“(A) IN GENERAL.—The Secretary may take into account the financial burden on providers with underserved populations in determining any penalty to be imposed under this subsection.

“(B) UNDERSERVED POPULATION DEFINED.—In this paragraph, the term ‘underserved population’ means the population of an area designated by the Secretary as an area with a shortage of elder justice programs or a population group designated by the Secretary as having a shortage of such programs. Such areas or groups designated by the Secretary may include—

“(i) areas or groups that are geographically isolated (such as isolated in a rural area);

“(ii) racial and ethnic minority populations; and

“(iii) populations underserved because of special needs (such as language barriers, disabilities, alien status, or age).

“(d) ADDITIONAL PENALTIES FOR RETALIATION.—

“(1) IN GENERAL.—A long-term care facility may not—

“(A) discharge, demote, suspend, threaten, harass, or deny a promotion or other employment-related benefit to an employee, or in any other manner discriminate against an employee in the terms and conditions of employment because of lawful acts done by the employee; or

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“(B) file a complaint or a report against a nurse or other employee with the appropriate State professional disciplinary agency because of lawful acts done by the nurse or employee, for making a report, causing a report to be made, or for taking steps in furtherance of making a report pursuant to subsection (b)(1).

“(2) PENALTIES FOR RETALIATION.—If a long-term care facility violates subparagraph (A) or (B) of paragraph (1) the facility shall be subject to a civil money penalty of not more than \$200,000 or the Secretary may classify the entity as an excluded entity for a period of 2 years pursuant to section 1128(b), or both.

“(3) REQUIREMENT TO POST NOTICE.—Each long-term care facility shall post conspicuously in an appropriate location a sign (in a form specified by the Secretary) specifying the rights of employees under this section. Such sign shall include a statement that an employee may file a complaint with the Secretary against a long-term care facility that violates the provisions of this subsection and information with respect to the manner of filing such a complaint.

“(e) PROCEDURE.—The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to a civil money penalty or exclusion under this section in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

“(f) DEFINITIONS.—In this section, the terms ‘elder justice’, ‘long-term care facility’, and ‘law enforcement’ have the meanings given those terms in section 2011.”

(c) NATIONAL NURSE AIDE REGISTRY.—

(1) DEFINITION OF NURSE AIDE.—In this subsection, the term “nurse aide” has the meaning given that term in sections 1819(b)(5)(F) and 1919(b)(5)(F) of the Social Security Act (42 U.S.C. 1395i–3(b)(5)(F); 1396r(b)(5)(F)).

(2) STUDY AND REPORT.—

(A) IN GENERAL.—The Secretary, in consultation with appropriate government agencies and private sector organizations, shall conduct a study on establishing a national nurse aide registry.

(B) AREAS EVALUATED.—The study conducted under this subsection shall include an evaluation of—

- (i) who should be included in the registry;
- (ii) how such a registry would comply with Federal and State privacy laws and regulations;
- (iii) how data would be collected for the registry;
- (iv) what entities and individuals would have access to the data collected;
- (v) how the registry would provide appropriate information regarding violations of Federal and State law by individuals included in the registry;
- (vi) how the functions of a national nurse aide registry would be coordinated with the nationwide program for national and State background checks on direct patient access employees of long-term care facilities and providers under section 4301; and

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(vii) how the information included in State nurse aide registries developed and maintained under sections 1819(e)(2) and 1919(e)(2) of the Social Security Act (42 U.S.C. 1395i-3(e)(2); 1396r(e)(2)(2)) would be provided as part of a national nurse aide registry.

(C) CONSIDERATIONS.—In conducting the study and preparing the report required under this subsection, the Secretary shall take into consideration the findings and conclusions of relevant reports and other relevant resources, including the following:

(i) The Department of Health and Human Services Office of Inspector General Report, Nurse Aide Registries: State Compliance and Practices (February 2005).

(ii) The General Accounting Office (now known as the Government Accountability Office) Report, Nursing Homes: More Can Be Done to Protect Residents from Abuse (March 2002).

(iii) The Department of Health and Human Services Office of the Inspector General Report, Nurse Aide Registries: Long-Term Care Facility Compliance and Practices (July 2005).

(iv) The Department of Health and Human Services Health Resources and Services Administration Report, Nursing Aides, Home Health Aides, and Related Health Care Occupations—National and Local Workforce Shortages and Associated Data Needs (2004) (in particular with respect to chapter 7 and appendix F).

(v) The 2001 Report to CMS from the School of Rural Public Health, Texas A&M University, Preventing Abuse and Neglect in Nursing Homes: The Role of Nurse Aide Registries.

(vi) Information included in State nurse aide registries developed and maintained under sections 1819(e)(2) and 1919(e)(2) of the Social Security Act (42 U.S.C. 1395i-3(e)(2); 1396r(e)(2)(2)).

(D) REPORT.—Not later than 18 months after the date of enactment of this Act, the Secretary shall submit to the Elder Justice Coordinating Council established under section 2021 of the Social Security Act, as added by section 1805(a), the Committee on Finance of the Senate, and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report containing the findings and recommendations of the study conducted under this paragraph.

(E) FUNDING LIMITATION.—Funding for the study conducted under this subsection shall not exceed \$500,000.

(3) CONGRESSIONAL ACTION.—After receiving the report submitted by the Secretary under paragraph (2)(D), the Committee on Finance of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives shall, as they deem appropriate, take action based on the recommendations contained in the report.

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(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary for the purpose of carrying out this subsection.

(d) CONFORMING AMENDMENTS.—

(1) TITLE XX.—Title XX of the Social Security Act (42 U.S.C. 1397 et seq.), as amended by section 6703(a), is amended—

(A) in the heading of section 2001, by striking “TITLE” and inserting “SUBTITLE”; and

(B) in subtitle 1, by striking “this title” each place it appears and inserting “this subtitle”.

(2) TITLE IV.—Title IV of the Social Security Act (42 U.S.C. 601 et seq.) is amended—

(A) in section 404(d)—

(i) in paragraphs (1)(A), (2)(A), and (3)(B), by inserting “subtitle 1 of” before “title XX” each place it appears;

(ii) in the heading of paragraph (2), by inserting “SUBTITLE 1 OF” before “TITLE XX”; and

(iii) in the heading of paragraph (3)(B), by inserting “SUBTITLE 1 OF” before “TITLE XX”; and

(B) in sections 422(b), 471(a)(4), 472(h)(1), and 473(b)(2), by inserting “subtitle 1 of” before “title XX” each place it appears.

