option to execute such a document, are met; and".

(d) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2010.

TITLE III—IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE

Subtitle A—Transforming the Health Care Delivery System

PART I—LINKING PAYMENT TO QUALITY OUTCOMES UNDER THE MEDICARE PROGRAM

SEC. 3001. HOSPITAL VALUE-BASED PURCHASING PROGRAM.

(a) PROGRAM.—

(1) IN GENERAL.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by section 4102(a) of the HITECH Act (Public Law 111–5), is amended by adding at the end the following new subsection:

"(o) HOSPITAL VALUE-BASED PURCHASING PROGRAM.—

"(1) ESTABLISHMENT.—

"(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall establish a hospital value-based pur-

chasing program (in this subsection referred to as the 'Program') under which value-based incentive payments are made in a fiscal year to hospitals that meet the performance standards under paragraph (3) for the performance period for such fiscal year (as established under paragraph (4)).

"(B) PROGRAM TO BEGIN IN FISCAL YEAR 2013.—The Program shall apply to payments for discharges occurring on or after October 1, 2012.

"(C) APPLICABILITY OF PROGRAM TO HOSPITALS.—

"(i) IN GENERAL.—For purposes of this subsection, subject to clause (ii), the term 'hospital' means a subsection (d) hospital (as defined in subsection (d)(1)(B)).

"(ii) EXCLUSIONS.—The term 'hospital' shall not include, with respect to a fiscal year, a hospital—

"(I) that is subject to the payment reduction under subsection (b)(3)(B)(viii)(I) for such fiscal year;

"(II) for which, during the performance period for such fiscal year, the Secretary has cited deficiencies that

pose immediate jeopardy to the health or safety of patients;

"(III) for which there are not a minimum number (as determined by the Secretary) of measures that apply to the hospital for the performance period for such fiscal year; or

"(IV) for which there are not a minimum number (as determined by the Secretary) of cases for the measures that apply to the hospital for the performance period for such fiscal year.

"(iii) INDEPENDENT ANALYSIS.—For purposes of determining the minimum numbers under subclauses (III) and (IV) of clause (ii), the Secretary shall have conducted an independent analysis of what numbers are appropriate.

"(iv) EXEMPTION.—In the case of a hospital that is paid under section 1814(b)(3), the Secretary may exempt such hospital from the application of this subsection if the State which is paid under such section submits an annual report to the Secretary describing how a similar pro-

gram in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under this subsection.

"(2) MEASURES.—

"(A) IN GENERAL.—The Secretary shall select measures for purposes of the Program. Such measures shall be selected from the measures specified under subsection (b)(3)(B)(viii).

"(B) REQUIREMENTS.—

"(i) FOR FISCAL YEAR 2013.—For value-based incentive payments made with respect to discharges occurring during fiscal year 2013, the Secretary shall ensure the following:

"(I) CONDITIONS OR PROCEDURES.—Measures are selected under subparagraph (A) that cover at least the following 5 specific conditions or procedures:

"(aa) Acute myocardial infarction (AMI).

"(bb) Heart failure.

"(cc) Pneumonia.

"(dd) Surgeries, as measured by the Surgical Care Improvement Project (formerly referred to as 'Surgical Infection Prevention' for discharges occurring before July 2006).

"(ee) Healthcare-associated infections, as measured by the prevention metrics and targets established in the HHS Action Plan to Prevent Healthcare-Associated Infections (or any successor plan) of the Department of Health and Human Services.

"(II) HCAHPS.—Measures selected under subparagraph (A) shall be related to the Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS).

"(ii) INCLUSION OF EFFICIENCY MEASURES.—For value-based incentive payments made with respect to discharges occurring during fiscal year 2014 or a subsequent fiscal year, the Secretary shall ensure that measures selected under subparagraph (A)

include efficiency measures, including measures of 'Medicare spending per beneficiary'. Such measures shall be adjusted for factors such as age, sex, race, severity of illness, and other factors that the Secretary determines appropriate.

"(C) LIMITATIONS.—

"(i) TIME REQUIREMENT FOR PRIOR REPORTING AND NOTICE.—The Secretary may not select a measure under subparagraph (A) for use under the Program with respect to a performance period for a fiscal year (as established under paragraph (4)) unless such measure has been specified under subsection (b)(3)(B)(viii) and included on the Hospital Compare Internet website for at least 1 year prior to the beginning of such performance period.

"(ii) MEASURE NOT APPLICABLE UNLESS HOSPITAL FURNISHES SERVICES APPROPRIATE TO THE MEASURE.—A measure selected under subparagraph (A) shall not apply to a hospital if such hospital does not furnish services appropriate to such measure.

"(D) REPLACING MEASURES.—Subclause (VI) of subsection (b)(3)(B)(viii) shall apply to measures selected under subparagraph (A) in the same manner as such subclause applies to measures selected under such subsection.

"(3) PERFORMANCE STANDARDS.—

"(A) ESTABLISHMENT.—The Secretary shall establish performance standards with respect to measures selected under paragraph (2) for a performance period for a fiscal year (as established under paragraph (4)).

"(B) ACHIEVEMENT AND IMPROVEMENT.—The performance standards established under subparagraph (A) shall include levels of achievement and improvement.

"(C) TIMING.—The Secretary shall establish and announce the performance standards under subparagraph (A) not later than 60 days prior to the beginning of the performance period for the fiscal year involved.

"(D) CONSIDERATIONS IN ESTABLISHING STANDARDS.—In establishing performance standards with respect to measures under this paragraph, the Secretary shall take into account appropriate factors, such as—

"(i) practical experience with the measures involved, including whether a significant proportion of hospitals failed to meet the performance standard during previous performance periods;

"(ii) historical performance standards;

"(iii) improvement rates; and

"(iv) the opportunity for continued improvement.

"(4) PERFORMANCE PERIOD.—For purposes of the Program, the Secretary shall establish the performance period for a fiscal year. Such performance period shall begin and end prior to the beginning of such fiscal year.

"(5) HOSPITAL PERFORMANCE SCORE.—

"(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall develop a methodology for assessing the total performance of each hospital based on performance standards with respect to the measures selected under paragraph (2) for a performance period (as established under paragraph (4)). Using such methodology, the Secretary shall provide for an assessment (in this subsection referred to as the 'hospital per-

formance score') for each hospital for each performance period.

"(B) APPLICATION.—

"(i) APPROPRIATE DISTRIBUTION.—The Secretary shall ensure that the application of the methodology developed under subparagraph (A) results in an appropriate distribution of value-based incentive payments under paragraph (6) among hospitals achieving different levels of hospital performance scores, with hospitals achieving the highest hospital performance scores receiving the largest value-based incentive payments.

"(ii) HIGHER OF ACHIEVEMENT OR IMPROVEMENT.—The methodology developed under subparagraph (A) shall provide that the hospital performance score is determined using the higher of its achievement or improvement score for each measure.

"(iii) WEIGHTS.—The methodology developed under subparagraph (A) shall provide for the assignment of weights for categories of measures as the Secretary determines appropriate.

"(iv) NO MINIMUM PERFORMANCE STANDARD.—The Secretary shall not set a minimum performance standard in determining the hospital performance score for any hospital.

"(v) REFLECTION OF MEASURES APPLICABLE TO THE HOSPITAL.—The hospital performance score for a hospital shall reflect the measures that apply to the hospital.

"(6) CALCULATION OF VALUE-BASED INCENTIVE PAYMENTS.—

"(A) IN GENERAL.—In the case of a hospital that the Secretary determines meets (or exceeds) the performance standards under paragraph (3) for the performance period for a fiscal year (as established under paragraph (4)), the Secretary shall increase the base operating DRG payment amount (as defined in paragraph (7)(D)), as determined after application of paragraph (7)(B)(i), for a hospital for each discharge occurring in such fiscal year by the value-based incentive payment amount.

"(B) VALUE-BASED INCENTIVE PAYMENT AMOUNT.—The value-based incentive payment

amount for each discharge of a hospital in a fiscal year shall be equal to the product of—

"(i) the base operating DRG payment amount (as defined in paragraph (7)(D)) for the discharge for the hospital for such fiscal year; and

"(ii) the value-based incentive payment percentage specified under subparagraph (C) for the hospital for such fiscal year.

"(C) VALUE-BASED INCENTIVE PAYMENT PERCENTAGE.—

"(i) IN GENERAL.—The Secretary shall specify a value-based incentive payment percentage for a hospital for a fiscal year.

"(ii) REQUIREMENTS.—In specifying the value-based incentive payment percentage for each hospital for a fiscal year under clause (i), the Secretary shall ensure that—

"(I) such percentage is based on the hospital performance score of the hospital under paragraph (5); and

"(II) the total amount of value-based incentive payments under this paragraph to all hospitals in such fiscal year is equal to the total amount

available for value-based incentive payments for such fiscal year under paragraph (7)(A), as estimated by the Secretary.

"(7) FUNDING FOR VALUE-BASED INCENTIVE PAYMENTS.—

"(A) AMOUNT.—The total amount available for value-based incentive payments under paragraph (6) for all hospitals for a fiscal year shall be equal to the total amount of reduced payments for all hospitals under subparagraph (B) for such fiscal year, as estimated by the Secretary.

"(B) ADJUSTMENT TO PAYMENTS.—

"(i) IN GENERAL.—The Secretary shall reduce the base operating DRG payment amount (as defined in subparagraph (D)) for a hospital for each discharge in a fiscal year (beginning with fiscal year 2013) by an amount equal to the applicable percent (as defined in subparagraph (C)) of the base operating DRG payment amount for the discharge for the hospital for such fiscal year. The Secretary shall make such reductions for all hospitals in the fiscal year involved, regardless of whether or not the hos-

pital has been determined by the Secretary to have earned a value-based incentive payment under paragraph (6) for such fiscal year.

"(ii) NO EFFECT ON OTHER PAYMENTS.—Payments described in items (aa) and (bb) of subparagraph (D)(i)(II) for a hospital shall be determined as if this subsection had not been enacted.

"(C) APPLICABLE PERCENT DEFINED.—For purposes of subparagraph (B), the term 'applicable percent' means—

"(i) with respect to fiscal year 2013, 1.0 percent;

"(ii) with respect to fiscal year 2014, 1.25 percent;

"(iii) with respect to fiscal year 2015, 1.5 percent;

"(iv) with respect to fiscal year 2016, 1.75 percent; and

"(v) with respect to fiscal year 2017 and succeeding fiscal years, 2 percent.

"(D) BASE OPERATING DRG PAYMENT AMOUNT DEFINED.—

"(i) IN GENERAL.—Except as provided in clause (ii), in this subsection, the term 'base operating DRG payment amount' means, with respect to a hospital for a fiscal year—

"(I) the payment amount that would otherwise be made under subsection (d) (determined without regard to subsection (q)) for a discharge if this subsection did not apply; reduced by

"(II) any portion of such payment amount that is attributable to—

"(aa) payments under paragraphs (5)(A), (5)(B), (5)(F), and (12) of subsection (d); and

"(bb) such other payments under subsection (d) determined appropriate by the Secretary.

"(ii) SPECIAL RULES FOR CERTAIN HOSPITALS.—

"(I) SOLE COMMUNITY HOSPITALS AND MEDICARE-DEPENDENT, SMALL RURAL HOSPITALS.—In the case of a medicare-dependent, small rural hospital (with respect to discharges occur-

ring during fiscal year 2012 and 2013) or a sole community hospital, in applying subparagraph (A)(i), the payment amount that would otherwise be made under subsection (d) shall be determined without regard to subparagraphs (I) and (L) of subsection (b)(3) and subparagraphs (D) and (G) of subsection (d)(5).

"(II) HOSPITALS PAID UNDER SECTION 1814.—In the case of a hospital that is paid under section 1814(b)(3), the term 'base operating DRG payment amount' means the payment amount under such section.

"(8) ANNOUNCEMENT OF NET RESULT OF ADJUSTMENTS.—Under the Program, the Secretary shall, not later than 60 days prior to the fiscal year involved, inform each hospital of the adjustments to payments to the hospital for discharges occurring in such fiscal year under paragraphs (6) and (7)(B)(i).

"(9) NO EFFECT IN SUBSEQUENT FISCAL YEARS.—The value-based incentive payment under paragraph (6) and the payment reduction under paragraph (7)(B)(i) shall each apply only with re-

spect to the fiscal year involved, and the Secretary shall not take into account such value-based incentive payment or payment reduction in making payments to a hospital under this section in a subsequent fiscal year.

"(10) PUBLIC REPORTING.—

"(A) HOSPITAL SPECIFIC INFORMATION.—

"(i) IN GENERAL.—The Secretary shall make information available to the public regarding the performance of individual hospitals under the Program, including—

"(I) the performance of the hospital with respect to each measure that applies to the hospital;

"(II) the performance of the hospital with respect to each condition or procedure; and

"(III) the hospital performance score assessing the total performance of the hospital.

"(ii) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall ensure that a hospital has the opportunity to review, and submit corrections for, the information to be made public with respect

to the hospital under clause (i) prior to such information being made public.

"(iii) WEBSITE.—Such information shall be posted on the Hospital Compare Internet website in an easily understandable format.

"(B) AGGREGATE INFORMATION.—The Secretary shall periodically post on the Hospital Compare Internet website aggregate information on the Program, including—

"(i) the number of hospitals receiving value-based incentive payments under paragraph (6) and the range and total amount of such value-based incentive payments; and

"(ii) the number of hospitals receiving less than the maximum value-based incentive payment available to the hospital for the fiscal year involved and the range and amount of such payments.

"(11) IMPLEMENTATION.—

"(A) APPEALS.—The Secretary shall establish a process by which hospitals may appeal the calculation of a hospital's performance assessment with respect to the performance standards established under paragraph (3)(A) and the hos-

pital performance score under paragraph (5). The Secretary shall ensure that such process provides for resolution of such appeals in a timely manner.

"(B) LIMITATION ON REVIEW.—Except as provided in subparagraph (A), there shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

"(i) The methodology used to determine the amount of the value-based incentive payment under paragraph (6) and the determination of such amount.

"(ii) The determination of the amount of funding available for such value-based incentive payments under paragraph (7)(A) and the payment reduction under paragraph (7)(B)(i).

"(iii) The establishment of the performance standards under paragraph (3) and the performance period under paragraph (4).

"(iv) The measures specified under subsection (b)(3)(B)(viii) and the measures selected under paragraph (2).

"(v) The methodology developed under paragraph (5) that is used to calculate hospital performance scores and the calculation of such scores.

"(vi) The validation methodology specified in subsection (b)(3)(B)(viii)(XI).

"(C) CONSULTATION WITH SMALL HOSPITALS.—The Secretary shall consult with small rural and urban hospitals on the application of the Program to such hospitals.

"(12) PROMULGATION OF REGULATIONS.—The Secretary shall promulgate regulations to carry out the Program, including the selection of measures under paragraph (2), the methodology developed under paragraph (5) that is used to calculate hospital performance scores, and the methodology used to determine the amount of value-based incentive payments under paragraph (6).".

(2) AMENDMENTS FOR REPORTING OF HOSPITAL QUALITY INFORMATION.—Section 1886(b)(3)(B)(viii) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(viii)) is amended—

(A) in subclause (II), by adding at the end the following sentence: "The Secretary may require hospitals to submit data on measures that

are not used for the determination of value-based incentive payments under subsection (o).";

(B) in subclause (V), by striking "beginning with fiscal year 2008" and inserting "for fiscal years 2008 through 2012";

(C) in subclause (VII), in the first sentence, by striking "data submitted" and inserting "information regarding measures submitted"; and

(D) by adding at the end the following new subclauses:

"(VIII) Effective for payments beginning with fiscal year 2013, with respect to quality measures for outcomes of care, the Secretary shall provide for such risk adjustment as the Secretary determines to be appropriate to maintain incentives for hospitals to treat patients with severe illnesses or conditions.