(3) TITLE XI.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended—

(A) in section 1128(h)(3)—

(i) by inserting “subtitle 1 of” before “title XX”; and

(ii) by striking “such title” and inserting “such subtitle”; and

(B) in section 1128A(i)(1), by inserting “subtitle 1 of” before “title XX”.

Subtitle I—Sense of the Senate Regarding Medical Malpractice

SEC. 6801. SENSE OF THE SENATE REGARDING MEDICAL MALPRACTICE.

It is the sense of the Senate that—

(1) health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance;

(2) States should be encouraged to develop and test alternatives to the existing civil litigation system as a way of improving patient safety, reducing medical errors, encouraging the efficient resolution of disputes, increasing the availability of prompt and fair resolution of disputes, and improving access to liability insurance, while preserving an individual’s right to seek redress in court; and

(3) Congress should consider establishing a State demonstration program to evaluate alternatives to the existing civil litigation system with respect to the resolution of medical malpractice claims.

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by the Secretary as a standard code set under section 1173(c) of the Social Security Act (42 U.S.C. 1320d–2(c)), the Secretary shall, after consultation with the appropriate stakeholders, post on the website of the Centers for Medicare & Medicaid Services a crosswalk between the previous and subsequent version of the International Classification of Diseases not later than the date of implementation of such subsequent revision.

Subtitle B—Provisions Relating to Title II

PART 1—MEDICAID AND CHIP

SEC. 10201. AMENDMENTS TO THE SOCIAL SECURITY ACT AND TITLE II OF THIS ACT.

(a)(1) **[Replaced section 1902(a)(10)(A)(i)(IX) of the Social Security Act, as added by section 2004(a)]**

(2) Section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10), as amended by section 2001(a)(5)(A), is amended in the matter following subparagraph (G), by striking “and (XV)” and inserting “(XV)”, and by inserting “and (XVI) if an individual is described in subclause (IX) of subparagraph (A)(i) and is also described in subclause (VIII) of that subparagraph, the medical assistance shall be made available to the individual through subclause (IX) instead of through subclause (VIII)” before the semicolon.

(3) **[Amended section 2004(d)]**

(b) **[Amended section 1902(k)(2) of the Social Security Act, as added by section 2001(a)(4)(A)]**

(c) Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by sections 2001(a)(3), 2001(a)(5)(C), 2006, and 4107(a)(2), is amended—

(1) in subsection (a), in the matter preceding paragraph (1), by inserting in clause (xiv), “or 1902(a)(10)(A)(i)(IX)” before the comma;

(2) in subsection (b), in the first sentence, by inserting “, (z),” before “and (aa)”;

(3) in subsection (y)—

(A) in paragraph (1)(B)(ii)(II), in the first sentence, by inserting “includes inpatient hospital services,” after “100 percent of the poverty line, that”; and **[subclause (II) was redesignated by section 1201(1)(A) of HCERA]**

(B) **[Amended paragraph (2)(A)]**

(4) by inserting after subsection (y) the following:

“(z) **EQUITABLE SUPPORT FOR CERTAIN STATES.**—

“(1) **[As revised by section 1201(2)(A) of HCERA]** (A) During the period that begins on January 1, 2014, and ends on December 31, 2015, notwithstanding subsection (b), the Federal medical assistance percentage otherwise determined under subsection (b) with respect to a fiscal year occurring during that period shall be increased by 2.2 percentage points for any State described in subparagraph (B) for amounts expended for medical assistance for individuals who are not newly eligible (as defined in subsection (y)(2)) individuals described in subclause (VIII) of section 1902(a)(10)(A)(i).

“(B) For purposes of subparagraph (A), a State described in this subparagraph is a State that—

“(i) is an expansion State described in paragraph (3);

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“(ii) the Secretary determines will not receive any payments under this title on the basis of an increased Federal medical assistance percentage under subsection (y) for expenditures for medical assistance for newly eligible individuals (as so defined); and

“(iii) has not been approved by the Secretary to divert a portion of the DSH allotment for a State to the costs of providing medical assistance or other health benefits coverage under a waiver that is in effect on July 2009.

“(2) **[Paragraph (2)—shown below—substituted for previous paragraphs (2) - (4) by section 1201(2)(B) of HCERA]** (A) For calendar quarters in 2014 and each year thereafter, the Federal medical assistance percentage otherwise determined under subsection (b) for an expansion State described in paragraph (3) with respect to medical assistance for individuals described in section 1902(a)(10)(A)(i)(VIII) who are nonpregnant childless adults with respect to whom the State may require enrollment in benchmark coverage under section 1937 shall be equal to the percent specified in subparagraph (B)(i) for such year.

“(B)(i) The percent specified in this subparagraph for a State for a year is equal to the Federal medical assistance percentage (as defined in the first sentence of subsection (b)) for the State increased by a number of percentage points equal to the transition percentage (specified in clause (ii) for the year) of the number of percentage points by which—

“(I) such Federal medical assistance percentage for the State, is less than

“(II) the percent specified in subsection (y)(1) for the year.

“(ii) The transition percentage specified in this clause for—

“(I) 2014 is 50 percent;

“(II) 2015 is 60 percent;

“(III) 2016 is 70 percent;

“(IV) 2017 is 80 percent;

“(V) 2018 is 90 percent; and

“(VI) 2019 and each subsequent year is 100 percent.