"(IX)(aa) Subject to item (bb), effective for payments beginning with fiscal year 2013, each measure specified by the Secretary under this clause shall be endorsed by the entity with a contract under section 1890(a).

"(bb) In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as

due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

"(X) To the extent practicable, the Secretary shall, with input from consensus organizations and other stakeholders, take steps to ensure that the measures specified by the Secretary under this clause are coordinated and aligned with quality measures applicable to—

"(aa) physicians under section 1848(k); and

"(bb) other providers of services and suppliers under this title.

"(XI) The Secretary shall establish a process to validate measures specified under this clause as appropriate. Such process shall include the auditing of a number of randomly selected hospitals sufficient to ensure validity of the reporting program under this clause as a whole and shall provide a hospital with an opportunity to appeal the validation of measures reported by such hospital.".

(3) WEBSITE IMPROVEMENTS.—Section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)), as amended by section 4102(b) of the HITECH Act (Public Law 111–5), is amended by adding at the end the following new clause:

"(x)(I) The Secretary shall develop standard Internet website reports tailored to meet the needs of various stake-

holders such as hospitals, patients, researchers, and policymakers. The Secretary shall seek input from such stakeholders in determining the type of information that is useful and the formats that best facilitate the use of the information.

"(II) The Secretary shall modify the Hospital Compare Internet website to make the use and navigation of that website readily available to individuals accessing it.".

(4) GAO STUDY AND REPORT.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study on the performance of the hospital value-based purchasing program established under section 1886(o) of the Social Security Act, as added by paragraph (1). Such study shall include an analysis of the impact of such program on—

(i) the quality of care furnished to Medicare beneficiaries, including diverse Medicare beneficiary populations (such as diverse in terms of race, ethnicity, and socioeconomic status);

(ii) expenditures under the Medicare program, including any reduced expenditures under Part A of title XVIII of such Act that are attributable to the improve-

ment in the delivery of inpatient hospital services by reason of such hospital value-based purchasing program;

(iii) the quality performance among safety net hospitals and any barriers such hospitals face in meeting the performance standards applicable under such hospital value-based purchasing program; and

(iv) the quality performance among small rural and small urban hospitals and any barriers such hospitals face in meeting the performance standards applicable under such hospital value-based purchasing program.

(B) REPORTS.—

(i) INTERIM REPORT.—Not later than October 1, 2015, the Comptroller General of the United States shall submit to Congress an interim report containing the results of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(ii) FINAL REPORT.—Not later than July 1, 2017, the Comptroller General of the United States shall submit to Congress a report containing the results of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(5) HHS STUDY AND REPORT.—

(A) STUDY.—The Secretary of Health and Human Services shall conduct a study on the performance of the hospital value-based purchasing program established under section 1886(o) of the Social Security Act, as added by paragraph (1). Such study shall include an analysis—

(i) of ways to improve the hospital value-based purchasing program and ways to address any unintended consequences that may occur as a result of such program;

(ii) of whether the hospital value-based purchasing program resulted in lower spending under the Medicare program under title XVIII of such Act or other financial savings to hospitals;

(iii) the appropriateness of the Medicare program sharing in any savings generated through the hospital value-based purchasing program; and

(iv) any other area determined appropriate by the Secretary.

(B) REPORT.—Not later than January 1, 2016, the Secretary of Health and Human Services shall submit to Congress a report containing the results of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(b) VALUE-BASED PURCHASING DEMONSTRATION PROGRAMS.—

(1) VALUE-BASED PURCHASING DEMONSTRATION PROGRAM FOR INPATIENT CRITICAL ACCESS HOSPITALS.—

(A) ESTABLISHMENT.—

(i) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services (in this subsection referred to as the "Secretary") shall establish a demonstration program under which the Secretary estab-

lishes a value-based purchasing program under the Medicare program under title XVIII of the Social Security Act for critical access hospitals (as defined in paragraph (1) of section 1861(mm) of such Act (42 U.S.C. 1395x(mm))) with respect to inpatient critical access hospital services (as defined in paragraph (2) of such section) in order to test innovative methods of measuring and rewarding quality and efficient health care furnished by such hospitals.

(ii) DURATION.—The demonstration program under this paragraph shall be conducted for a 3-year period.

(iii) SITES.—The Secretary shall conduct the demonstration program under this paragraph at an appropriate number (as determined by the Secretary) of critical access hospitals. The Secretary shall ensure that such hospitals are representative of the spectrum of such hospitals that participate in the Medicare program.

(B) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be nec-

essary to carry out the demonstration program under this paragraph.

(C) BUDGET NEUTRALITY REQUIREMENT.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

(D) REPORT.—Not later than 18 months after the completion of the demonstration program under this paragraph, the Secretary shall submit to Congress a report on the demonstration program together with—

(i) recommendations on the establishment of a permanent value-based purchasing program under the Medicare program for critical access hospitals with respect to inpatient critical access hospital services; and

(ii) recommendations for such other legislation and administrative action as the Secretary determines appropriate.

(2) VALUE-BASED PURCHASING DEMONSTRATION PROGRAM FOR HOSPITALS EXCLUDED FROM HOSPITAL

VALUE-BASED PURCHASING PROGRAM AS A RESULT OF INSUFFICIENT NUMBERS OF MEASURES AND CASES.—

(A) ESTABLISHMENT.—

(i) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Secretary shall establish a demonstration program under which the Secretary establishes a value-based purchasing program under the Medicare program under title XVIII of the Social Security Act for applicable hospitals (as defined in clause (ii)) with respect to inpatient hospital services (as defined in section 1861(b) of the Social Security Act (42 U.S.C. 1395x(b))) in order to test innovative methods of measuring and rewarding quality and efficient health care furnished by such hospitals.

(ii) APPLICABLE HOSPITAL DEFINED.—For purposes of this paragraph, the term "applicable hospital" means a hospital described in subclause (III) or (IV) of section 1886(o)(1)(C)(ii) of the Social Security Act, as added by subsection (a)(1).

(iii) DURATION.—The demonstration program under this paragraph shall be conducted for a 3-year period.

(iv) SITES.—The Secretary shall conduct the demonstration program under this paragraph at an appropriate number (as determined by the Secretary) of applicable hospitals. The Secretary shall ensure that such hospitals are representative of the spectrum of such hospitals that participate in the Medicare program.

(B) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be necessary to carry out the demonstration program under this paragraph.

(C) BUDGET NEUTRALITY REQUIREMENT.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

(D) REPORT.—Not later than 18 months after the completion of the demonstration pro-

gram under this paragraph, the Secretary shall submit to Congress a report on the demonstration program together with—

(i) recommendations on the establishment of a permanent value-based purchasing program under the Medicare program for applicable hospitals with respect to inpatient hospital services; and

(ii) recommendations for such other legislation and administrative action as the Secretary determines appropriate.

SEC. 3002. IMPROVEMENTS TO THE PHYSICIAN QUALITY REPORTING SYSTEM.

(a) EXTENSION.—Section 1848(m) of the Social Security Act (42 U.S.C. 1395w–4(m)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (A), in the matter preceding clause (i), by striking "2010" and inserting "2014"; and

(B) in subparagraph (B)—

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

(ii) in clause (ii), by striking the period at the end and inserting a semicolon; and

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

"(iii) for 2011, 1.0 percent; and

"(iv) for 2012, 2013, and 2014, 0.5 percent.";

(2) in paragraph (3)—

(A) in subparagraph (A), in the matter preceding clause (i), by inserting "(or, for purposes of subsection (a)(8), for the quality reporting period for the year)" after "reporting period"; and

(B) in subparagraph (C)(i), by inserting ", or, for purposes of subsection (a)(8), for a quality reporting period for the year" after "(a)(5), for a reporting period for a year";

(3) in paragraph (5)(E)(iv), by striking "subsection (a)(5)(A)" and inserting "paragraphs (5)(A) and (8)(A) of subsection (a)"; and

(4) in paragraph (6)(C)—

(A) in clause (i)(II), by striking ", 2009, 2010, and 2011" and inserting "and subsequent years"; and

(B) in clause (iii)—

(i) by inserting "(a)(8)" after "(a)(5)"; and

(ii) by striking "under subparagraph (D)(iii) of such subsection" and inserting "under subsection (a)(5)(D)(iii) or the quality reporting period under subsection (a)(8)(D)(iii), respectively".

(b) INCENTIVE PAYMENT ADJUSTMENT FOR QUALITY REPORTING.—Section 1848(a) of the Social Security Act (42 U.S.C. 1395w–4(a)) is amended by adding at the end the following new paragraph:

"(8) INCENTIVES FOR QUALITY REPORTING.—

"(A) ADJUSTMENT.—

"(i) IN GENERAL.—With respect to covered professional services furnished by an eligible professional during 2015 or any subsequent year, if the eligible professional does not satisfactorily submit data on quality measures for covered professional services for the quality reporting period for the year (as determined under subsection (m)(3)(A)), the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule

amount that would otherwise apply to such services under this subsection (determined after application of paragraphs (3), (5), and (7), but without regard to this paragraph).

"(ii) APPLICABLE PERCENT.—For purposes of clause (i), the term 'applicable percent' means—

"(I) for 2015, 98.5 percent; and

"(II) for 2016 and each subsequent year, 98 percent.

"(B) APPLICATION.—

"(i) PHYSICIAN REPORTING SYSTEM RULES.—Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of this paragraph in the same manner as they apply for purposes of such subsection.

"(ii) INCENTIVE PAYMENT VALIDATION RULES.—Clauses (ii) and (iii) of subsection (m)(5)(D) shall apply for purposes of this paragraph in a similar manner as they apply for purposes of such subsection.

"(C) DEFINITIONS.—For purposes of this paragraph:

"(i) ELIGIBLE PROFESSIONAL; COVERED PROFESSIONAL SERVICES.—The terms 'eligible professional' and 'covered professional services' have the meanings given such terms in subsection (k)(3).

"(ii) PHYSICIAN REPORTING SYSTEM.—The term 'physician reporting system' means the system established under subsection (k).

"(iii) QUALITY REPORTING PERIOD.—The term 'quality reporting period' means, with respect to a year, a period specified by the Secretary.".

(c) MAINTENANCE OF CERTIFICATION PROGRAMS.—

(1) IN GENERAL.—Section 1848(k)(4) of the Social Security Act (42 U.S.C. 1395w–4(k)(4)) is amended by inserting "or through a Maintenance of Certification program operated by a specialty body of the American Board of Medical Specialties that meets the criteria for such a registry" after "Database)".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply for years after 2010.

(d) INTEGRATION OF PHYSICIAN QUALITY REPORTING AND EHR REPORTING.—Section 1848(m) of the Social Se-

curity Act (42 U.S.C. 1395w–4(m)) is amended by adding at the end the following new paragraph:

"(7) INTEGRATION OF PHYSICIAN QUALITY REPORTING AND EHR REPORTING.—Not later than January 1, 2012, the Secretary shall develop a plan to integrate reporting on quality measures under this subsection with reporting requirements under subsection (o) relating to the meaningful use of electronic health records. Such integration shall consist of the following:

"(A) The selection of measures, the reporting of which would both demonstrate—

"(i) meaningful use of an electronic health record for purposes of subsection (o); and

"(ii) quality of care furnished to an individual.

"(B) Such other activities as specified by the Secretary.".

(e) FEEDBACK.—Section 1848(m)(5) of the Social Security Act (42 U.S.C. 1395w–4(m)(5)) is amended by adding at the end the following new subparagraph:

"(H) FEEDBACK.—The Secretary shall provide timely feedback to eligible professionals on the performance of the eligible professional with

respect to satisfactorily submitting data on quality measures under this subsection.".

(f) APPEALS.—Such section is further amended—

(1) in subparagraph (E), by striking "There shall" and inserting "Except as provided in subparagraph (I), there shall"; and

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

"(I) INFORMAL APPEALS PROCESS.—The Secretary shall, by not later than January 1, 2011, establish and have in place an informal process for eligible professionals to seek a review of the determination that an eligible professional did not satisfactorily submit data on quality measures under this subsection.".

SEC. 3003. IMPROVEMENTS TO THE PHYSICIAN FEEDBACK PROGRAM.

(a) IN GENERAL.—Section 1848(n) of the Social Security Act (42 U.S.C. 1395w–4(n)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (A)—

(i) by striking "GENERAL.—The Secretary" and inserting "GENERAL.—

"(i) ESTABLISHMENT.—The Secretary";

(ii) in clause (i), as added by clause (i), by striking "the 'Program')" and all that follows through the period at the end of the second sentence and inserting "the 'Program')."; and

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

"(ii) REPORTS ON RESOURCES.—The Secretary shall use claims data under this title (and may use other data) to provide confidential reports to physicians (and, as determined appropriate by the Secretary, to groups of physicians) that measure the resources involved in furnishing care to individuals under this title.

"(iii) INCLUSION OF CERTAIN INFORMATION.—If determined appropriate by the Secretary, the Secretary may include information on the quality of care furnished to individuals under this title by the physician (or group of physicians) in such reports."; and

(B) in subparagraph (B), by striking "subparagraph (A)" and inserting "subparagraph (A)(ii)";

(2) in paragraph (4)—

(A) in the heading, by inserting "INITIAL" after "FOCUS"; and

(B) in the matter preceding subparagraph (A), by inserting "initial" after "focus the";

(3) in paragraph (6), by adding at the end the following new sentence: "For adjustments for reports on utilization under paragraph (9), see subparagraph (D) of such paragraph."; and

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

"(9) REPORTS ON UTILIZATION.—

"(A) DEVELOPMENT OF EPISODE GROUPER.—

"(i) IN GENERAL.—The Secretary shall develop an episode grouper that combines separate but clinically related items and services into an episode of care for an individual, as appropriate.

"(ii) TIMELINE FOR DEVELOPMENT.—The episode grouper described in subparagraph (A) shall be developed by not later than January 1, 2012.

"(iii) PUBLIC AVAILABILITY.—The Secretary shall make the details of the episode

grouper described in subparagraph (A) available to the public.

"(iv) ENDORSEMENT.—The Secretary shall seek endorsement of the episode grouper described in subparagraph (A) by the entity with a contract under section 1890(a).

"(B) REPORTS ON UTILIZATION.—Effective beginning with 2012, the Secretary shall provide reports to physicians that compare, as determined appropriate by the Secretary, patterns of resource use of the individual physician to such patterns of other physicians.

"(C) ANALYSIS OF DATA.—The Secretary shall, for purposes of preparing reports under this paragraph, establish methodologies as appropriate, such as to—

"(i) attribute episodes of care, in whole or in part, to physicians;

"(ii) identify appropriate physicians for purposes of comparison under subparagraph (B); and

"(iii) aggregate episodes of care attributed to a physician under clause (i) into a composite measure per individual.

"(D) DATA ADJUSTMENT.—In preparing reports under this paragraph, the Secretary shall make appropriate adjustments, including adjustments—

"(i) to account for differences in socioeconomic and demographic characteristics, ethnicity, and health status of individuals (such as to recognize that less healthy individuals may require more intensive interventions); and

"(ii) to eliminate the effect of geographic adjustments in payment rates (as described in subsection (e)).

"(E) PUBLIC AVAILABILITY OF METHODOLOGY.—The Secretary shall make available to the public—

"(i) the methodologies established under subparagraph (C);

"(ii) information regarding any adjustments made to data under subparagraph (D); and

"(iii) aggregate reports with respect to physicians.

"(F) DEFINITION OF PHYSICIAN.—In this paragraph:

"(i) IN GENERAL.—The term 'physician' has the meaning given that term in section 1861(r)(1).

"(ii) TREATMENT OF GROUPS.—Such term includes, as the Secretary determines appropriate, a group of physicians.

"(G) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the establishment of the methodology under subparagraph (C), including the determination of an episode of care under such methodology.

"(10) COORDINATION WITH OTHER VALUE-BASED PURCHASING REFORMS.—The Secretary shall coordinate the Program with the value-based payment modifier established under subsection (p) and, as the Secretary determines appropriate, other similar provisions of this title.".

(b) CONFORMING AMENDMENT.—Section 1890(b) of the Social Security Act (42 U.S.C. 1395aaa(b)) is amended by adding at the end the following new paragraph:

"(6) REVIEW AND ENDORSEMENT OF EPISODE GROUPER UNDER THE PHYSICIAN FEEDBACK PROGRAM.—The entity shall provide for the review and, as appropriate, the endorsement of the episode group-

er developed by the Secretary under section 1848(n)(9)(A). Such review shall be conducted on an expedited basis.".

SEC. 3004. QUALITY REPORTING FOR LONG-TERM CARE HOSPITALS, INPATIENT REHABILITATION HOSPITALS, AND HOSPICE PROGRAMS.

(a) LONG-TERM CARE HOSPITALS.—Section 1886(m) of the Social Security Act (42 U.S.C. 1395ww(m)), as amended by section 3401(c), is amended by adding at the end the following new paragraph:

"(5) QUALITY REPORTING.—

"(A) REDUCTION IN UPDATE FOR FAILURE TO REPORT.—

"(i) IN GENERAL.—Under the system described in paragraph (1), for rate year 2014 and each subsequent rate year, in the case of a long-term care hospital that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a rate year, any annual update to a standard Federal rate for discharges for the hospital during the rate year, and after application of paragraph (3), shall be reduced by 2 percentage points.

"(ii) SPECIAL RULE.—The application of this subparagraph may result in such annual update being less than 0.0 for a rate year, and may result in payment rates under the system described in paragraph (1) for a rate year being less than such payment rates for the preceding rate year.

"(B) NONCUMULATIVE APPLICATION.—Any reduction under subparagraph (A) shall apply only with respect to the rate year involved and the Secretary shall not take into account such reduction in computing the payment amount under the system described in paragraph (1) for a subsequent rate year.

"(C) SUBMISSION OF QUALITY DATA.—For rate year 2014 and each subsequent rate year, each long-term care hospital shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

"(D) QUALITY MEASURES.—

"(i) IN GENERAL.—Subject to clause (ii), any measure specified by the Secretary

under this subparagraph must have been endorsed by the entity with a contract under section 1890(a).

"(ii) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

"(iii) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to rate year 2014.

"(E) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under subparagraph (C) available to the public. Such procedures shall ensure that a long-term care hospital has the opportunity to review the data that is to

be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality measures that relate to services furnished in inpatient settings in long-term care hospitals on the Internet website of the Centers for Medicare & Medicaid Services.".

(b) INPATIENT REHABILITATION HOSPITALS.—Section 1886(j) of the Social Security Act (42 U.S.C. 1395ww(j)) is amended—

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

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

"(7) QUALITY REPORTING.—

"(A) REDUCTION IN UPDATE FOR FAILURE TO REPORT.—

"(i) IN GENERAL.—For purposes of fiscal year 2014 and each subsequent fiscal year, in the case of a rehabilitation facility that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a fiscal year, after determining the increase factor described in paragraph (3)(C), and after application of paragraph (3)(D), the Secretary shall re-

duce such increase factor for payments for discharges occurring during such fiscal year by 2 percentage points.

"(ii) SPECIAL RULE.—The application of this subparagraph may result in the increase factor described in paragraph (3)(C) being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.

"(B) NONCUMULATIVE APPLICATION.—Any reduction under subparagraph (A) shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the payment amount under this subsection for a subsequent fiscal year.

"(C) SUBMISSION OF QUALITY DATA.—For fiscal year 2014 and each subsequent rate year, each rehabilitation facility shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time,

specified by the Secretary for purposes of this subparagraph.

"(D) QUALITY MEASURES.—

"(i) IN GENERAL.—Subject to clause (ii), any measure specified by the Secretary under this subparagraph must have been endorsed by the entity with a contract under section 1890(a).

"(ii) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

"(iii) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to fiscal year 2014.

"(E) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under subparagraph (C) available to the public. Such procedures shall ensure that a rehabilitation facility has the opportunity to review the data that is to be made public with respect to the facility prior to such data being made public. The Secretary shall report quality measures that relate to services furnished in inpatient settings in rehabilitation facilities on the Internet website of the Centers for Medicare & Medicaid Services.".

(c) HOSPICE PROGRAMS.—Section 1814(i) of the Social Security Act (42 U.S.C. 1395f(i)) is amended—

(1) by redesignating paragraph (5) as paragraph (6); and

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

"(5) QUALITY REPORTING.—

"(A) REDUCTION IN UPDATE FOR FAILURE TO REPORT.—

"(i) IN GENERAL.—For purposes of fiscal year 2014 and each subsequent fiscal year, in the case of a hospice program that does not submit data to the Secretary in ac-

cordance with subparagraph (C) with respect to such a fiscal year, after determining the market basket percentage increase under paragraph (1)(C)(ii)(VII) or paragraph (1)(C)(iii), as applicable, and after application of paragraph (1)(C)(iv), with respect to the fiscal year, the Secretary shall reduce such market basket percentage increase by 2 percentage points.

''(ii) SPECIAL RULE.—The application of this subparagraph may result in the market basket percentage increase under paragraph (1)(C)(ii)(VII) or paragraph (1)(C)(iii), as applicable, being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.

''(B) NONCUMULATIVE APPLICATION.—Any reduction under subparagraph (A) shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the payment amount under this subsection for a subsequent fiscal year.

"(C) SUBMISSION OF QUALITY DATA.—For fiscal year 2014 and each subsequent fiscal year, each hospice program shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

"(D) QUALITY MEASURES.—

"(i) IN GENERAL.—Subject to clause (ii), any measure specified by the Secretary under this subparagraph must have been endorsed by the entity with a contract under section 1890(a).

"(ii) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

"(iii) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to fiscal year 2014.

"(E) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under subparagraph (C) available to the public. Such procedures shall ensure that a hospice program has the opportunity to review the data that is to be made public with respect to the hospice program prior to such data being made public. The Secretary shall report quality measures that relate to hospice care provided by hospice programs on the Internet website of the Centers for Medicare & Medicaid Services.".

SEC. 3005. QUALITY REPORTING FOR PPS-EXEMPT CANCER HOSPITALS.

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

(1) in subsection (a)(1)—

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

(B) in subparagraph (V), by striking the period at the end and inserting ", and"; and

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

"(W) in the case of a hospital described in section 1886(d)(1)(B)(v), to report quality data to the Secretary in accordance with subsection (k).."; and

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

"(k) QUALITY REPORTING BY CANCER HOSPITALS.—

"(1) IN GENERAL.—For purposes of fiscal year 2014 and each subsequent fiscal year, a hospital described in section 1886(d)(1)(B)(v) shall submit data to the Secretary in accordance with paragraph (2) with respect to such a fiscal year.

"(2) SUBMISSION OF QUALITY DATA.—For fiscal year 2014 and each subsequent fiscal year, each hospital described in such section shall submit to the Secretary data on quality measures specified under paragraph (3). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

"(3) QUALITY MEASURES.—

"(A) IN GENERAL.—Subject to subparagraph (B), any measure specified by the Secretary under this paragraph must have been endorsed by the entity with a contract under section 1890(a).

"(B) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

"(C) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this paragraph that will be applicable with respect to fiscal year 2014.

"(4) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under paragraph (4) available to the public. Such procedures shall ensure that a hospital described in section 1886(d)(1)(B)(v) has the opportunity to review the data that is to be made public with respect to the hospital prior to such data

being made public. The Secretary shall report quality measures of process, structure, outcome, patients' perspective on care, efficiency, and costs of care that relate to services furnished in such hospitals on the Internet website of the Centers for Medicare & Medicaid Services.".

SEC. 3006. PLANS FOR A VALUE-BASED PURCHASING PROGRAM FOR SKILLED NURSING FACILITIES AND HOME HEALTH AGENCIES.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall develop a plan to implement a value-based purchasing program for payments under the Medicare program under title XVIII of the Social Security Act for skilled nursing facilities (as defined in section 1819(a) of such Act (42 U.S.C. 1395i–3(a))).

(2) DETAILS.—In developing the plan under paragraph (1), the Secretary shall consider the following issues:

(A) The ongoing development, selection, and modification process for measures (including under section 1890 of the Social Security Act (42 U.S.C. 1395aaa) and section 1890A such Act, as

added by section 3014), to the extent feasible and practicable, of all dimensions of quality and efficiency in skilled nursing facilities.

(i) IN GENERAL.—Subject to clause (ii), any measure specified by the Secretary under subparagraph (A)(iii) must have been endorsed by the entity with a contract under section 1890(a).

(ii) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

(B) The reporting, collection, and validation of quality data.

(C) The structure of value-based payment adjustments, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, the

size of such payments, and the sources of funding for the value-based bonus payments.

(D) Methods for the public disclosure of information on the performance of skilled nursing facilities.

(E) Any other issues determined appropriate by the Secretary.

(3) CONSULTATION.—In developing the plan under paragraph (1), the Secretary shall—

(A) consult with relevant affected parties; and

(B) consider experience with such demonstrations that the Secretary determines are relevant to the value-based purchasing program described in paragraph (1).

(4) REPORT TO CONGRESS.—Not later than October 1, 2011, the Secretary shall submit to Congress a report containing the plan developed under paragraph (1).

(b) HOME HEALTH AGENCIES.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall develop a plan to implement a value-based purchasing program for payments under the Medicare program under title XVIII of the Social

Security Act for home health agencies (as defined in section 1861(o) of such Act (42 U.S.C. 1395x(o))).

(2) DETAILS.—In developing the plan under paragraph (1), the Secretary shall consider the following issues:

(A) The ongoing development, selection, and modification process for measures (including under section 1890 of the Social Security Act (42 U.S.C. 1395aaa) and section 1890A such Act, as added by section 3014), to the extent feasible and practicable, of all dimensions of quality and efficiency in home health agencies.

(B) The reporting, collection, and validation of quality data.

(C) The structure of value-based payment adjustments, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the sources of funding for the value-based bonus payments.

(D) Methods for the public disclosure of information on the performance of home health agencies.

(E) Any other issues determined appropriate by the Secretary.

(3) CONSULTATION.—In developing the plan under paragraph (1), the Secretary shall—

(A) consult with relevant affected parties; and

(B) consider experience with such demonstrations that the Secretary determines are relevant to the value-based purchasing program described in paragraph (1).

(4) REPORT TO CONGRESS.—Not later than October 1, 2011, the Secretary shall submit to Congress a report containing the plan developed under paragraph (1).

SEC. 3007. VALUE-BASED PAYMENT MODIFIER UNDER THE PHYSICIAN FEE SCHEDULE.

Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(1) in subsection (b)(1), by inserting "subject to subsection (p)," after "1998,"; and

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

"(p) ESTABLISHMENT OF VALUE-BASED PAYMENT MODIFIER.—

"(1) IN GENERAL.—The Secretary shall establish a payment modifier that provides for differential payment to a physician or a group of physicians

under the fee schedule established under subsection (b) based upon the quality of care furnished compared to cost (as determined under paragraphs (2) and (3), respectively) during a performance period. Such payment modifier shall be separate from the geographic adjustment factors established under subsection (e).

"(2) QUALITY.—

"(A) IN GENERAL.—For purposes of paragraph (1), quality of care shall be evaluated, to the extent practicable, based on a composite of measures of the quality of care furnished (as established by the Secretary under subparagraph (B)).

"(B) MEASURES.—

"(i) The Secretary shall establish appropriate measures of the quality of care furnished by a physician or group of physicians to individuals enrolled under this part, such as measures that reflect health outcomes. Such measures shall be risk adjusted as determined appropriate by the Secretary.

"(ii) The Secretary shall seek endorsement of the measures established under this

subparagraph by the entity with a contract under section 1890(a).

"(3) COSTS.—For purposes of paragraph (1), costs shall be evaluated, to the extent practicable, based on a composite of appropriate measures of costs established by the Secretary (such as the composite measure under the methodology established under subsection (n)(9)(C)(iii)) that eliminate the effect of geographic adjustments in payment rates (as described in subsection (e)), and take into account risk factors (such as socioeconomic and demographic characteristics, ethnicity, and health status of individuals (such as to recognize that less healthy individuals may require more intensive interventions) and other factors determined appropriate by the Secretary.

"(4) IMPLEMENTATION.—

"(A) PUBLICATION OF MEASURES, DATES OF IMPLEMENTATION, PERFORMANCE PERIOD.—Not later than January 1, 2012, the Secretary shall publish the following:

"(i) The measures of quality of care and costs established under paragraphs (2) and (3), respectively.

"(ii) The dates for implementation of the payment modifier (as determined under subparagraph (B)).

"(iii) The initial performance period (as specified under subparagraph (B)(ii)).

"(B) DEADLINES FOR IMPLEMENTATION.—

"(i) INITIAL IMPLEMENTATION.—Subject to the preceding provisions of this subparagraph, the Secretary shall begin implementing the payment modifier established under this subsection through the rulemaking process during 2013 for the physician fee schedule established under subsection (b).

"(ii) INITIAL PERFORMANCE PERIOD.—

"(I) IN GENERAL.—The Secretary shall specify an initial performance period for application of the payment modifier established under this subsection with respect to 2015.

"(II) PROVISION OF INFORMATION DURING INITIAL PERFORMANCE PERIOD.—During the initial performance period, the Secretary shall, to the extent practicable, provide information

to physicians and groups of physicians about the quality of care furnished by the physician or group of physicians to individuals enrolled under this part compared to cost (as determined under paragraphs (2) and (3), respectively) with respect to the performance period.

"(iii) APPLICATION.—The Secretary shall apply the payment modifier established under this subsection for items and services furnished—

"(I) beginning on January 1, 2015, with respect to specific physicians and groups of physicians the Secretary determines appropriate; and

"(II) beginning not later than January 1, 2017, with respect to all physicians and groups of physicians.

"(C) BUDGET NEUTRALITY.—The payment modifier established under this subsection shall be implemented in a budget neutral manner.

"(5) SYSTEMS-BASED CARE.—The Secretary shall, as appropriate, apply the payment modifier established under this subsection in a manner that promotes systems-based care.

"(6) CONSIDERATION OF SPECIAL CIRCUMSTANCES OF CERTAIN PROVIDERS.—In applying the payment modifier under this subsection, the Secretary shall, as appropriate, take into account the special circumstances of physicians or groups of physicians in rural areas and other underserved communities.

"(7) APPLICATION.—For purposes of the initial application of the payment modifier established under this subsection during the period beginning on January 1, 2015, and ending on December 31, 2016, the term 'physician' has the meaning given such term in section 1861(r). On or after January 1, 2017, the Secretary may apply this subsection to eligible professionals (as defined in subsection (k)(3)(B)) as the Secretary determines appropriate.

"(8) DEFINITIONS.—For purposes of this subsection:

"(A) COSTS.—The term 'costs' means expenditures per individual as determined appropriate by the Secretary. In making the determination under the preceding sentence, the Secretary may take into account the amount of growth in expenditures per individual for a phy-

sician compared to the amount of such growth for other physicians.

"(B) PERFORMANCE PERIOD.—The term 'performance period' means a period specified by the Secretary.

"(9) COORDINATION WITH OTHER VALUE-BASED PURCHASING REFORMS.—The Secretary shall coordinate the value-based payment modifier established under this subsection with the Physician Feedback Program under subsection (n) and, as the Secretary determines appropriate, other similar provisions of this title.

"(10) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

"(A) the establishment of the value-based payment modifier under this subsection;

"(B) the evaluation of quality of care under paragraph (2), including the establishment of appropriate measures of the quality of care under paragraph (2)(B);

"(C) the evaluation of costs under paragraph (3), including the establishment of appropriate measures of costs under such paragraph;

"(D) the dates for implementation of the value-based payment modifier;

"(E) the specification of the initial performance period and any other performance period under paragraphs (4)(B)(ii) and (8)(B), respectively;

"(F) the application of the value-based payment modifier under paragraph (7); and

"(G) the determination of costs under paragraph (8)(A).".