[Previous paragraphs (3) and (4) stricken by section 1201(2)(B) of HCERA]

“(3) **[this paragraph added originally as a subclause (II) of paragraph (1)(B)(ii) of subsection (y) by section 2001(a)(3), amended by section 10201(c), and redesignated as paragraph (5) of subsection (z) by section 1201(1)(A) of HCERA, and redesignated as paragraph (3) and amended by section 1201(2)(C) of HCERA]** A State is an expansion State if, on the date of the enactment of the Patient Protection and Affordable Care Act, the State offers health benefits coverage statewide to parents and nonpregnant, childless adults whose income is at least 100 percent of the poverty line, includes inpatient hospital services, that is not dependent on access to employer coverage, employer contribution, or employment and is not limited to premium assistance, hospital-only benefits, a high deductible health plan, or alternative benefits under a demonstration program authorized under section 1938. A State that offers health benefits coverage to only parents or only nonpregnant childless adults described in the preceding sentence shall not be considered to be an expansion State.”;

(5) **[Struck and inserted language in subsection (aa)]**

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(6) by adding after subsection (bb), the following:

“(cc) REQUIREMENT FOR CERTAIN STATES.—Notwithstanding subsections (y), (z), and (aa), in the case of a State that requires political subdivisions within the State to contribute toward the non-Federal share of expenditures required under the State plan under section 1902(a)(2), the State shall not be eligible for an increase in its Federal medical assistance percentage under such subsections if it requires that political subdivisions pay a greater percentage of the non-Federal share of such expenditures, or a greater percentage of the non-Federal share of payments under section 1923, than the respective percentages that would have been required by the State under the State plan under this title, State law, or both, as in effect on December 31, 2009, and without regard to any such increase. Voluntary contributions by a political subdivision to the non-Federal share of expenditures under the State plan under this title or to the non-Federal share of payments under section 1923, shall not be considered to be required contributions for purposes of this subsection. The treatment of voluntary contributions, and the treatment of contributions required by a State under the State plan under this title, or State law, as provided by this subsection, shall also apply to the increases in the Federal medical assistance percentage under section 5001 of the American Recovery and Reinvestment Act of 2009.”

(d) **Amended section 1108(g)(4)(B) of the Social Security Act (42 U.S.C. 1308(g)(4)(B)), as added by section 2005(b)**

(e)(1) Section 1923(f) of the Social Security Act (42 U.S.C. 1396r-4(f)), as amended by section 2551, is amended—

(A) in paragraph (6)—

(i) by striking the paragraph heading and inserting the following: “ALLOTMENT ADJUSTMENTS”; and

(ii) in subparagraph (B), by adding at the end the following:

“(iii) ALLOTMENT FOR 2D, 3RD, AND 4TH QUARTER OF FISCAL YEAR 2012, FISCAL YEAR 2013, AND SUCCEEDING FISCAL YEARS.—Notwithstanding the table set forth in paragraph (2) or paragraph (7):

“(I) 2D, 3RD, AND 4TH QUARTER OF FISCAL YEAR 2012.—The DSH allotment for Hawaii for the 2d, 3rd, and 4th quarters of fiscal year 2012 shall be \$7,500,000.

“(II) TREATMENT AS A LOW-DSH STATE FOR FISCAL YEAR 2013 AND SUCCEEDING FISCAL YEARS.—With respect to fiscal year 2013, and each fiscal year thereafter, the DSH allotment for Hawaii shall be increased in the same manner as allotments for low DSH States are increased for such fiscal year under clause (iii) of paragraph (5)(B).

“(III) CERTAIN HOSPITAL PAYMENTS.—The Secretary may not impose a limitation on the total amount of payments made to hospitals under the QUEST section 1115 Demonstration Project except to the extent that such limitation is necessary to ensure that a hospital does not receive payments in excess of the amounts described in subsection (g), or as necessary to ensure that such payments under the waiver and such payments pursuant to the allotment provided in this clause do not,

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in the aggregate in any year, exceed the amount that the Secretary determines is equal to the Federal medical assistance percentage component attributable to disproportionate share hospital payment adjustments for such year that is reflected in the budget neutrality provision of the QUEST Demonstration Project.”; and

[(B) in paragraph (7)—[Amendments superseded by amendment made by section 1203(w) of HCERA]]

[(i) in subparagraph (A), in the matter preceding clause (i), by striking “subparagraph (E)” and inserting “subparagraphs (E) and (G)”];

[(ii) in subparagraph (B)—]

[(I) in clause (i), by striking subclauses (I) and (II), and inserting the following:]

[(I) if the State is a low DSH State described in paragraph (5)(B) and has spent not more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to 25 percent;]

[(II) if the State is a low DSH State described in paragraph (5)(B) and has spent more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to 17.5 percent;]

[(III) if the State is not a low DSH State described in paragraph (5)(B) and has spent not more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to 50 percent; and]

[(IV) if the State is not a low DSH State described in paragraph (5)(B) and has spent more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to 35 percent.”];

[(II) in clause (ii), by striking subclauses (I) and (II), and inserting the following:]

[(I) if the State is a low DSH State described in paragraph (5)(B) and has spent not more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to the product of the percentage reduction in uncovered individuals for the fiscal year from the preceding fiscal year and 27.5 percent;]

[(II) if the State is a low DSH State described in paragraph (5)(B) and has spent more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable

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percentage is equal to the product of the percentage reduction in uncovered individuals for the fiscal year from the preceding fiscal year and 20 percent;】

【“(III) if the State is not a low DSH State described in paragraph (5)(B) and has spent not more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to the product of the percentage reduction in uncovered individuals for the fiscal year from the preceding fiscal year and 55 percent; and】

【“(IV) if the State is not a low DSH State described in paragraph (5)(B) and has spent more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to the product of the percentage reduction in uncovered individuals for the fiscal year from the preceding fiscal year and 40 percent.”;】

【(III) in subparagraph (E), by striking “35 percent” and inserting “50 percent”; and】

【(IV) by adding at the end the following:】

【“(G) NONAPPLICATION.—The preceding provisions of this paragraph shall not apply to the DSH allotment determined for the State of Hawaii for a fiscal year under paragraph (6).”】

(f) **【Struck subsection (b) of section 2551】**

(g) **【Inserted sentence at the end of section 2105(d)(3)(B) of the Social Security Act, as added by section 2101(b)(1)】**

(h) **【Replaced section 513(b)(2)(C)(i) of the Social Security Act, as added by section 2953】**

(i) Section 1115 of the Social Security Act (42 U.S.C. 1315) is amended by inserting after subsection (c) the following:

“(d)(1) An application or renewal of any experimental, pilot, or demonstration project undertaken under subsection (a) to promote the objectives of title XIX or XXI in a State that would result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing with respect to a State program under title XIX or XXI (in this subsection referred to as a ‘demonstration project’) shall be considered by the Secretary in accordance with the regulations required to be promulgated under paragraph (2).