SEC. 3008. PAYMENT ADJUSTMENT FOR CONDITIONS ACQUIRED IN HOSPITALS.

(a) IN GENERAL.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by section 3001, is amended by adding at the end the following new subsection:

"(p) ADJUSTMENT TO HOSPITAL PAYMENTS FOR HOSPITAL ACQUIRED CONDITIONS.—

"(1) IN GENERAL.—In order to provide an incentive for applicable hospitals to reduce hospital acquired conditions under this title, with respect to discharges from an applicable hospital occurring during fiscal year 2015 or a subsequent fiscal year, the amount of payment under this section or section 1814(b)(3), as applicable, for such discharges during the fiscal year shall be equal to 99 percent of the

amount of payment that would otherwise apply to such discharges under this section or section 1814(b)(3) (determined after the application of subsections (o) and (q) and section 1814(l)(4) but without regard to this subsection).

"(2) APPLICABLE HOSPITALS.—

"(A) IN GENERAL.—For purposes of this subsection, the term 'applicable hospital' means a subsection (d) hospital that meets the criteria described in subparagraph (B).

"(B) CRITERIA DESCRIBED.—

"(i) IN GENERAL.—The criteria described in this subparagraph, with respect to a subsection (d) hospital, is that the subsection (d) hospital is in the top quartile of all subsection (d) hospitals, relative to the national average, of hospital acquired conditions during the applicable period, as determined by the Secretary.

"(ii) RISK ADJUSTMENT.—In carrying out clause (i), the Secretary shall establish and apply an appropriate risk adjustment methodology.

"(C) EXEMPTION.—In the case of a hospital that is paid under section 1814(b)(3), the Sec-

retary may exempt such hospital from the application of this subsection if the State which is paid under such section submits an annual report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under this subsection.

"(3) HOSPITAL ACQUIRED CONDITIONS.—For purposes of this subsection, the term 'hospital acquired condition' means a condition identified for purposes of subsection (d)(4)(D)(iv) and any other condition determined appropriate by the Secretary that an individual acquires during a stay in an applicable hospital, as determined by the Secretary.

"(4) APPLICABLE PERIOD.—In this subsection, the term 'applicable period' means, with respect to a fiscal year, a period specified by the Secretary.

"(5) REPORTING TO HOSPITALS.—Prior to fiscal year 2015 and each subsequent fiscal year, the Secretary shall provide confidential reports to applicable hospitals with respect to hospital acquired conditions of the applicable hospital during the applicable period.

"(6) REPORTING HOSPITAL SPECIFIC INFORMATION.—

"(A) IN GENERAL.—The Secretary shall make information available to the public regarding hospital acquired conditions of each applicable hospital.

"(B) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall ensure that an applicable hospital has the opportunity to review, and submit corrections for, the information to be made public with respect to the hospital under subparagraph (A) prior to such information being made public.

"(C) WEBSITE.—Such information shall be posted on the Hospital Compare Internet website in an easily understandable format.

"(7) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

"(A) The criteria described in paragraph (2)(A).

"(B) The specification of hospital acquired conditions under paragraph (3).

"(C) The specification of the applicable period under paragraph (4).

"(D) The provision of reports to applicable hospitals under paragraph (5) and the information made available to the public under paragraph (6).".

(b) STUDY AND REPORT ON EXPANSION OF HEALTHCARE ACQUIRED CONDITIONS POLICY TO OTHER PROVIDERS.—

(1) STUDY.—The Secretary of Health and Human Services shall conduct a study on expanding the healthcare acquired conditions policy under subsection (d)(4)(D) of section 1886 of the Social Security Act (42 U.S.C. 1395ww) to payments made to other facilities under the Medicare program under title XVIII of the Social Security Act, including such payments made to inpatient rehabilitation facilities, long-term care hospitals (as described in subsection(d)(1)(B)(iv) of such section), hospital outpatient departments, and other hospitals excluded from the inpatient prospective payment system under such section, skilled nursing facilities, ambulatory surgical centers, and health clinics. Such study shall include an analysis of how such policies could impact quality of patient care, patient safety, and spending under the Medicare program.

(2) REPORT.—Not later than January 1, 2012, the Secretary shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

PART II—NATIONAL STRATEGY TO IMPROVE HEALTH CARE QUALITY

SEC. 3011. NATIONAL STRATEGY.

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by adding at the end the following:

"PART S—HEALTH CARE QUALITY PROGRAMS

"Subpart I—National Strategy for Quality Improvement in Health Care

"SEC. 399HH. NATIONAL STRATEGY FOR QUALITY IMPROVEMENT IN HEALTH CARE.

"(a) ESTABLISHMENT OF NATIONAL STRATEGY AND PRIORITIES.—

"(1) NATIONAL STRATEGY.—The Secretary, through a transparent collaborative process, shall establish a national strategy to improve the delivery of health care services, patient health outcomes, and population health.

"(2) IDENTIFICATION OF PRIORITIES.—

"(A) IN GENERAL.—The Secretary shall identify national priorities for improvement in developing the strategy under paragraph (1).

"(B) REQUIREMENTS.—The Secretary shall ensure that priorities identified under subparagraph (A) will—

"(i) have the greatest potential for improving the health outcomes, efficiency, and patient-centeredness of health care for all populations, including children and vulnerable populations;

"(ii) identify areas in the delivery of health care services that have the potential for rapid improvement in the quality and efficiency of patient care;

"(iii) address gaps in quality, efficiency, comparative effectiveness information, and health outcomes measures and data aggregation techniques;

"(iv) improve Federal payment policy to emphasize quality and efficiency;

"(v) enhance the use of health care data to improve quality, efficiency, transparency, and outcomes;

"(vi) address the health care provided to patients with high-cost chronic diseases;

"(vii) improve research and dissemination of strategies and best practices to improve patient safety and reduce medical errors, preventable admissions and readmissions, and health care-associated infections;

"(viii) reduce health disparities across health disparity populations (as defined in section 485E) and geographic areas; and

"(ix) address other areas as determined appropriate by the Secretary.

"(C) CONSIDERATIONS.—In identifying priorities under subparagraph (A), the Secretary shall take into consideration the recommendations submitted by the entity with a contract under section 1890(a) of the Social Security Act and other stakeholders.

"(D) COORDINATION WITH STATE AGENCIES.—The Secretary shall collaborate, coordinate, and consult with State agencies responsible for administering the Medicaid program under title XIX of the Social Security Act and the Children's Health Insurance Program under title XXI of such Act with respect to developing and

disseminating strategies, goals, models, and timetables that are consistent with the national priorities identified under subparagraph (A).

"(b) STRATEGIC PLAN.—

"(1) IN GENERAL.—The national strategy shall include a comprehensive strategic plan to achieve the priorities described in subsection (a).

"(2) REQUIREMENTS.—The strategic plan shall include provisions for addressing, at a minimum, the following:

"(A) Coordination among agencies within the Department, which shall include steps to minimize duplication of efforts and utilization of common quality measures, where available. Such common quality measures shall be measures identified by the Secretary under section 1139A or 1139B of the Social Security Act or endorsed under section 1890 of such Act.

"(B) Agency-specific strategic plans to achieve national priorities.

"(C) Establishment of annual benchmarks for each relevant agency to achieve national priorities.

"(D) A process for regular reporting by the agencies to the Secretary on the implementation of the strategic plan.

"(E) Strategies to align public and private payers with regard to quality and patient safety efforts.

"(F) Incorporating quality improvement and measurement in the strategic plan for health information technology required by the American Recovery and Reinvestment Act of 2009 (Public Law 111–5).

"(c) PERIODIC UPDATE OF NATIONAL STRATEGY.—The Secretary shall update the national strategy not less than annually. Any such update shall include a review of short- and long-term goals.

"(d) SUBMISSION AND AVAILABILITY OF NATIONAL STRATEGY AND UPDATES.—

"(1) DEADLINE FOR INITIAL SUBMISSION OF NATIONAL STRATEGY.—Not later than January 1, 2011, the Secretary shall submit to the relevant committees of Congress the national strategy described in subsection (a).

"(2) UPDATES.—

"(A) IN GENERAL.—The Secretary shall submit to the relevant committees of Congress an

annual update to the strategy described in paragraph (1).

"(B) INFORMATION SUBMITTED.—Each update submitted under subparagraph (A) shall include—

"(i) a review of the short- and long-term goals of the national strategy and any gaps in such strategy;

"(ii) an analysis of the progress, or lack of progress, in meeting such goals and any barriers to such progress;

"(iii) the information reported under section 1139A of the Social Security Act, consistent with the reporting requirements of such section; and

"(iv) in the case of an update required to be submitted on or after January 1, 2014, the information reported under section 1139B(b)(4) of the Social Security Act, consistent with the reporting requirements of such section.

"(C) SATISFACTION OF OTHER REPORTING REQUIREMENTS.—Compliance with the requirements of clauses (iii) and (iv) of subparagraph (B) shall satisfy the reporting requirements

under sections 1139A(a)(6) and 1139B(b)(4), respectively, of the Social Security Act.

"(e) HEALTH CARE QUALITY INTERNET WEBSITE.—Not later than January 1, 2011, the Secretary shall create an Internet website to make public information regarding—

"(1) the national priorities for health care quality improvement established under subsection (a)(2);

"(2) the agency-specific strategic plans for health care quality described in subsection (b)(2)(B); and

"(3) other information, as the Secretary determines to be appropriate.".

SEC. 3012. INTERAGENCY WORKING GROUP ON HEALTH CARE QUALITY.

(a) IN GENERAL.—The President shall convene a working group to be known as the Interagency Working Group on Health Care Quality (referred to in this section as the "Working Group").

(b) GOALS.—The goals of the Working Group shall be to achieve the following:

(1) Collaboration, cooperation, and consultation between Federal departments and agencies with respect to developing and disseminating strategies, goals, models, and timetables that are consistent with the national priorities identified under section

399HH(a)(2) of the Public Health Service Act (as added by section 3011).

(2) Avoidance of inefficient duplication of quality improvement efforts and resources, where practicable, and a streamlined process for quality reporting and compliance requirements.

(3) Assess alignment of quality efforts in the public sector with private sector initiatives.

(c) COMPOSITION.—

(1) IN GENERAL.—The Working Group shall be composed of senior level representatives of—

(A) the Department of Health and Human Services;

(B) the Centers for Medicare & Medicaid Services;

(C) the National Institutes of Health;

(D) the Centers for Disease Control and Prevention;

(E) the Food and Drug Administration;

(F) the Health Resources and Services Administration;

(G) the Agency for Healthcare Research and Quality;

(H) the Office of the National Coordinator for Health Information Technology;

(I) the Substance Abuse and Mental Health Services Administration;

(J) the Administration for Children and Families;

(K) the Department of Commerce;

(L) the Office of Management and Budget;

(M) the United States Coast Guard;

(N) the Federal Bureau of Prisons;

(O) the National Highway Traffic Safety Administration;

(P) the Federal Trade Commission;

(Q) the Social Security Administration;

(R) the Department of Labor;

(S) the United States Office of Personnel Management;

(T) the Department of Defense;

(U) the Department of Education;

(V) the Department of Veterans Affairs;

(W) the Veterans Health Administration; and

(X) any other Federal agencies and departments with activities relating to improving health care quality and safety, as determined by the President.

(2) CHAIR AND VICE-CHAIR.—

(A) CHAIR.—The Working Group shall be chaired by the Secretary of Health and Human Services.

(B) VICE CHAIR.—Members of the Working Group, other than the Secretary of Health and Human Services, shall serve as Vice Chair of the Group on a rotating basis, as determined by the Group.

(d) REPORT TO CONGRESS.—Not later than December 31, 2010, and annually thereafter, the Working Group shall submit to the relevant Committees of Congress, and make public on an Internet website, a report describing the progress and recommendations of the Working Group in meeting the goals described in subsection (b).

SEC. 3013. QUALITY MEASURE DEVELOPMENT.

(a) PUBLIC HEALTH SERVICE ACT.—Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.) is amended—

(1) by redesignating part D as part E;

(2) by redesignating sections 931 through 938 as sections 941 through 948, respectively;

(3) in section 948(1), as so redesignated, by striking "931" and inserting "941"; and

(4) by inserting after section 926 the following:

"PART D—HEALTH CARE QUALITY IMPROVEMENT

"Subpart I—Quality Measure Development

"SEC. 931. QUALITY MEASURE DEVELOPMENT.

"(a) QUALITY MEASURE.—In this subpart, the term 'quality measure' means a standard for measuring the performance and improvement of population health or of health plans, providers of services, and other clinicians in the delivery of health care services.

"(b) IDENTIFICATION OF QUALITY MEASURES.—

"(1) IDENTIFICATION.—The Secretary, in consultation with the Director of the Agency for Healthcare Research and Quality and the Administrator of the Centers for Medicare & Medicaid Services, shall identify, not less often than triennially, gaps where no quality measures exist and existing quality measures that need improvement, updating, or expansion, consistent with the national strategy under section 399HH, to the extent available, for use in Federal health programs. In identifying such gaps and existing quality measures that need improvement, the Secretary shall take into consideration—

"(A) the gaps identified by the entity with a contract under section 1890(a) of the Social Security Act and other stakeholders;

"(B) quality measures identified by the pediatric quality measures program under section 1139A of the Social Security Act; and

"(C) quality measures identified through the Medicaid Quality Measurement Program under section 1139B of the Social Security Act.

"(2) PUBLICATION.—The Secretary shall make available to the public on an Internet website a report on any gaps identified under paragraph (1) and the process used to make such identification.

"(c) GRANTS OR CONTRACTS FOR QUALITY MEASURE DEVELOPMENT.—

"(1) IN GENERAL.—The Secretary shall award grants, contracts, or intergovernmental agreements to eligible entities for purposes of developing, improving, updating, or expanding quality measures identified under subsection (b).

"(2) PRIORITIZATION IN THE DEVELOPMENT OF QUALITY MEASURES.—In awarding grants, contracts, or agreements under this subsection, the Secretary shall give priority to the development of quality measures that allow the assessment of—

"(A) health outcomes and functional status of patients;

"(B) the management and coordination of health care across episodes of care and care transitions for patients across the continuum of providers, health care settings, and health plans;

"(C) the experience, quality, and use of information provided to and used by patients, caregivers, and authorized representatives to inform decisionmaking about treatment options, including the use of shared decisionmaking tools and preference sensitive care (as defined in section 936);

"(D) the meaningful use of health information technology;

"(E) the safety, effectiveness, patient-centeredness, appropriateness, and timeliness of care;

"(F) the efficiency of care;

"(G) the equity of health services and health disparities across health disparity populations (as defined in section 485E) and geographic areas;

"(H) patient experience and satisfaction;

"(I) the use of innovative strategies and methodologies identified under section 933; and

"(J) other areas determined appropriate by the Secretary.

"(3) ELIGIBLE ENTITIES.—To be eligible for a grant or contract under this subsection, an entity shall—

"(A) have demonstrated expertise and capacity in the development and evaluation of quality measures;

"(B) have adopted procedures to include in the quality measure development process—

"(i) the views of those providers or payers whose performance will be assessed by the measure; and

"(ii) the views of other parties who also will use the quality measures (such as patients, consumers, and health care purchasers);

"(C) collaborate with the entity with a contract under section 1890(a) of the Social Security Act and other stakeholders, as practicable, and the Secretary so that quality measures developed by the eligible entity will meet the requirements to be considered for endorsement by the entity with a contract under such section 1890(a);

"(D) have transparent policies regarding governance and conflicts of interest; and

"(E) submit an application to the Secretary at such time and in such manner, as the Secretary may require.

"(4) USE OF FUNDS.—An entity that receives a grant, contract, or agreement under this subsection shall use such award to develop quality measures that meet the following requirements:

"(A) Such measures support measures required to be reported under the Social Security Act, where applicable, and in support of gaps and existing quality measures that need improvement, as described in subsection (b)(1)(A).

"(B) Such measures support measures developed under section 1139A of the Social Security Act and the Medicaid Quality Measurement Program under section 1139B of such Act, where applicable.

"(C) To the extent practicable, data on such quality measures is able to be collected using health information technologies.

"(D) Each quality measure is free of charge to users of such measure.

"(E) Each quality measure is publicly available on an Internet website.

"(d) OTHER ACTIVITIES BY THE SECRETARY.—The Secretary may use amounts available under this section to update and test, where applicable, quality measures endorsed by the entity with a contract under section 1890(a) of the Social Security Act or adopted by the Secretary.

"(e) COORDINATION OF GRANTS.—The Secretary shall ensure that grants or contracts awarded under this section are coordinated with grants and contracts awarded under sections 1139A(5) and 1139B(4)(A) of the Social Security Act.".

(b) SOCIAL SECURITY ACT.—Section 1890A of the Social Security Act, as added by section 3014(b), is amended by adding at the end the following new subsection:

"(e) DEVELOPMENT OF QUALITY MEASURES.—The Administrator of the Center for Medicare & Medicaid Services shall through contracts develop quality measures (as determined appropriate by the Administrator) for use under this Act. In developing such measures, the Administrator shall consult with the Director of the Agency for Healthcare Research and Quality.".

(c) FUNDING.—There are authorized to be appropriated to the Secretary of Health and Human Services to carry out this section, $75,000,000 for each of fiscal years

2010 through 2014. Of the amounts appropriated under the preceding sentence in a fiscal year, not less than 50 percent of such amounts shall be used pursuant to subsection (e) of section 1890A of the Social Security Act, as added by subsection (b), with respect to programs under such Act. Amounts appropriated under this subsection for a fiscal year shall remain available until expended.

SEC. 3014. QUALITY MEASUREMENT.

(a) NEW DUTIES FOR CONSENSUS-BASED ENTITY.—

(1) MULTI-STAKEHOLDER GROUP INPUT.—Section 1890(b) of the Social Security Act (42 U.S.C. 1395aaa(b)), as amended by section 3003, is amended by adding at the end the following new paragraphs:

"(7) CONVENING MULTI-STAKEHOLDER GROUPS.—

"(A) IN GENERAL.—The entity shall convene multi-stakeholder groups to provide input on—

"(i) the selection of quality measures described in subparagraph (B), from among—

"(I) such measures that have been endorsed by the entity; and

"(II) such measures that have not been considered for endorsement by

such entity but are used or proposed to be used by the Secretary for the collection or reporting of quality measures; and

"(ii) national priorities (as identified under section 399HH of the Public Health Service Act) for improvement in population health and in the delivery of health care services for consideration under the national strategy established under section 399HH of the Public Health Service Act.

"(B) QUALITY MEASURES.—

"(i) IN GENERAL.—Subject to clause (ii), the quality measures described in this subparagraph are quality measures—

"(I) for use pursuant to sections 1814(i)(5)(D), 1833(i)(7), 1833(t)(17), 1848(k)(2)(C), 1866(k)(3), 1881(h)(2)(A)(iii), 1886(b)(3)(B)(viii), 1886(j)(7)(D), 1886(m)(5)(D), 1886(o)(2), and 1895(b)(3)(B)(v);

"(II) for use in reporting performance information to the public; and

"(III) for use in health care programs other than for use under this Act.

"(ii) EXCLUSION.—Data sets (such as the outcome and assessment information set for home health services and the minimum data set for skilled nursing facility services) that are used for purposes of classification systems used in establishing payment rates under this title shall not be quality measures described in this subparagraph.

"(C) REQUIREMENT FOR TRANSPARENCY IN PROCESS.—

"(i) IN GENERAL.—In convening multi-stakeholder groups under subparagraph (A) with respect to the selection of quality measures, the entity shall provide for an open and transparent process for the activities conducted pursuant to such convening.

"(ii) SELECTION OF ORGANIZATIONS PARTICIPATING IN MULTI-STAKEHOLDER GROUPS.—The process described in clause (i) shall ensure that the selection of representatives comprising such groups pro-

vides for public nominations for, and the opportunity for public comment on, such selection.

"(D) MULTI-STAKEHOLDER GROUP DEFINED.—In this paragraph, the term 'multi-stakeholder group' means, with respect to a quality measure, a voluntary collaborative of organizations representing a broad group of stakeholders interested in or affected by the use of such quality measure.

"(8) TRANSMISSION OF MULTI-STAKEHOLDER INPUT.—Not later than February 1 of each year (beginning with 2012), the entity shall transmit to the Secretary the input of multi-stakeholder groups provided under paragraph (7).".

(2) ANNUAL REPORT.—Section 1890(b)(5)(A) of the Social Security Act (42 U.S.C. 1395aaa(b)(5)(A)) is amended—

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

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

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

"(iv) gaps in endorsed quality measures, which shall include measures that are within priority areas identified by the Secretary under the national strategy established under section 399HH of the Public Health Service Act, and where quality measures are unavailable or inadequate to identify or address such gaps;

"(v) areas in which evidence is insufficient to support endorsement of quality measures in priority areas identified by the Secretary under the national strategy established under section 399HH of the Public Health Service Act and where targeted research may address such gaps; and

"(vi) the matters described in clauses (i) and (ii) of paragraph (7)(A).".

(b) MULTI-STAKEHOLDER GROUP INPUT INTO SELECTION OF QUALITY MEASURES.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by inserting after section 1890 the following:

"QUALITY MEASUREMENT

"SEC. 1890A. (a) MULTI-STAKEHOLDER GROUP INPUT INTO SELECTION OF QUALITY MEASURES.—The Secretary shall establish a pre-rulemaking process under which the

following steps occur with respect to the selection of quality measures described in section 1890(b)(7)(B):

"(1) INPUT.—Pursuant to section 1890(b)(7), the entity with a contract under section 1890 shall convene multi-stakeholder groups to provide input to the Secretary on the selection of quality measures described in subparagraph (B) of such paragraph.

"(2) PUBLIC AVAILABILITY OF MEASURES CONSIDERED FOR SELECTION.—Not later than December 1 of each year (beginning with 2011), the Secretary shall make available to the public a list of quality measures described in section 1890(b)(7)(B) that the Secretary is considering under this title.

"(3) TRANSMISSION OF MULTI-STAKEHOLDER INPUT.—Pursuant to section 1890(b)(8), not later than February 1 of each year (beginning with 2012), the entity shall transmit to the Secretary the input of multi-stakeholder groups described in paragraph (1).

"(4) CONSIDERATION OF MULTI-STAKEHOLDER INPUT.—The Secretary shall take into consideration the input from multi-stakeholder groups described in paragraph (1) in selecting quality measures described in section 1890(b)(7)(B) that have been endorsed by the entity with a contract under section 1890 and measures that have not been endorsed by such entity.

"(5) RATIONALE FOR USE OF QUALITY MEASURES.—The Secretary shall publish in the Federal Register the rationale for the use of any quality measure described in section 1890(b)(7)(B) that has not been endorsed by the entity with a contract under section 1890.

"(6) ASSESSMENT OF IMPACT.—Not later than March 1, 2012, and at least once every three years thereafter, the Secretary shall—

"(A) conduct an assessment of the quality impact of the use of endorsed measures described in section 1890(b)(7)(B); and

"(B) make such assessment available to the public.

"(b) PROCESS FOR DISSEMINATION OF MEASURES USED BY THE SECRETARY.—

"(1) IN GENERAL.—The Secretary shall establish a process for disseminating quality measures used by the Secretary. Such process shall include the following:

"(A) The incorporation of such measures, where applicable, in workforce programs, training curricula, and any other means of dissemination determined appropriate by the Secretary.

"(B) The dissemination of such quality measures through the national strategy developed under section 399HH of the Public Health Service Act.

"(2) EXISTING METHODS.—To the extent practicable, the Secretary shall utilize and expand existing dissemination methods in disseminating quality measures under the process established under paragraph (1).

"(c) REVIEW OF QUALITY MEASURES USED BY THE SECRETARY.—

"(1) IN GENERAL.—The Secretary shall—

"(A) periodically (but in no case less often than once every 3 years) review quality measures described in section 1890(b)(7)(B); and

"(B) with respect to each such measure, determine whether to—

"(i) maintain the use of such measure; or

"(ii) phase out such measure.

"(2) CONSIDERATIONS.—In conducting the review under paragraph (1), the Secretary shall take steps to—

"(A) seek to avoid duplication of measures used; and

"(B) take into consideration current innovative methodologies and strategies for quality improvement practices in the delivery of health care services that represent best practices for such quality improvement and measures endorsed by the entity with a contract under section 1890 since the previous review by the Secretary.

"(d) RULE OF CONSTRUCTION.—Nothing in this section shall preclude a State from using the quality measures identified under sections 1139A and 1139B.".

(c) FUNDING.—For purposes of carrying out the amendments made by this section, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines appropriate, of $20,000,000, to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2010 through 2014. Amounts transferred under the preceding sentence shall remain available until expended.

SEC. 3015. DATA COLLECTION; PUBLIC REPORTING.

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.), as amended by section 3011, is further amended by adding at the end the following:

"SEC. 399II. COLLECTION AND ANALYSIS OF DATA FOR QUALITY AND RESOURCE USE MEASURES.

"(a) IN GENERAL.—The Secretary shall collect and aggregate consistent data on quality and resource use measures from information systems used to support health care delivery to implement the public reporting of performance information, as described in section 399JJ, and may award grants or contracts for this purpose. The Secretary shall ensure that such collection, aggregation, and analysis systems span an increasingly broad range of patient populations, providers, and geographic areas over time.

"(b) GRANTS OR CONTRACTS FOR DATA COLLECTION.—

"(1) IN GENERAL.—The Secretary may award grants or contracts to eligible entities to support new, or improve existing, efforts to collect and aggregate quality and resource use measures described under subsection (c).

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

"(A) be—

"(i) a multi-stakeholder entity that coordinates the development of methods and implementation plans for the consistent reporting of summary quality and cost information;

"(ii) an entity capable of submitting such summary data for a particular population and providers, such as a disease registry, regional collaboration, health plan collaboration, or other population-wide source; or

"(iii) a Federal Indian Health Service program or a health program operated by an Indian tribe (as defined in section 4 of the Indian Health Care Improvement Act);

"(B) promote the use of the systems that provide data to improve and coordinate patient care;

"(C) support the provision of timely, consistent quality and resource use information to health care providers, and other groups and organizations as appropriate, with an opportunity for providers to correct inaccurate measures; and

"(D) agree to report, as determined by the Secretary, measures on quality and resource use

to the public in accordance with the public reporting process established under section 399JJ.

"(c) CONSISTENT DATA AGGREGATION.—The Secretary may award grants or contracts under this section only to entities that enable summary data that can be integrated and compared across multiple sources. The Secretary shall provide standards for the protection of the security and privacy of patient data.

"(d) MATCHING FUNDS.—The Secretary may not award a grant or contract under this section to an entity unless the entity agrees that it will make available (directly or through contributions from other public or private entities) non-Federal contributions toward the activities to be carried out under the grant or contract in an amount equal to $1 for each $5 of Federal funds provided under the grant or contract. Such non-Federal matching funds may be provided directly or through donations from public or private entities and may be in cash or in-kind, fairly evaluated, including plant, equipment, or services.

"(e) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2010 through 2014.

"SEC. 399JJ. PUBLIC REPORTING OF PERFORMANCE INFORMATION.

"(a) DEVELOPMENT OF PERFORMANCE WEBSITES.—The Secretary shall make available to the public, through standardized Internet websites, performance information summarizing data on quality measures. Such information shall be tailored to respond to the differing needs of hospitals and other institutional health care providers, physicians and other clinicians, patients, consumers, researchers, policymakers, States, and other stakeholders, as the Secretary may specify.

"(b) INFORMATION ON CONDITIONS.—The performance information made publicly available on an Internet website, as described in subsection (a), shall include information regarding clinical conditions to the extent such information is available, and the information shall, where appropriate, be provider-specific and sufficiently disaggregated and specific to meet the needs of patients with different clinical conditions.

"(c) CONSULTATION.—

"(1) IN GENERAL.—In carrying out this section, the Secretary shall consult with the entity with a contract under section 1890(a) of the Social Security Act, and other entities, as appropriate, to determine the type of information that is useful to stakeholders

and the format that best facilitates use of the reports and of performance reporting Internet websites.

"(2) CONSULTATION WITH STAKEHOLDERS.—The entity with a contract under section 1890(a) of the Social Security Act shall convene multi-stakeholder groups, as described in such section, to review the design and format of each Internet website made available under subsection (a) and shall transmit to the Secretary the views of such multi-stakeholder groups with respect to each such design and format.

"(d) COORDINATION.—Where appropriate, the Secretary shall coordinate the manner in which data are presented through Internet websites described in subsection (a) and for public reporting of other quality measures by the Secretary, including such quality measures under title XVIII of the Social Security Act.

"(e) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2010 through 2014.".

PART III—ENCOURAGING DEVELOPMENT OF NEW PATIENT CARE MODELS

SEC. 3021. ESTABLISHMENT OF CENTER FOR MEDICARE AND MEDICAID INNOVATION WITHIN CMS.

(a) IN GENERAL.—Title XI of the Social Security Act is amended by inserting after section 1115 the following new section:

"CENTER FOR MEDICARE AND MEDICAID INNOVATION

"SEC. 1115A. (a) CENTER FOR MEDICARE AND MEDICAID INNOVATION ESTABLISHED.—

"(1) IN GENERAL.—There is created within the Centers for Medicare & Medicaid Services a Center for Medicare and Medicaid Innovation (in this section referred to as the 'CMI') to carry out the duties described in this section. The purpose of the CMI is to test innovative payment and service delivery models to reduce program expenditures under the applicable titles while preserving or enhancing the quality of care furnished to individuals under such titles. In selecting such models, the Secretary shall give preference to models that also improve the coordination, quality, and efficiency of health care services furnished to applicable individuals defined in paragraph (4)(A).

"(2) DEADLINE.—The Secretary shall ensure that the CMI is carrying out the duties described in this section by not later than January 1, 2011.

"(3) CONSULTATION.—In carrying out the duties under this section, the CMI shall consult representatives of relevant Federal agencies, and clinical and analytical experts with expertise in medicine and health care management. The CMI shall use open door forums or other mechanisms to seek input from interested parties.

"(4) DEFINITIONS.—In this section:

"(A) APPLICABLE INDIVIDUAL.—The term 'applicable individual' means—

"(i) an individual who is entitled to, or enrolled for, benefits under part A of title XVIII or enrolled for benefits under part B of such title;

"(ii) an individual who is eligible for medical assistance under title XIX, under a State plan or waiver; or

"(iii) an individual who meets the criteria of both clauses (i) and (ii).

"(B) APPLICABLE TITLE.—The term 'applicable title' means title XVIII, title XIX, or both.

"(b) TESTING OF MODELS (PHASE I).—

"(1) IN GENERAL.—The CMI shall test payment and service delivery models in accordance with selection criteria under paragraph (2) to determine the effect of applying such models under the applicable title (as defined in subsection (a)(4)(B)) on program expenditures under such titles and the quality of care received by individuals receiving benefits under such title.

"(2) SELECTION OF MODELS TO BE TESTED.—

"(A) IN GENERAL.—The Secretary shall select models to be tested from models where the Secretary determines that there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures. The models selected under the preceding sentence may include the models described in subparagraph (B).