“(2) Not later than 180 days after the date of enactment of this subsection, the Secretary shall promulgate regulations relating to applications for, and renewals of, a demonstration project that provide for—

“(A) a process for public notice and comment at the State level, including public hearings, sufficient to ensure a meaningful level of public input;

“(B) requirements relating to—

“(i) the goals of the program to be implemented or renewed under the demonstration project;

“(ii) the expected State and Federal costs and coverage projections of the demonstration project; and

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“(iii) the specific plans of the State to ensure that the demonstration project will be in compliance with title XIX or XXI;

“(C) a process for providing public notice and comment after the application is received by the Secretary, that is sufficient to ensure a meaningful level of public input;

“(D) a process for the submission to the Secretary of periodic reports by the State concerning the implementation of the demonstration project; and

“(E) a process for the periodic evaluation by the Secretary of the demonstration project.

“(3) The Secretary shall annually report to Congress concerning actions taken by the Secretary with respect to applications for demonstration projects under this section.”.

(j) *[Added section 3512 to subtitle F of title III]*

SEC. 10202. INCENTIVES FOR STATES TO OFFER HOME AND COMMUNITY-BASED SERVICES AS A LONG-TERM CARE ALTERNATIVE TO NURSING HOMES.

(a) STATE BALANCING INCENTIVE PAYMENTS PROGRAM.—Notwithstanding section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), in the case of a balancing incentive payment State, as defined in subsection (b), that meets the conditions described in subsection (c), during the balancing incentive period, the Federal medical assistance percentage determined for the State under section 1905(b) of such Act and, if applicable, increased under subsection (z) or (aa) shall be increased by the applicable percentage points determined under subsection (d) with respect to eligible medical assistance expenditures described in subsection (e).

(b) BALANCING INCENTIVE PAYMENT STATE.—A balancing incentive payment State is a State—

(1) in which less than 50 percent of the total expenditures for medical assistance under the State Medicaid program for a fiscal year for long-term services and supports (as defined by the Secretary under subsection (f))(1) are for non-institutionally-based long-term services and supports described in subsection (f)(1)(B);

(2) that submits an application and meets the conditions described in subsection (c); and

(3) that is selected by the Secretary to participate in the State balancing incentive payment program established under this section.

(c) CONDITIONS.—The conditions described in this subsection are the following:

(1) APPLICATION.—The State submits an application to the Secretary that includes, in addition to such other information as the Secretary shall require—

(A) a proposed budget that details the State’s plan to expand and diversify medical assistance for non-institutionally-based long-term services and supports described in subsection (f)(1)(B) under the State Medicaid program during the balancing incentive period and achieve the target spending percentage applicable to the State under paragraph (2), including through structural changes to how the State furnishes such assistance, such as through the establishment of a “no wrong door—single entry point system”, optional presumptive eligibility, case management

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services, and the use of core standardized assessment instruments, and that includes a description of the new or expanded offerings of such services that the State will provide and the projected costs of such services; and

(B) in the case of a State that proposes to expand the provision of home and community-based services under its State Medicaid program through a State plan amendment under section 1915(i) of the Social Security Act, at the option of the State, an election to increase the income eligibility for such services from 150 percent of the poverty line to such higher percentage as the State may establish for such purpose, not to exceed 300 percent of the supplemental security income benefit rate established by section 1611(b)(1) of the Social Security Act (42 U.S.C. 1382(b)(1)).

(2) TARGET SPENDING PERCENTAGES.—

(A) In the case of a balancing incentive payment State in which less than 25 percent of the total expenditures for long-term services and supports under the State Medicaid program for fiscal year 2009 are for home and community-based services, the target spending percentage for the State to achieve by not later than October 1, 2015, is that 25 percent of the total expenditures for long-term services and supports under the State Medicaid program are for home and community-based services.

(B) In the case of any other balancing incentive payment State, the target spending percentage for the State to achieve by not later than October 1, 2015, is that 50 percent of the total expenditures for long-term services and supports under the State Medicaid program are for home and community-based services.

(3) MAINTENANCE OF ELIGIBILITY REQUIREMENTS.—The State does not apply eligibility standards, methodologies, or procedures for determining eligibility for medical assistance for non-institutionally-based long-term services and supports described in subsection (f)(1)(B) under the State Medicaid program that are more restrictive than the eligibility standards, methodologies, or procedures in effect for such purposes on December 31, 2010.

(4) USE OF ADDITIONAL FUNDS.—The State agrees to use the additional Federal funds paid to the State as a result of this section only for purposes of providing new or expanded offerings of non-institutionally-based long-term services and supports described in subsection (f)(1)(B) under the State Medicaid program.

(5) STRUCTURAL CHANGES.—The State agrees to make, not later than the end of the 6-month period that begins on the date the State submits an application under this section, the following changes:

(A) “NO WRONG DOOR—SINGLE ENTRY POINT SYSTEM”.—Development of a statewide system to enable consumers to access all long-term services and supports through an agency, organization, coordinated network, or portal, in accordance with such standards as the State shall establish and that shall provide information regarding the availability of such services, how to apply for such services, referral services for services and supports otherwise available in the community, and determinations of financial

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and functional eligibility for such services and supports, or assistance with assessment processes for financial and functional eligibility.

(B) CONFLICT-FREE CASE MANAGEMENT SERVICES.—Conflict-free case management services to develop a service plan, arrange for services and supports, support the beneficiary (and, if appropriate, the beneficiary's caregivers) in directing the provision of services and supports for the beneficiary, and conduct ongoing monitoring to assure that services and supports are delivered to meet the beneficiary's needs and achieve intended outcomes.

(C) CORE STANDARDIZED ASSESSMENT INSTRUMENTS.—Development of core standardized assessment instruments for determining eligibility for non-institutionally-based long-term services and supports described in subsection (f)(1)(B), which shall be used in a uniform manner throughout the State, to determine a beneficiary's needs for training, support services, medical care, transportation, and other services, and develop an individual service plan to address such needs.

(6) DATA COLLECTION.—The State agrees to collect from providers of services and through such other means as the State determines appropriate the following data:

(A) SERVICES DATA.—Services data from providers of non-institutionally-based long-term services and supports described in subsection (f)(1)(B) on a per-beneficiary basis and in accordance with such standardized coding procedures as the State shall establish in consultation with the Secretary.

(B) QUALITY DATA.—Quality data on a selected set of core quality measures agreed upon by the Secretary and the State that are linked to population-specific outcomes measures and accessible to providers.

(C) OUTCOMES MEASURES.—Outcomes measures data on a selected set of core population-specific outcomes measures agreed upon by the Secretary and the State that are accessible to providers and include—

(i) measures of beneficiary and family caregiver experience with providers;

(ii) measures of beneficiary and family caregiver satisfaction with services; and

(iii) measures for achieving desired outcomes appropriate to a specific beneficiary, including employment, participation in community life, health stability, and prevention of loss in function.

(d) APPLICABLE PERCENTAGE POINTS INCREASE IN FMAP.—The applicable percentage points increase is—

(1) in the case of a balancing incentive payment State subject to the target spending percentage described in subsection (c)(2)(A), 5 percentage points; and

(2) in the case of any other balancing incentive payment State, 2 percentage points.

(e) ELIGIBLE MEDICAL ASSISTANCE EXPENDITURES.—

(1) IN GENERAL.—Subject to paragraph (2), medical assistance described in this subsection is medical assistance for non-institutionally-based long-term services and supports described in subsection (f)(1)(B) that is provided by a balancing incentive

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payment State under its State Medicaid program during the balancing incentive payment period.

(2) LIMITATION ON PAYMENTS.—In no case may the aggregate amount of payments made by the Secretary to balancing incentive payment States under this section during the balancing incentive period exceed \$3,000,000,000.

(f) DEFINITIONS.—In this section:

(1) LONG-TERM SERVICES AND SUPPORTS DEFINED.—The term “long-term services and supports” has the meaning given that term by Secretary and may include any of the following (as defined for purposes of State Medicaid programs):

(A) INSTITUTIONALLY-BASED LONG-TERM SERVICES AND SUPPORTS.—Services provided in an institution, including the following:

(i) Nursing facility services.

(ii) Services in an intermediate care facility for the mentally retarded described in subsection (a)(15) of section 1905 of such Act.

(B) NON-INSTITUTIONALLY-BASED LONG-TERM SERVICES AND SUPPORTS.—Services not provided in an institution, including the following:

(i) Home and community-based services provided under subsection (c), (d), or (i) of section 1915 of such Act or under a waiver under section 1115 of such Act.

(ii) Home health care services.

(iii) Personal care services.

(iv) Services described in subsection (a)(26) of section 1905 of such Act (relating to PACE program services).

(v) Self-directed personal assistance services described in section 1915(j) of such Act.

(2) BALANCING INCENTIVE PERIOD.—The term “balancing incentive period” means the period that begins on October 1, 2011, and ends on September 30, 2015.

(3) 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. 1397j(c)(5)).

(4) STATE MEDICAID PROGRAM.—The term “State Medicaid program” means the State program for medical assistance provided under a State plan under title XIX of the Social Security Act and under any waiver approved with respect to such State plan.

SEC. 10203. EXTENSION OF FUNDING FOR CHIP THROUGH FISCAL YEAR 2015 AND OTHER CHIP-RELATED PROVISIONS.

(a) *Inserted subparagraph (I) at the end of section 1311(c)(1)*

(b) Effective as if included in the enactment of the Children’s Health Insurance Program Reauthorization Act of 2009 (Public Law 111–3):

(1) Section 1906(e)(2) of the Social Security Act (42 U.S.C. 1396e(e)(2)) is amended by striking “means” and all that follows through the period and inserting “has the meaning given that term in section 2105(c)(3)(A).”.

(2)(A) Section 1906A(a) of the Social Security Act (42 U.S.C. 1396e–1(a)), is amended by inserting before the period the

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following: “and the offering of such a subsidy is cost-effective, as defined for purposes of section 2105(c)(3)(A)”.

(B) This Act shall be applied without regard to subparagraph (A) of section 2003(a)(1) of this Act and that subparagraph and the amendment made by that subparagraph are hereby deemed null, void, and of no effect.

(3) Section 2105(c)(10) of the Social Security Act (42 U.S.C. 1397ee(c)(10)) is amended—

(A) in subparagraph (A), in the first sentence, by inserting before the period the following: “if the offering of such a subsidy is cost-effective, as defined for purposes of paragraph (3)(A)”;

(B) by striking subparagraph (M); and

(C) by redesignating subparagraph (N) as subparagraph (M).

(4) Section 2105(c)(3)(A) of the Social Security Act (42 U.S.C. 1397ee(c)(3)(A)) is amended—

(A) in the matter preceding clause (i), by striking “to” and inserting “to—”; and

(B) in clause (ii), by striking the period and inserting a semicolon.

(c) *[Amended subsections (b) and (d)(3) of section 2105 of the Social Security Act (42 U.S.C. 1397ee), as amended by section 2101]*

(d)(1) Section 2104(a) of such Act (42 U.S.C. 1397dd(a)) is amended—

(A) in paragraph (15), by striking “and” at the end; and

(B) by striking paragraph (16) and inserting the following:

“(16) for fiscal year 2013, \$17,406,000,000;

“(17) for fiscal year 2014, \$19,147,000,000; and

“(18) for fiscal year 2015, for purposes of making 2 semi-annual allotments—

“(A) \$2,850,000,000 for the period beginning on October 1, 2014, and ending on March 31, 2015, and

“(B) \$2,850,000,000 for the period beginning on April 1, 2015, and ending on September 30, 2015.”.

(2)(A) Section 2104(m) of such Act (42 U.S.C. 1397dd(m)), as amended by section 2102(a)(1), is amended—

(i) in the subsection heading, by striking “2013” and inserting “2015”;

(ii) in paragraph (2)—

(I) in the paragraph heading, by striking “2012” and inserting “2014”; and

(II) by adding at the end the following:

“(B) FISCAL YEARS 2013 AND 2014.—Subject to paragraphs (4) and (6), from the amount made available under paragraphs (16) and (17) of subsection (a) for fiscal years 2013 and 2014, respectively, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and territory) for each such fiscal year as follows:

“(i) REBASING IN FISCAL YEAR 2013.—For fiscal year 2013, the allotment of the State is equal to the Federal payments to the State that are attributable to (and countable towards) the total amount of allotments available under this section to the State in fiscal year 2012 (including payments made to the State under subsection (n) for fiscal year 2012 as well as amounts

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redistributed to the State in fiscal year 2012), multiplied by the allotment increase factor under paragraph (5) for fiscal year 2013.