"(B) OPPORTUNITIES.—The models described in this subparagraph are the following models:

"(i) Promoting broad payment and practice reform in primary care, including patient-centered medical home models for high-need applicable individuals, medical

homes that address women's unique health care needs, and models that transition primary care practices away from fee-for-service based reimbursement and toward comprehensive payment or salary-based payment.

"(ii) Contracting directly with groups of providers of services and suppliers to promote innovative care delivery models, such as through risk-based comprehensive payment or salary-based payment.

"(iii) Utilizing geriatric assessments and comprehensive care plans to coordinate the care (including through interdisciplinary teams) of applicable individuals with multiple chronic conditions and at least one of the following:

"(I) An inability to perform 2 or more activities of daily living.

"(II) Cognitive impairment, including dementia.

"(iv) Promote care coordination between providers of services and suppliers that transition health care providers away

from fee-for-service based reimbursement and toward salary-based payment.

"(v) Supporting care coordination for chronically-ill applicable individuals at high risk of hospitalization through a health information technology-enabled provider network that includes care coordinators, a chronic disease registry, and home telehealth technology.

"(vi) Varying payment to physicians who order advanced diagnostic imaging services (as defined in section 1834(e)(1)(B)) according to the physician's adherence to appropriateness criteria for the ordering of such services, as determined in consultation with physician specialty groups and other relevant stakeholders.

"(vii) Utilizing medication therapy management services, such as those described in section 935 of the Public Health Service Act.

"(viii) Establishing community-based health teams to support small-practice medical homes by assisting the primary care practitioner in chronic care management,

including patient self-management, activities.

"(ix) Assisting applicable individuals in making informed health care choices by paying providers of services and suppliers for using patient decision-support tools, including tools that meet the standards developed and identified under section 936(c)(2)(A) of the Public Health Service Act, that improve applicable individual and caregiver understanding of medical treatment options.

"(x) Allowing States to test and evaluate fully integrating care for dual eligible individuals in the State, including the management and oversight of all funds under the applicable titles with respect to such individuals.

"(xi) Allowing States to test and evaluate systems of all-payer payment reform for the medical care of residents of the State, including dual eligible individuals.

"(xii) Aligning nationally recognized, evidence-based guidelines of cancer care with payment incentives under title XVIII

in the areas of treatment planning and follow-up care planning for applicable individuals described in clause (i) or (iii) of subsection (a)(4)(A) with cancer, including the identification of gaps in applicable quality measures.

"(xiii) Improving post-acute care through continuing care hospitals that offer inpatient rehabilitation, long-term care hospitals, and home health or skilled nursing care during an inpatient stay and the 30 days immediately following discharge.

"(xiv) Funding home health providers who offer chronic care management services to applicable individuals in cooperation with interdisciplinary teams.

"(xv) Promoting improved quality and reduced cost by developing a collaborative of high-quality, low-cost health care institutions that is responsible for—

"(I) developing, documenting, and disseminating best practices and proven care methods;

"(II) implementing such best practices and proven care methods

within such institutions to demonstrate further improvements in quality and efficiency; and

"(III) providing assistance to other health care institutions on how best to employ such best practices and proven care methods to improve health care quality and lower costs.

"(xvi) Facilitate inpatient care, including intensive care, of hospitalized applicable individuals at their local hospital through the use of electronic monitoring by specialists, including intensivists and critical care specialists, based at integrated health systems.

"(xvii) Promoting greater efficiencies and timely access to outpatient services (such as outpatient physical therapy services) through models that do not require a physician or other health professional to refer the service or be involved in establishing the plan of care for the service, when such service is furnished by a health professional who has the authority to furnish the service under existing State law.

"(xviii) Establishing comprehensive payments to Healthcare Innovation Zones, consisting of groups of providers that include a teaching hospital, physicians, and other clinical entities, that, through their structure, operations, and joint-activity deliver a full spectrum of integrated and comprehensive health care services to applicable individuals while also incorporating innovative methods for the clinical training of future health care professionals.

"(C) ADDITIONAL FACTORS FOR CONSIDERATION.—In selecting models for testing under subparagraph (A), the CMI may consider the following additional factors:

"(i) Whether the model includes a regular process for monitoring and updating patient care plans in a manner that is consistent with the needs and preferences of applicable individuals.

"(ii) Whether the model places the applicable individual, including family members and other informal caregivers of the applicable individual, at the center of the care team of the applicable individual.

"(iii) Whether the model provides for in-person contact with applicable individuals.

"(iv) Whether the model utilizes technology, such as electronic health records and patient-based remote monitoring systems, to coordinate care over time and across settings.

"(v) Whether the model provides for the maintenance of a close relationship between care coordinators, primary care practitioners, specialist physicians, community-based organizations, and other providers of services and suppliers.

"(vi) Whether the model relies on a team-based approach to interventions, such as comprehensive care assessments, care planning, and self-management coaching.

"(vii) Whether, under the model, providers of services and suppliers are able to share information with patients, caregivers, and other providers of services and suppliers on a real time basis.

"(3) BUDGET NEUTRALITY.—

"(A) INITIAL PERIOD.—The Secretary shall not require, as a condition for testing a model under paragraph (1), that the design of such model ensure that such model is budget neutral initially with respect to expenditures under the applicable title.

"(B) TERMINATION OR MODIFICATION.—The Secretary shall terminate or modify the design and implementation of a model unless the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services, with respect to program spending under the applicable title, certifies), after testing has begun, that the model is expected to—

"(i) improve the quality of care (as determined by the Administrator of the Centers for Medicare & Medicaid Services) without increasing spending under the applicable title;

"(ii) reduce spending under the applicable title without reducing the quality of care; or

"(iii) improve the quality of care and reduce spending.

Such termination may occur at any time after such testing has begun and before completion of the testing.

"(4) EVALUATION.—

"(A) IN GENERAL.—The Secretary shall conduct an evaluation of each model tested under this subsection. Such evaluation shall include an analysis of—

"(i) the quality of care furnished under the model, including the measurement of patient-level outcomes and patient-centeredness criteria determined appropriate by the Secretary; and

"(ii) the changes in spending under the applicable titles by reason of the model.

"(B) INFORMATION.—The Secretary shall make the results of each evaluation under this paragraph available to the public in a timely fashion and may establish requirements for States and other entities participating in the testing of models under this section to collect and report information that the Secretary determines is necessary to monitor and evaluate such models.

"(c) EXPANSION OF MODELS (PHASE II).—Taking into account the evaluation under subsection (b)(4), the Secretary may, through rulemaking, expand (including implementation on a nationwide basis) the duration and the scope of a model that is being tested under subsection (b) or a demonstration project under section 1866C, to the extent determined appropriate by the Secretary, if—

"(1) the Secretary determines that such expansion is expected to—

"(A) reduce spending under applicable title without reducing the quality of care; or

"(B) improve the quality of care and reduce spending; and

"(2) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce program spending under applicable titles.

"(d) IMPLEMENTATION.—

"(1) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII and of sections 1902(a)(1), 1902(a)(13), and 1903(m)(2)(A)(iii) as may be necessary solely for purposes of carrying out this section with respect to testing models described in subsection (b).

"(2) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

"(A) the selection of models for testing or expansion under this section;

"(B) the selection of organizations, sites, or participants to test those models selected;

"(C) the elements, parameters, scope, and duration of such models for testing or dissemination;

"(D) determinations regarding budget neutrality under subsection (b)(3);

"(E) the termination or modification of the design and implementation of a model under subsection (b)(3)(B); and

"(F) determinations about expansion of the duration and scope of a model under subsection (c), including the determination that a model is not expected to meet criteria described in paragraph (1) or (2) of such subsection.

"(3) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the testing and evaluation of models or expansion of such models under this section.

"(e) APPLICATION TO CHIP.—The Center may carry out activities under this section with respect to title XXI in the same manner as provided under this section with respect to the program under the applicable titles.

"(f) FUNDING.—

"(1) IN GENERAL.—There are appropriated, from amounts in the Treasury not otherwise appropriated—

"(A) $5,000,000 for the design, implementation, and evaluation of models under subsection (b) for fiscal year 2010;

"(B) $10,000,000,000 for the activities initiated under this section for the period of fiscal years 2011 through 2019; and

"(C) the amount described in subparagraph (B) for the activities initiated under this section for each subsequent 10-year fiscal period (beginning with the 10-year fiscal period beginning with fiscal year 2020).

Amounts appropriated under the preceding sentence shall remain available until expended.

"(2) USE OF CERTAIN FUNDS.—Out of amounts appropriated under subparagraphs (B) and (C) of paragraph (1), not less than $25,000,000 shall be

made available each such fiscal year to design, implement, and evaluate models under subsection (b).

"(g) REPORT TO CONGRESS.—Beginning in 2012, and not less than once every other year thereafter, the Secretary shall submit to Congress a report on activities under this section. Each such report shall describe the models tested under subsection (b), including the number of individuals described in subsection (a)(4)(A)(i) and of individuals described in subsection (a)(4)(A)(ii) participating in such models and payments made under applicable titles for services on behalf of such individuals, any models chosen for expansion under subsection (c), and the results from evaluations under subsection (b)(4). In addition, each such report shall provide such recommendations as the Secretary determines are appropriate for legislative action to facilitate the development and expansion of successful payment models.".

(b) MEDICAID CONFORMING AMENDMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 8002(b), is amended—

(1) in paragraph (81), by striking "and" at the end;

(2) in paragraph (82), by striking the period at the end and inserting "; and"; and

(3) by inserting after paragraph (82) the following new paragraph:

"(83) provide for implementation of the payment models specified by the Secretary under section 1115A(c) for implementation on a nationwide basis unless the State demonstrates to the satisfaction of the Secretary that implementation would not be administratively feasible or appropriate to the health care delivery system of the State.".

(c) REVISIONS TO HEALTH CARE QUALITY DEMONSTRATION PROGRAM.—Subsections (b) and (f) of section 1866C of the Social Security Act (42 U.S.C. 1395cc–3) are amended by striking "5-year" each place it appears.

SEC. 3022. MEDICARE SHARED SAVINGS PROGRAM.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

"SHARED SAVINGS PROGRAM

"SEC. 1899. (a) ESTABLISHMENT.—

"(1) IN GENERAL.—Not later than January 1, 2012, the Secretary shall establish a shared savings program (in this section referred to as the 'program') that promotes accountability for a patient population and coordinates items and services under parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery. Under such program—

"(A) groups of providers of services and suppliers meeting criteria specified by the Secretary may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an accountable care organization (referred to in this section as an 'ACO'); and

"(B) ACOs that meet quality performance standards established by the Secretary are eligible to receive payments for shared savings under subsection (d)(2).

"(b) ELIGIBLE ACOS.—

"(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, as determined appropriate by the Secretary, the following groups of providers of services and suppliers which have established a mechanism for shared governance are eligible to participate as ACOs under the program under this section:

"(A) ACO professionals in group practice arrangements.

"(B) Networks of individual practices of ACO professionals.

"(C) Partnerships or joint venture arrangements between hospitals and ACO professionals.

"(D) Hospitals employing ACO professionals.

"(E) Such other groups of providers of services and suppliers as the Secretary determines appropriate.

"(2) REQUIREMENTS.—An ACO shall meet the following requirements:

"(A) The ACO shall be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it.

"(B) The ACO shall enter into an agreement with the Secretary to participate in the program for not less than a 3-year period (referred to in this section as the 'agreement period').

"(C) The ACO shall have a formal legal structure that would allow the organization to receive and distribute payments for shared savings under subsection (d)(2) to participating providers of services and suppliers.

"(D) The ACO shall include primary care ACO professionals that are sufficient for the number of Medicare fee-for-service beneficiaries assigned to the ACO under subsection (c). At a

minimum, the ACO shall have at least 5,000 such beneficiaries assigned to it under subsection (c) in order to be eligible to participate in the ACO program.

"(E) The ACO shall provide the Secretary with such information regarding ACO professionals participating in the ACO as the Secretary determines necessary to support the assignment of Medicare fee-for-service beneficiaries to an ACO, the implementation of quality and other reporting requirements under paragraph (3), and the determination of payments for shared savings under subsection (d)(2).

"(F) The ACO shall have in place a leadership and management structure that includes clinical and administrative systems.

"(G) The ACO shall define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies.

"(H) The ACO shall demonstrate to the Secretary that it meets patient-centeredness criteria specified by the Secretary, such as the use of pa-

tient and caregiver assessments or the use of individualized care plans.

"(3) QUALITY AND OTHER REPORTING REQUIREMENTS.—

"(A) IN GENERAL.—The Secretary shall determine appropriate measures to assess the quality of care furnished by the ACO, such as measures of—

"(i) clinical processes and outcomes;

"(ii) patient and, where practicable, caregiver experience of care; and

"(iii) utilization (such as rates of hospital admissions for ambulatory care sensitive conditions).

"(B) REPORTING REQUIREMENTS.—An ACO shall submit data in a form and manner specified by the Secretary on measures the Secretary determines necessary for the ACO to report in order to evaluate the quality of care furnished by the ACO. Such data may include care transitions across health care settings, including hospital discharge planning and post-hospital discharge follow-up by ACO professionals, as the Secretary determines appropriate.

"(C) QUALITY PERFORMANCE STANDARDS.—The Secretary shall establish quality performance standards to assess the quality of care furnished by ACOs. The Secretary shall seek to improve the quality of care furnished by ACOs over time by specifying higher standards, new measures, or both for purposes of assessing such quality of care.

"(D) OTHER REPORTING REQUIREMENTS.—The Secretary may, as the Secretary determines appropriate, incorporate reporting requirements and incentive payments related to the physician quality reporting initiative (PQRI) under section 1848, including such requirements and such payments related to electronic prescribing, electronic health records, and other similar initiatives under section 1848, and may use alternative criteria than would otherwise apply under such section for determining whether to make such payments. The incentive payments described in the preceding sentence shall not be taken into consideration when calculating any payments otherwise made under subsection (d).

"(4) NO DUPLICATION IN PARTICIPATION IN SHARED SAVINGS PROGRAMS.—A provider of services

or supplier that participates in any of the following shall not be eligible to participate in an ACO under this section:

"(A) A model tested or expanded under section 1115A that involves shared savings under this title, or any other program or demonstration project that involves such shared savings.

"(B) The independence at home medical practice pilot program under section 1866E.

"(c) ASSIGNMENT OF MEDICARE FEE-FOR-SERVICE BENEFICIARIES TO ACOS.—The Secretary shall determine an appropriate method to assign Medicare fee-for-service beneficiaries to an ACO based on their utilization of primary care services provided under this title by an ACO professional described in subsection (h)(1)(A).

"(d) PAYMENTS AND TREATMENT OF SAVINGS.—

"(1) PAYMENTS.—

"(A) IN GENERAL.—Under the program, subject to paragraph (3), payments shall continue to be made to providers of services and suppliers participating in an ACO under the original Medicare fee-for-service program under parts A and B in the same manner as they would otherwise be made except that a partici-

pating ACO is eligible to receive payment for shared savings under paragraph (2) if—

"(i) the ACO meets quality performance standards established by the Secretary under subsection (b)(3); and

"(ii) the ACO meets the requirement under subparagraph (B)(i).

"(B) SAVINGS REQUIREMENT AND BENCHMARK.—

"(i) DETERMINING SAVINGS.—In each year of the agreement period, an ACO shall be eligible to receive payment for shared savings under paragraph (2) only if the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for parts A and B services, adjusted for beneficiary characteristics, is at least the percent specified by the Secretary below the applicable benchmark under clause (ii). The Secretary shall determine the appropriate percent described in the preceding sentence to account for normal variation in expenditures under this title, based upon the number of Medicare

fee-for-service beneficiaries assigned to an ACO.