“(ii) GROWTH FACTOR UPDATE FOR FISCAL YEAR 2014.—For fiscal year 2014, the allotment of the State is equal to the sum of—

“(I) the amount of the State allotment under clause (i) for fiscal year 2013; and

“(II) the amount of any payments made to the State under subsection (n) for fiscal year 2013, multiplied by the allotment increase factor under paragraph (5) for fiscal year 2014.”;

(iii) in paragraph (3)—

(I) in the paragraph heading, by striking “2013” and inserting “2015”;

(II) in subparagraphs (A) and (B), by striking “paragraph (16)” each place it appears and inserting “paragraph (18)”;

(III) in subparagraph (C)—

(aa) by striking “2012” each place it appears and inserting “2014”; and

(bb) by striking “2013” and inserting “2015”;

and

(IV) in subparagraph (D)—

(aa) in clause (i)(I), by striking “subsection (a)(16)(A)” and inserting “subsection (a)(18)(A)”;

and

(bb) in clause (ii)(II), by striking “subsection (a)(16)(B)” and inserting “subsection (a)(18)(B)”;

(iv) in paragraph (4), by striking “2013” and inserting “2015”;

(v) in paragraph (6)—

(I) in subparagraph (A), by striking “2013” and inserting “2015”; and

(II) in the flush language after and below subparagraph (B)(ii), by striking “or fiscal year 2012” and inserting “, fiscal year 2012, or fiscal year 2014”; and

(vi) in paragraph (8)—

(I) in the paragraph heading, by striking “2013” and inserting “2015”; and

(II) by striking “2013” and inserting “2015”.

(B) Section 2104(n) of such Act (42 U.S.C. 1397dd(n)) is amended—

(i) in paragraph (2)—

(I) in subparagraph (A)(ii)—

(aa) by striking “2012” and inserting “2014”; and

(bb) by striking “2013” and inserting “2015”;

(II) in subparagraph (B)—

(aa) by striking “2012” and inserting “2014”; and

(bb) by striking “2013” and inserting “2015”; and

(ii) in paragraph (3)(A), by striking “or a semi-annual allotment period for fiscal year 2013” and inserting “fiscal year 2013, fiscal year 2014, or a semi-annual allotment period for fiscal year 2015”.

(C) Section 2105(g)(4) of such Act (42 U.S.C. 1397ee(g)(4)) is amended—

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(i) in the paragraph heading, by striking “2013” and inserting “2015”; and

(ii) in subparagraph (A), by striking “2013” and inserting “2015”.

(D) Section 2110(b) of such Act (42 U.S.C. 1397jj(b)) is amended—

(i) in paragraph (2)(B), by inserting “except as provided in paragraph (6),” before “a child”; and

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

“(6) EXCEPTIONS TO EXCLUSION OF CHILDREN OF EMPLOYEES OF A PUBLIC AGENCY IN THE STATE.—

“(A) IN GENERAL.—A child shall not be considered to be described in paragraph (2)(B) if—

“(i) the public agency that employs a member of the child’s family to which such paragraph applies satisfies subparagraph (B); or

“(ii) subparagraph (C) applies to such child.

“(B) MAINTENANCE OF EFFORT WITH RESPECT TO PER PERSON AGENCY CONTRIBUTION FOR FAMILY COVERAGE.—For purposes of subparagraph (A)(i), a public agency satisfies this subparagraph if the amount of annual agency expenditures made on behalf of each employee enrolled in health coverage paid for by the agency that includes dependent coverage for the most recent State fiscal year is not less than the amount of such expenditures made by the agency for the 1997 State fiscal year, increased by the percentage increase in the medical care expenditure category of the Consumer Price Index for All-Urban Consumers (all items: U.S. City Average) for such preceding fiscal year.

“(C) HARDSHIP EXCEPTION.—For purposes of subparagraph (A)(ii), this subparagraph applies to a child if the State determines, on a case-by-case basis, that the annual aggregate amount of premiums and cost-sharing imposed for coverage of the family of the child would exceed 5 percent of such family’s income for the year involved.”.

(E) Section 2113 of such Act (42 U.S.C. 1397mm) is amended—

(i) in subsection (a)(1), by striking “2013” and inserting “2015”; and

(ii) in subsection (g), by striking “\$100,000,000 for the period of fiscal years 2009 through 2013” and inserting “\$140,000,000 for the period of fiscal years 2009 through 2015”.

(F) Section 108 of Public Law 111–3 is amended by striking “\$11,706,000,000” and all that follows through the second sentence and inserting “\$15,361,000,000 to accompany the allotment made for the period beginning on October 1, 2014, and ending on March 31, 2015, under section 2104(a)(18)(A) of the Social Security Act (42 U.S.C. 1397dd(a)(18)(A)), to remain available until expended. Such amount shall be used to provide allotments to States under paragraph (3) of section 2104(m) of the Social Security Act (42 U.S.C. 1397dd(m)) for the first 6 months of fiscal year 2015 in the same manner as allotments are provided under subsection (a)(18)(A) of such section 2104 and subject to the same terms and conditions as apply to the allotments provided from such subsection (a)(18)(A).”.

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(D) **[Amended percentage in clause (iii)]**

(2) **[Amended dollar amounts in subparagraphs (A), (B), and (D) of paragraph (3)]**

(b) THRESHOLD.—Section 5000A of such Code, as so added and amended, is amended—

(1) **[Struck subsection (c)(4)(D)]**

(2) **[Amended subsection (e)(2)]**

SEC. 1003. EMPLOYER RESPONSIBILITY [AMENDMENTS FULLY INCORPORATED INTO PPACA].

(a) PAYMENT CALCULATION.—**[Replaced section 4980H(d)(2)(D) of the IRC, as added by section 1513 (and amended by section 10106) of PPACA, before redesignation by subsection (d)]**

(b) APPLICABLE PAYMENT AMOUNT.—Section 4980H of such Code, as so added and amended, is amended—

(1) **[Amended flush text in subsection (c)(1), before redesignation by subsection (d)]**

(2) **[Amended amount in subsection (d)(1), before redesignation by subsection (d)]**

(3) **[Amended subsection (d)(5)(A), before redesignation by subsection (d)]**

(c) COUNTING PART-TIME WORKERS IN SETTING THE THRESHOLD FOR EMPLOYER RESPONSIBILITY.—**[Added a subparagraph (E) at the end of section 4980H(d)(2) of the IRC, as so added, before redesignation by subsection (d)]**

(d) ELIMINATING WAITING PERIOD ASSESSMENT.—**[Struck subsection (b) of section 4980H of the IRC and redesignated succeeding subsections accordingly]**

SEC. 1004. INCOME DEFINITIONS.