"(ii) ESTABLISH AND UPDATE BENCHMARK.—The Secretary shall estimate a benchmark for each agreement period for each ACO using the most recent available 3 years of per-beneficiary expenditures for parts A and B services for Medicare fee-for-service beneficiaries assigned to the ACO. Such benchmark shall be adjusted for beneficiary characteristics and such other factors as the Secretary determines appropriate and updated by the projected absolute amount of growth in national per capita expenditures for parts A and B services under the original Medicare fee-for-service program, as estimated by the Secretary. Such benchmark shall be reset at the start of each agreement period.

"(2) PAYMENTS FOR SHARED SAVINGS.—Subject to performance with respect to the quality performance standards established by the Secretary under subsection (b)(3), if an ACO meets the requirements under paragraph (1), a percent (as determined appropriate by the Secretary) of the difference between such

estimated average per capita Medicare expenditures in a year, adjusted for beneficiary characteristics, under the ACO and such benchmark for the ACO may be paid to the ACO as shared savings and the remainder of such difference shall be retained by the program under this title. The Secretary shall establish limits on the total amount of shared savings that may be paid to an ACO under this paragraph.

"(3) MONITORING AVOIDANCE OF AT-RISK PATIENTS.—If the Secretary determines that an ACO has taken steps to avoid patients at risk in order to reduce the likelihood of increasing costs to the ACO the Secretary may impose an appropriate sanction on the ACO, including termination from the program.

"(4) TERMINATION.—The Secretary may terminate an agreement with an ACO if it does not meet the quality performance standards established by the Secretary under subsection (b)(3).

"(e) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the program.

"(f) WAIVER AUTHORITY.—The Secretary may waive such requirements of sections 1128A and 1128B and title XVIII of this Act as may be necessary to carry out the provisions of this section.

"(g) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

"(1) the specification of criteria under subsection (a)(1)(B);

"(2) the assessment of the quality of care furnished by an ACO and the establishment of performance standards under subsection (b)(3);

"(3) the assignment of Medicare fee-for-service beneficiaries to an ACO under subsection (c);

"(4) the determination of whether an ACO is eligible for shared savings under subsection (d)(2) and the amount of such shared savings, including the determination of the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries assigned to the ACO and the average benchmark for the ACO under subsection (d)(1)(B);

"(5) the percent of shared savings specified by the Secretary under subsection (d)(2) and any limit on the total amount of shared savings established by the Secretary under such subsection; and

"(6) the termination of an ACO under subsection (d)(4).

"(h) DEFINITIONS.—In this section:

"(1) ACO PROFESSIONAL.—The term 'ACO professional' means—

"(A) a physician (as defined in section 1861(r)(1)); and

"(B) a practitioner described in section 1842(b)(18)(C)(i).

"(2) HOSPITAL.—The term 'hospital' means a subsection (d) hospital (as defined in section 1886(d)(1)(B)).

"(3) MEDICARE FEE-FOR-SERVICE BENEFICIARY.—The term 'Medicare fee-for-service beneficiary' means an individual who is enrolled in the original Medicare fee-for-service program under parts A and B and is not enrolled in an MA plan under part C, an eligible organization under section 1876, or a PACE program under section 1894.".

SEC. 3023. NATIONAL PILOT PROGRAM ON PAYMENT BUNDLING.

Title XVIII of the Social Security Act, as amended by section 3021, is amended by inserting after section 1886C the following new section:

"NATIONAL PILOT PROGRAM ON PAYMENT BUNDLING

"SEC. 1866D. (a) IMPLEMENTATION.—

"(1) IN GENERAL.—The Secretary shall establish a pilot program for integrated care during an episode of care provided to an applicable beneficiary around

a hospitalization in order to improve the coordination, quality, and efficiency of health care services under this title.

"(2) DEFINITIONS.—In this section:

"(A) APPLICABLE BENEFICIARY.—The term 'applicable beneficiary' means an individual who—

"(i) is entitled to, or enrolled for, benefits under part A and enrolled for benefits under part B of such title, but not enrolled under part C or a PACE program under section 1894; and

"(ii) is admitted to a hospital for an applicable condition.

"(B) APPLICABLE CONDITION.—The term 'applicable condition' means 1 or more of 8 conditions selected by the Secretary. In selecting conditions under the preceding sentence, the Secretary shall take into consideration the following factors:

"(i) Whether the conditions selected include a mix of chronic and acute conditions.

"(ii) Whether the conditions selected include a mix of surgical and medical conditions.

"(iii) Whether a condition is one for which there is evidence of an opportunity for providers of services and suppliers to improve the quality of care furnished while reducing total expenditures under this title.

"(iv) Whether a condition has significant variation in—

"(I) the number of readmissions; and

"(II) the amount of expenditures for post-acute care spending under this title.

"(v) Whether a condition is high-volume and has high post-acute care expenditures under this title.

"(vi) Which conditions the Secretary determines are most amenable to bundling across the spectrum of care given practice patterns under this title.

"(C) APPLICABLE SERVICES.—The term 'applicable services' means the following:

"(i) Acute care inpatient services.

"(ii) Physicians' services delivered in and outside of an acute care hospital setting.

"(iii) Outpatient hospital services, including emergency department services.

"(iv) Post-acute care services, including home health services, skilled nursing services, inpatient rehabilitation services, and inpatient hospital services furnished by a long-term care hospital.

"(v) Other services the Secretary determines appropriate.

"(D) EPISODE OF CARE.—

"(i) IN GENERAL.—Subject to clause (ii), the term 'episode of care' means, with respect to an applicable condition and an applicable beneficiary, the period that includes—

"(I) the 3 days prior to the admission of the applicable beneficiary to a hospital for the applicable condition;

"(II) the length of stay of the applicable beneficiary in such hospital; and

"(III) the 30 days following the discharge of the applicable beneficiary from such hospital.

"(ii) ESTABLISHMENT OF PERIOD BY THE SECRETARY.—The Secretary, as appropriate, may establish a period (other than the period described in clause (i)) for an episode of care under the pilot program.

"(E) PHYSICIANS' SERVICES.—The term 'physicians' services' has the meaning given such term in section 1861(q).

"(F) PILOT PROGRAM.—The term 'pilot program' means the pilot program under this section.

"(G) PROVIDER OF SERVICES.—The term 'provider of services' has the meaning given such term in section 1861(u).

"(H) READMISSION.—The term 'readmission' has the meaning given such term in section 1886(q)(5)(E).

"(I) SUPPLIER.—The term 'supplier' has the meaning given such term in section 1861(d).

"(3) DEADLINE FOR IMPLEMENTATION.—The Secretary shall establish the pilot program not later than January 1, 2013.

"(b) DEVELOPMENTAL PHASE.—

"(1) DETERMINATION OF PATIENT ASSESSMENT INSTRUMENT.—The Secretary shall determine which

patient assessment instrument (such as the Continuity Assessment Record and Evaluation (CARE) tool) shall be used under the pilot program to evaluate the applicable condition of an applicable beneficiary for purposes of determining the most clinically appropriate site for the provision of post-acute care to the applicable beneficiary.

"(2) DEVELOPMENT OF QUALITY MEASURES FOR AN EPISODE OF CARE AND FOR POST-ACUTE CARE.—

"(A) IN GENERAL.—The Secretary, in consultation with the Agency for Healthcare Research and Quality and the entity with a contract under section 1890(a) of the Social Security Act, shall develop quality measures for use in the pilot program—

"(i) for episodes of care; and

"(ii) for post-acute care.

"(B) SITE-NEUTRAL POST-ACUTE CARE QUALITY MEASURES.—Any quality measures developed under subparagraph (A)(ii) shall be site-neutral.

"(C) COORDINATION WITH QUALITY MEASURE DEVELOPMENT AND ENDORSEMENT PROCEDURES.—The Secretary shall ensure that the development of quality measures under subpara-

graph (A) is done in a manner that is consistent with the measures developed and endorsed under section 1890 and 1890A that are applicable to all post-acute care settings.

"(c) DETAILS.—

"(1) DURATION.—

"(A) IN GENERAL.—Subject to subparagraph (B), the pilot program shall be conducted for a period of 5 years.

"(B) EXTENSION.—The Secretary may extend the duration of the pilot program for providers of services and suppliers participating in the pilot program as of the day before the end of the 5-year period described in subparagraph (A), for a period determined appropriate by the Secretary, if the Secretary determines that such extension will result in improving or not reducing the quality of patient care and reducing spending under this title.

"(2) PARTICIPATING PROVIDERS OF SERVICES AND SUPPLIERS.—

"(A) IN GENERAL.—An entity comprised of providers of services and suppliers, including a hospital, a physician group, a skilled nursing facility, and a home health agency, who are other-

wise participating under this title, may submit an application to the Secretary to provide applicable services to applicable individuals under this section.

"(B) REQUIREMENTS.—The Secretary shall develop requirements for entities to participate in the pilot program under this section. Such requirements shall ensure that applicable beneficiaries have an adequate choice of providers of services and suppliers under the pilot program.

"(3) PAYMENT METHODOLOGY.—

"(A) IN GENERAL.—

"(i) ESTABLISHMENT OF PAYMENT METHODS.—The Secretary shall develop payment methods for the pilot program for entities participating in the pilot program. Such payment methods may include bundled payments and bids from entities for episodes of care. The Secretary shall make payments to the entity for services covered under this section.

"(ii) NO ADDITIONAL PROGRAM EXPENDITURES.—Payments under this section for applicable items and services under this title (including payment for services de-

scribed in subparagraph (B)) for applicable beneficiaries for a year shall be established in a manner that does not result in spending more for such entity for such beneficiaries than would otherwise be expended for such entity for such beneficiaries for such year if the pilot program were not implemented, as estimated by the Secretary.

"(B) INCLUSION OF CERTAIN SERVICES.—A payment methodology tested under the pilot program shall include payment for the furnishing of applicable services and other appropriate services, such as care coordination, medication reconciliation, discharge planning, transitional care services, and other patient-centered activities as determined appropriate by the Secretary.

"(C) BUNDLED PAYMENTS.—

"(i) IN GENERAL.—A bundled payment under the pilot program shall—

"(I) be comprehensive, covering the costs of applicable services and other appropriate services furnished to an individual during an episode of care (as determined by the Secretary); and

"(II) be made to the entity which is participating in the pilot program.

"(ii) REQUIREMENT FOR PROVISION OF APPLICABLE SERVICES AND OTHER APPROPRIATE SERVICES.—Applicable services and other appropriate services for which payment is made under this subparagraph shall be furnished or directed by the entity which is participating in the pilot program.

"(D) PAYMENT FOR POST-ACUTE CARE SERVICES AFTER THE EPISODE OF CARE.—The Secretary shall establish procedures, in the case where an applicable beneficiary requires continued post-acute care services after the last day of the episode of care, under which payment for such services shall be made.

"(4) QUALITY MEASURES.—

"(A) IN GENERAL.—The Secretary shall establish quality measures (including quality measures of process, outcome, and structure) related to care provided by entities participating in the pilot program. Quality measures established under the preceding sentence shall include measures of the following:

"(i) Functional status improvement.

"(ii) Reducing rates of avoidable hospital readmissions.

"(iii) Rates of discharge to the community.

"(iv) Rates of admission to an emergency room after a hospitalization.

"(v) Incidence of health care acquired infections.

"(vi) Efficiency measures.

"(vii) Measures of patient-centeredness of care.

"(viii) Measures of patient perception of care.

"(ix) Other measures, including measures of patient outcomes, determined appropriate by the Secretary.

"(B) REPORTING ON QUALITY MEASURES.—

"(i) IN GENERAL.—A entity shall submit data to the Secretary on quality measures established under subparagraph (A) during each year of the pilot program (in a form and manner, subject to clause (iii), specified by the Secretary).

"(ii) SUBMISSION OF DATA THROUGH ELECTRONIC HEALTH RECORD.—To the ex-

tent practicable, the Secretary shall specify that data on measures be submitted under clause (i) through the use of an qualified electronic health record (as defined in section 3000(13) of the Public Health Service Act (42 U.S.C. 300jj–11(13)) in a manner specified by the Secretary.

"(d) WAIVER.—The Secretary may waive such provisions of this title and title XI as may be necessary to carry out the pilot program.

"(e) INDEPENDENT EVALUATION AND REPORTS ON PILOT PROGRAM.—

"(1) INDEPENDENT EVALUATION.—The Secretary shall conduct an independent evaluation of the pilot program, including the extent to which the pilot program has—

"(A) improved quality measures established under subsection (c)(4)(A);

"(B) improved health outcomes;

"(C) improved applicable beneficiary access to care; and

"(D) reduced spending under this title.

"(2) REPORTS.—

"(A) INTERIM REPORT.—Not later than 2 years after the implementation of the pilot pro-

gram, the Secretary shall submit to Congress a report on the initial results of the independent evaluation conducted under paragraph (1).

"(B) FINAL REPORT.—Not later than 3 years after the implementation of the pilot program, the Secretary shall submit to Congress a report on the final results of the independent evaluation conducted under paragraph (1).

"(f) CONSULTATION.—The Secretary shall consult with representatives of small rural hospitals, including critical access hospitals (as defined in section 1861(mm)(1)), regarding their participation in the pilot program. Such consultation shall include consideration of innovative methods of implementing bundled payments in hospitals described in the preceding sentence, taking into consideration any difficulties in doing so as a result of the low volume of services provided by such hospitals.

"(g) IMPLEMENTATION PLAN.—

"(1) IN GENERAL.—Not later than January 1, 2016, the Secretary shall submit a plan for the implementation of an expansion of the pilot program if the Secretary determines that such expansion will result in improving or not reducing the quality of patient care and reducing spending under this title.

"(h) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the selection, testing, and evaluation of models or the expansion of such models under this section.".

SEC. 3024. INDEPENDENCE AT HOME DEMONSTRATION PROGRAM.

Title XVIII of the Social Security Act is amended by inserting after section 1866D, as inserted by section 3023, the following new section:

"INDEPENDENCE AT HOME MEDICAL PRACTICE DEMONSTRATION PROGRAM

"SEC. 1866D. (a) ESTABLISHMENT.—

"(1) IN GENERAL.—The Secretary shall conduct a demonstration program (in this section referred to as the 'demonstration program') to test a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams designed to reduce expenditures and improve health outcomes in the provision of items and services under this title to applicable beneficiaries (as defined in subsection (d)).

"(2) REQUIREMENT.—The demonstration program shall test whether a model described in paragraph (1), which is accountable for providing comprehensive, coordinated, continuous, and accessible care to high-need populations at home and coordi-

nating health care across all treatment settings, results in—

"(A) reducing preventable hospitalizations;

"(B) preventing hospital readmissions;

"(C) reducing emergency room visits;

"(D) improving health outcomes commensurate with the beneficiaries' stage of chronic illness;

"(E) improving the efficiency of care, such as by reducing duplicative diagnostic and laboratory tests;

"(F) reducing the cost of health care services covered under this title; and

"(G) achieving beneficiary and family caregiver satisfaction.

"(b) INDEPENDENCE AT HOME MEDICAL PRACTICE.—

"(1) INDEPENDENCE AT HOME MEDICAL PRACTICE DEFINED.—In this section:

"(A) IN GENERAL.—The term 'independence at home medical practice' means a legal entity that—

"(i) is comprised of an individual physician or nurse practitioner or group of physicians and nurse practitioners that provides care as part of a team that in-

cludes physicians, nurses, physician assistants, pharmacists, and other health and social services staff as appropriate who have experience providing home-based primary care to applicable beneficiaries, make in-home visits, and are available 24 hours per day, 7 days per week to carry out plans of care that are tailored to the individual beneficiary's chronic conditions and designed to achieve the results in subsection (a);

"(ii) is organized at least in part for the purpose of providing physicians' services;

"(iii) has documented experience in providing home-based primary care services to high-cost chronically ill beneficiaries, as determined appropriate by the Secretary;

"(iv) furnishes services to at least 200 applicable beneficiaries (as defined in subsection (d)) during each year of the demonstration program;

"(v) has entered into an agreement with the Secretary;

"(vi) uses electronic health information systems, remote monitoring, and mobile diagnostic technology; and

"(vii) meets such other criteria as the Secretary determines to be appropriate to participate in the demonstration program.