(a) MODIFIED ADJUSTED GROSS INCOME.—

(1) IN GENERAL.—**[Amended section 36B(d)(2)(A)(i) & (ii) of the IRC, added by section 1401 of PPACA, 6103(l)(21)(A)(iv) of IRC, added by section 1414 of PPACA, and 5000A(c)(4) [sic] (i) & (ii) of IRC, added by section 1501(b) of PPACA—executed as if referenced 5000A(c)(4)(B)]**

(2) DEFINITION.—

(A) **[Replaced section 36(d)(2)(B) of IRC]**

(B) **[Replaced section 5000A(c)(4)(C) of the IRC]**

(b) MODIFIED ADJUSTED GROSS INCOME DEFINITION.—

(1) MEDICAID.—**[Amended section 1902(e)(14) of the Social Security Act, added by section 2002(a) of PPACA, and 1902(gg)(4)(A) of the SSA, added by section 2001(b) of PPACA]**

(2) CHIP.—

(A) STATE PLAN REQUIREMENTS.—**[Amended section 2102(b)(1)(B)(v) of the Social Security Act, added by section 2101(d)(1) of PPACA].**

(B) PLAN ADMINISTRATION.—**[Amended section 2107(e)(1)(E) of the SSA, added by section 2101(d)(2) of PPACA]**

(c) NO EXCESS PAYMENTS.—**[Added paragraph (3) to section 36B(f) of the IRC, added by section 1401(a) of PPACA]**

(d) ADULT DEPENDENTS.—

(1) EXCLUSION OF AMOUNTS EXPENDED FOR MEDICAL CARE.—The first sentence of section 105(b) of the Internal Revenue Code of 1986 (relating to amounts expended for medical care) is amended—

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(A) by striking “and his dependents” and inserting “his dependents”; and

(B) by inserting before the period the following: “, and any child (as defined in section 152(f)(1)) of the taxpayer who as of the end of the taxable year has not attained age 27”.

(2) SELF-EMPLOYED HEALTH INSURANCE DEDUCTION.—Section 162(l)(1) of such Code is amended to read as follows:

“(1) ALLOWANCE OF DEDUCTION.—In the case of a taxpayer who is an employee within the meaning of section 401(c)(1), there shall be allowed as a deduction under this section an amount equal to the amount paid during the taxable year for insurance which constitutes medical care for—

“(A) the taxpayer,

“(B) the taxpayer’s spouse,

“(C) the taxpayer’s dependents, and

“(D) any child (as defined in section 152(f)(1)) of the taxpayer who as of the end of the taxable year has not attained age 27.”.

(3) COVERAGE UNDER SELF-EMPLOYED DEDUCTION.—Section 162(l)(2)(B) of such Code is amended by inserting “, or any dependent, or individual described in subparagraph (D) of paragraph (1) with respect to,” after “spouse of”.

(4) SICK AND ACCIDENT BENEFITS PROVIDED TO MEMBERS OF A VOLUNTARY EMPLOYEES’ BENEFICIARY ASSOCIATION AND THEIR DEPENDENTS.—Section 501(c)(9) of such Code is amended by adding at the end the following new sentence: “For purposes of providing for the payment of sick and accident benefits to members of such an association and their dependents, the term ‘dependent’ shall include any individual who is a child (as defined in section 152(f)(1)) of a member who as of the end of the calendar year has not attained age 27.”.

(5) MEDICAL AND OTHER BENEFITS FOR RETIRED EMPLOYEES.—Section 401(h) of such Code is amended by adding at the end the following: “For purposes of this subsection, the term ‘dependent’ shall include any individual who is a child (as defined in section 152(f)(1)) of a retired employee who as of the end of the calendar year has not attained age 27.”.

(e) FIVE PERCENT INCOME DISREGARD FOR CERTAIN INDIVIDUALS.—*[Amended section 1902(e)(14) of the SSA, added by section 2002(a) of PPACA, including adding a subparagraph (I)]*

SEC. 1005. IMPLEMENTATION FUNDING.

(a) IN GENERAL.—There is hereby established a Health Insurance Reform Implementation Fund (referred to in this section as the “Fund”) within the Department of Health and Human Services to carry out the Patient Protection and Affordable Care Act and this Act (and the amendments made by such Acts).

(b) FUNDING.—There is appropriated to the Fund, out of any funds in the Treasury not otherwise appropriated, \$1,000,000,000 for Federal administrative expenses to carry out such Act (and the amendments made by such Acts).

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for fiscal year 2009 bears to the sum of all such payments to all qualifying hospitals for such fiscal year.

(d) **QUALIFYING HOSPITAL DEFINED.**—In this section, the term “qualifying hospital” means a subsection (d) hospital (as defined for purposes of section 1886(d) of the Social Security Act) that is located in a county that ranks, based upon its ranking in age, sex, and race adjusted spending for benefits under parts A and B under title XVIII of such Act per enrollee, within the lowest quartile of such counties in the United States.

Subtitle C—Medicaid

SEC. 1201. FEDERAL FUNDING FOR STATES [AMENDMENTS FULLY INCORPORATED INTO PPACA].

Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by sections 2001(a)(3) and 10201(c) of the Patient Protection and Affordable Care Act, is amended—

(1) in subsection (y)—

(A) by redesignating subclause (II) of paragraph (1)(B)(ii) as paragraph (5) of subsection (z) and realigning the left margins accordingly [see subsection (z) in section 10201(c), p. 796]; and

(B) [Replaced paragraph (1)]

(2) in subsection (z)—

(A) [Amended paragraph (1)]

(B) [Struck paragraphs (2) through (4) and inserted a new paragraph (2)]

(C) by redesignating paragraph (5) (as added by paragraph (1)(A) of this section) as paragraph (3), realigning the left margins to align with paragraph (2), and striking the heading and all that follows through “a State is” and inserting “A State is”.

SEC. 1202. PAYMENTS TO PRIMARY CARE PHYSICIANS.

(a) **IN GENERAL.**—

(1) **FEE-FOR-SERVICE PAYMENTS.**—Section 1902 of the Social Security Act (42 U.S.C. 1396a), as amended by section 2303(a)(2) of the Patient Protection and Affordable Care Act, is amended—

(A) in subsection (a)(13)—

(i) by striking “and” at the end of subparagraph

(A);

(ii) by adding “and” at the end of subparagraph

(B); and

(iii) by adding at the end the following new

subparagraph:

“(C) payment for primary care services (as defined in subsection (jj)) furnished in 2013 and 2014 by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine at a rate not less than 100 percent of the payment rate that applies to such services and physician under part B of title XVIII (or, if greater, the payment rate that would be applicable under such part if the conversion factor under section 1848(d) for the year involved were the conversion factor under such section for 2009);” and

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(B) by adding at the end the following new subsection:

“(jj) PRIMARY CARE SERVICES DEFINED.—For purposes of subsection (a)(13)(C), the term ‘primary care services’ means—

“(1) evaluation and management services that are procedure codes (for services covered under title XVIII) for services in the category designated Evaluation and Management in the Healthcare Common Procedure Coding System (established by the Secretary under section 1848(c)(5) as of December 31, 2009, and as subsequently modified); and

“(2) services related to immunization administration for vaccines and toxoids for which CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473, or 90474 (as subsequently modified) apply under such System.”.

(2) UNDER MEDICAID MANAGED CARE PLANS.—Section 1932(f) of such Act (42 U.S.C. 1396u–2(f)) is amended—

(A) in the heading, by adding at the end the following:

“; ADEQUACY OF PAYMENT FOR PRIMARY CARE SERVICES”; and

(B) by inserting before the period at the end the following: “and, in the case of primary care services described in section 1902(a)(13)(C), consistent with the minimum payment rates specified in such section (regardless of the manner in which such payments are made, including in the form of capitation or partial capitation)”.

(b) INCREASE IN PAYMENT USING INCREASED FMAP.—Section 1905 of the Social Security Act, as amended by section 1004(b) of this Act and section 10201(c)(6) of the Patient Protection and Affordable Care Act, is amended by adding at the end the following new subsection:

“(dd) INCREASED FMAP FOR ADDITIONAL EXPENDITURES FOR PRIMARY CARE SERVICES.—Notwithstanding subsection (b), with respect to the portion of the amounts expended for medical assistance for services described in section 1902(a)(13)(C) furnished on or after January 1, 2013, and before January 1, 2015, that is attributable to the amount by which the minimum payment rate required under such section (or, by application, section 1932(f)) exceeds the payment rate applicable to such services under the State plan as of July 1, 2009, the Federal medical assistance percentage for a State that is one of the 50 States or the District of Columbia shall be equal to 100 percent. The preceding sentence does not prohibit the payment of Federal financial participation based on the Federal medical assistance percentage for amounts in excess of those specified in such sentence.”.

SEC. 1203. DISPROPORTIONATE SHARE HOSPITAL PAYMENTS.

(a) IN GENERAL.—Section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)), as amended by sections 2551(a)(4) and 10201(e)(1) of the Patient Protection and Affordable Care Act, is amended—

(1) in paragraph (6)(B)(iii), in the matter preceding subclause (I), by striking “or paragraph (7)”; and

(2) **【Replaced paragraph (7)】**

(b) EXTENSION OF DSH ALLOTMENT.—Section 1923(f)(6)(A) of the Social Security Act (42 U.S.C. 1396r–4(f)(6)(A)) is amended by adding at the end the following:

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“(v) ALLOTMENT FOR 2D, 3RD, AND 4TH QUARTERS OF FISCAL YEAR 2012 AND FOR FISCAL YEAR 2013.—Notwithstanding the table set forth in paragraph (2):

“(I) 2D, 3RD, AND 4TH QUARTERS OF FISCAL YEAR 2012.—In the case of a State that has a DSH allotment of \$0 for the 2d, 3rd, and 4th quarters of fiscal year 2012, the DSH allotment shall be \$47,200,000 for such quarters.

“(II) FISCAL YEAR 2013.—In the case of a State that has a DSH allotment of \$0 for fiscal year 2013, the DSH allotment shall be \$53,100,000 for such fiscal year.”.

SEC. 1204. FUNDING FOR THE TERRITORIES.

(a) IN GENERAL.—*[Inserted a new section 1323 relating to funding for the territories]*

(b) MEDICAID FUNDING.—

(1) INCREASE IN FUNDING CAPS.—Section 1108(g) of the Social Security Act (42 U.S.C. 1308(g)), as amended by section 2005(a) of the Patient Protection and Affordable Care Act, is amended—

(A) in paragraph (2), by inserting “and section 1323(a)(2) of the Patient Protection and Affordable Care Act” after “subject to”; and

(B) *[Replaced paragraph (5)]*

(2) DISREGARD OF PAYMENTS; INCREASED FMAP.—Section 2005 of the Patient Protection and Affordable Care Act is amended—

(A) by repealing subsection (b) (and the amendments made by that subsection) and section 1108(g)(4) of the Social Security Act shall be applied as if such amendments had never been enacted; and

(B) *[Amended subsection (c)(2)]*

SEC. 1205. DELAY IN COMMUNITY FIRST CHOICE OPTION *[AMENDMENT FULLY INCORPORATED INTO PPACA].*

[Amended section 1915(k)(1) of the Social Security Act, as added by section 2401 of PPACA]

SEC. 1206. DRUG REBATES FOR NEW FORMULATIONS OF EXISTING DRUGS *[AMENDMENT FULLY INCORPORATED INTO PPACA].*

(a) TREATMENT OF NEW FORMULATIONS.—*[Replaced subparagraph (C) of section 1927(c)(2) of the Social Security Act, as added by section 2501(d)(1) of PPACA]*

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as if included in the enactment of the Patient Protection and Affordable Care Act.

Subtitle D—Reducing Fraud, Waste, and Abuse

SEC. 1301. COMMUNITY MENTAL HEALTH CENTERS.

(a) IN GENERAL.—Section 1861(ff)(3)(B) of the Social Security Act (42 U.S.C. 1395x(ff)(3)(B)) is amended—

(1) in clause (ii), by striking “and” at the end;

(2) by redesignating clause (iii) as clause (iv); and