The entity shall report on quality measures (in such form, manner, and frequency as specified by the Secretary, which may be for the group, for providers of services and suppliers, or both) and report to the Secretary (in a form, manner, and frequency as specified by the Secretary) such data as the Secretary determines appropriate to monitor and evaluate the demonstration program.

"(B) PHYSICIAN.—The term 'physician' includes, except as the Secretary may otherwise provide, any individual who furnishes services for which payment may be made as physicians' services and has the medical training or experience to fulfill the physician's role described in subparagraph (A)(i).

"(2) PARTICIPATION OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.—Nothing in this section shall be construed to prevent a nurse practitioner or

physician assistant from participating in, or leading, a home-based primary care team as part of an independence at home medical practice if—

"(A) all the requirements of this section are met;

"(B) the nurse practitioner or physician assistant, as the case may be, is acting consistent with State law; and

"(C) the nurse practitioner or physician assistant has the medical training or experience to fulfill the nurse practitioner or physician assistant role described in paragraph (1)(A)(i).

"(3) INCLUSION OF PROVIDERS AND PRACTITIONERS.—Nothing in this subsection shall be construed as preventing an independence at home medical practice from including a provider of services or a participating practitioner described in section 1842(b)(18)(C) that is affiliated with the practice under an arrangement structured so that such provider of services or practitioner participates in the demonstration program and shares in any savings under the demonstration program.

"(4) QUALITY AND PERFORMANCE STANDARDS.—The Secretary shall develop quality performance

standards for independence at home medical practices participating in the demonstration program.

"(c) PAYMENT METHODOLOGY.—

"(1) ESTABLISHMENT OF TARGET SPENDING LEVEL.—The Secretary shall establish an estimated annual spending target, for the amount the Secretary estimates would have been spent in the absence of the demonstration, for items and services covered under parts A and B furnished to applicable beneficiaries for each qualifying independence at home medical practice under this section. Such spending targets shall be determined on a per capita basis. Such spending targets shall include a risk corridor that takes into account normal variation in expenditures for items and services covered under parts A and B furnished to such beneficiaries with the size of the corridor being related to the number of applicable beneficiaries furnished services by each independence at home medical practice. The spending targets may also be adjusted for other factors as the Secretary determines appropriate.

"(2) INCENTIVE PAYMENTS.—Subject to performance on quality measures, a qualifying independence at home medical practice is eligible to receive an incentive payment under this section if actual expendi-

tures for a year for the applicable beneficiaries it enrolls are less than the estimated spending target established under paragraph (1) for such year. An incentive payment for such year shall be equal to a portion (as determined by the Secretary) of the amount by which actual expenditures (including incentive payments under this paragraph) for applicable beneficiaries under parts A and B for such year are estimated to be less than 5 percent less than the estimated spending target for such year, as determined under paragraph (1).

"(d) APPLICABLE BENEFICIARIES.—

"(1) DEFINITION.—In this section, the term 'applicable beneficiary' means, with respect to a qualifying independence at home medical practice, an individual who the practice has determined—

"(A) is entitled to benefits under part A and enrolled for benefits under part B;

"(B) is not enrolled in a Medicare Advantage plan under part C or a PACE program under section 1894;

"(C) has 2 or more chronic illnesses, such as congestive heart failure, diabetes, other dementias designated by the Secretary, chronic obstructive pulmonary disease, ischemic heart disease,

stroke, Alzheimer's Disease and neurodegenerative diseases, and other diseases and conditions designated by the Secretary which result in high costs under this title;

"(D) within the past 12 months has had a nonelective hospital admission;

"(E) within the past 12 months has received acute or subacute rehabilitation services;

"(F) has 2 or more functional dependencies requiring the assistance of another person (such as bathing, dressing, toileting, walking, or feeding); and

"(G) meets such other criteria as the Secretary determines appropriate.

"(2) PATIENT ELECTION TO PARTICIPATE.—The Secretary shall determine an appropriate method of ensuring that applicable beneficiaries have agreed to enroll in an independence at home medical practice under the demonstration program. Enrollment in the demonstration program shall be voluntary.

"(3) BENEFICIARY ACCESS TO SERVICES.—Nothing in this section shall be construed as encouraging physicians or nurse practitioners to limit applicable beneficiary access to services covered under this title and applicable beneficiaries shall not be required to

relinquish access to any benefit under this title as a condition of receiving services from an independence at home medical practice.

"(e) IMPLEMENTATION.—

"(1) STARTING DATE.—The demonstration program shall begin no later than January 1, 2012. An agreement with an independence at home medical practice under the demonstration program may cover not more than a 3-year period.

"(2) NO PHYSICIAN DUPLICATION IN DEMONSTRATION PARTICIPATION.—The Secretary shall not pay an independence at home medical practice under this section that participates in section 1899.

"(3) NO BENEFICIARY DUPLICATION IN DEMONSTRATION PARTICIPATION.—The Secretary shall ensure that no applicable beneficiary enrolled in an independence at home medical practice under this section is participating in the programs under section 1899.

"(4) PREFERENCE.—In approving an independence at home medical practice, the Secretary shall give preference to practices that are—

"(A) located in high-cost areas of the country;

"(B) have experience in furnishing health care services to applicable beneficiaries in the home; and

"(C) use electronic medical records, health information technology, and individualized plans of care.

"(5) LIMITATION ON NUMBER OF PRACTICES.—In selecting qualified independence at home medical practices to participate under the demonstration program, the Secretary shall limit the number of such practices so that the number of applicable beneficiaries that may participate in the demonstration program does not exceed 10,000.

"(6) WAIVER.—The Secretary may waive such provisions of this title and title XI as the Secretary determines necessary in order to implement the demonstration program.

"(7) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to this section.

"(f) EVALUATION AND MONITORING.—

"(1) IN GENERAL.—The Secretary shall evaluate each independence at home medical practice under the demonstration program to assess whether the practice achieved the results described in subsection (a).

"(2) MONITORING APPLICABLE BENEFICIARIES.—The Secretary may monitor data on expenditures and quality of services under this title after an applicable beneficiary discontinues receiving services under this title through a qualifying independence at home medical practice.

"(g) REPORTS TO CONGRESS.—The Secretary shall conduct an independent evaluation of the demonstration program and submit to Congress a final report, including best practices under the demonstration program. Such report shall include an analysis of the demonstration program on coordination of care, expenditures under this title, applicable beneficiary access to services, and the quality of health care services provided to applicable beneficiaries.

"(h) FUNDING.—For purposes of administering and carrying out the demonstration program, other than for payments for items and services furnished under this title and incentive payments under subsection (c), in addition to funds otherwise appropriated, there shall be transferred to the Secretary for the Center for Medicare & Medicaid Services Program Management Account from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841 (in proportions determined appropriate by the Secretary) $5,000,000 for each of fiscal years 2010

through 2015. Amounts transferred under this subsection for a fiscal year shall be available until expended.

"(i) TERMINATION.—

"(1) MANDATORY TERMINATION.—The Secretary shall terminate an agreement with an independence at home medical practice if—

"(A) the Secretary estimates or determines that such practice will not receive an incentive payment for the second of 2 consecutive years under the demonstration program; or

"(B) such practice fails to meet quality standards during any year of the demonstration program.

"(2) PERMISSIVE TERMINATION.—The Secretary may terminate an agreement with an independence at home medical practice for such other reasons determined appropriate by the Secretary.".

SEC. 3025. HOSPITAL READMISSIONS REDUCTION PROGRAM.

(a) IN GENERAL.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by sections 3001 and 3008, is amended by adding at the end the following new subsection:

"(q) HOSPITAL READMISSIONS REDUCTION PROGRAM.—

"(1) IN GENERAL.—With respect to payment for discharges from an applicable hospital (as defined in paragraph (5)(C)) occurring during a fiscal year beginning on or after October 1, 2012, in order to account for excess readmissions in the hospital, the Secretary shall reduce the payments that would otherwise be made to such hospital under subsection (d) (or section 1814(b)(3), as the case may be) for such a discharge by an amount equal to the product of—

"(A) the base operating DRG payment amount (as defined in paragraph (2)) for the discharge; and

"(B) the adjustment factor (described in paragraph (3)(A)) for the hospital for the fiscal year.

"(2) BASE OPERATING DRG PAYMENT AMOUNT DEFINED.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), in this subsection, the term 'base operating DRG payment amount' means, with respect to a hospital for a fiscal year—

"(i) the payment amount that would otherwise be made under subsection (d) (determined without regard to subsection (o))

for a discharge if this subsection did not apply; reduced by

"(ii) any portion of such payment amount that is attributable to payments under paragraphs (5)(A), (5)(B), (5)(F), and (12) of subsection (d).

"(B) SPECIAL RULES FOR CERTAIN HOSPITALS.—

"(i) SOLE COMMUNITY HOSPITALS AND MEDICARE-DEPENDENT, SMALL RURAL HOSPITALS.—In the case of a medicare-dependent, small rural hospital (with respect to discharges occurring during fiscal years 2012 and 2013) or a sole community hospital, in applying subparagraph (A)(i), the payment amount that would otherwise be made under subsection (d) shall be determined without regard to subparagraphs (I) and (L) of subsection (b)(3) and subparagraphs (D) and (G) of subsection (d)(5).

"(ii) HOSPITALS PAID UNDER SECTION 1814.—In the case of a hospital that is paid under section 1814(b)(3), the Secretary may exempt such hospitals provided that States paid under such section submit an annual

report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established herein with respect to this section.

"(3) ADJUSTMENT FACTOR.—

"(A) IN GENERAL.—For purposes of paragraph (1), the adjustment factor under this paragraph for an applicable hospital for a fiscal year is equal to the greater of—

"(i) the ratio described in subparagraph (B) for the hospital for the applicable period (as defined in paragraph (5)(D)) for such fiscal year; or

"(ii) the floor adjustment factor specified in subparagraph (C).

"(B) RATIO.—The ratio described in this subparagraph for a hospital for an applicable period is equal to 1 minus the ratio of—

"(i) the aggregate payments for excess readmissions (as defined in paragraph (4)(A)) with respect to an applicable hospital for the applicable period; and

"(ii) the aggregate payments for all discharges (as defined in paragraph (4)(B)) with respect to such applicable hospital for such applicable period.

"(C) FLOOR ADJUSTMENT FACTOR.—For purposes of subparagraph (A), the floor adjustment factor specified in this subparagraph for—

"(i) fiscal year 2013 is 0.99;

"(ii) fiscal year 2014 is 0.98; or

"(iii) fiscal year 2015 and subsequent fiscal years is 0.97.

"(4) AGGREGATE PAYMENTS, EXCESS READMISSION RATIO DEFINED.—For purposes of this subsection:

"(A) AGGREGATE PAYMENTS FOR EXCESS READMISSIONS.—The term 'aggregate payments for excess readmissions' means, for a hospital for an applicable period, the sum, for applicable conditions (as defined in paragraph (5)(A)), of the product, for each applicable condition, of—

"(i) the base operating DRG payment amount for such hospital for such applicable period for such condition;

"(ii) the number of admissions for such condition for such hospital for such applicable period; and

"(iii) the excess readmissions ratio (as defined in subparagraph (C)) for such hospital for such applicable period minus 1.

"(B) AGGREGATE PAYMENTS FOR ALL DISCHARGES.—The term 'aggregate payments for all discharges' means, for a hospital for an applicable period, the sum of the base operating DRG payment amounts for all discharges for all conditions from such hospital for such applicable period.

"(C) EXCESS READMISSION RATIO.—

"(i) IN GENERAL.—Subject to clause (ii), the term 'excess readmissions ratio' means, with respect to an applicable condition for a hospital for an applicable period, the ratio (but not less than 1.0) of—

"(I) the risk adjusted readmissions based on actual readmissions, as determined consistent with a readmission measure methodology that has been endorsed under paragraph (5)(A)(ii)(I), for an applicable hospital

for such condition with respect to such applicable period; to

"(II) the risk adjusted expected readmissions (as determined consistent with such a methodology) for such hospital for such condition with respect to such applicable period.

"(ii) EXCLUSION OF CERTAIN READMISSIONS.—For purposes of clause (i), with respect to a hospital, excess readmissions shall not include readmissions for an applicable condition for which there are fewer than a minimum number (as determined by the Secretary) of discharges for such applicable condition for the applicable period and such hospital.

"(5) DEFINITIONS.—For purposes of this subsection:

"(A) APPLICABLE CONDITION.—The term 'applicable condition' means, subject to subparagraph (B), a condition or procedure selected by the Secretary among conditions and procedures for which—

"(i) readmissions (as defined in subparagraph (E)) that represent conditions or

procedures that are high volume or high expenditures under this title (or other criteria specified by the Secretary); and

"(ii) measures of such readmissions—

"(I) have been endorsed by the entity with a contract under section 1890(a); and

"(II) such endorsed measures have exclusions for readmissions that are unrelated to the prior discharge (such as a planned readmission or transfer to another applicable hospital).

"(B) EXPANSION OF APPLICABLE CONDITIONS.—Beginning with fiscal year 2015, the Secretary shall, to the extent practicable, expand the applicable conditions beyond the 3 conditions for which measures have been endorsed as described in subparagraph (A)(ii)(I) as of the date of the enactment of this subsection to the additional 4 conditions that have been identified by the Medicare Payment Advisory Commission in its report to Congress in June 2007 and to other conditions and procedures as determined appropriate by the Secretary. In expanding such applicable conditions, the Secretary shall seek the

endorsement described in subparagraph (A)(ii)(I) but may apply such measures without such an endorsement in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a) as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

''(C) APPLICABLE HOSPITAL.—The term 'applicable hospital' means a subsection (d) hospital or a hospital that is paid under section 1814(b)(3), as the case may be.

''(D) APPLICABLE PERIOD.—The term 'applicable period' means, with respect to a fiscal year, such period as the Secretary shall specify.

''(E) READMISSION.—The term 'readmission' means, in the case of an individual who is discharged from an applicable hospital, the admission of the individual to the same or another applicable hospital within a time period specified by the Secretary from the date of such discharge. Insofar as the discharge relates to an applicable condition for which there is an endorsed

measure described in subparagraph (A)(ii)(I), such time period (such as 30 days) shall be consistent with the time period specified for such measure.

"(6) REPORTING HOSPITAL SPECIFIC INFORMATION.—

"(A) IN GENERAL.—The Secretary shall make information available to the public regarding readmission rates of each subsection (d) hospital under the program.

"(B) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall ensure that a subsection (d) hospital has the opportunity to review, and submit corrections for, the information to be made public with respect to the hospital under subparagraph (A) prior to such information being made public.

"(C) WEBSITE.—Such information shall be posted on the Hospital Compare Internet website in an easily understandable format.

"(7) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

"(A) The determination of base operating DRG payment amounts.

"(B) The methodology for determining the adjustment factor under paragraph (3), including excess readmissions ratio under paragraph (4)(C), aggregate payments for excess readmissions under paragraph (4)(A), and aggregate payments for all discharges under paragraph (4)(B), and applicable periods and applicable conditions under paragraph (5).

"(C) The measures of readmissions as described in paragraph (5)(A)(ii).

"(8) READMISSION RATES FOR ALL PATIENTS.—

"(A) CALCULATION OF READMISSION.—The Secretary shall calculate readmission rates for all patients (as defined in subparagraph (D)) for a specified hospital (as defined in subparagraph (D)(ii)) for an applicable condition (as defined in paragraph (5)(B)) and other conditions deemed appropriate by the Secretary for an applicable period (as defined in paragraph (5)(D)) in the same manner as used to calculate such readmission rates for hospitals with respect to this title and posted on the CMS Hospital Compare website.

"(B) POSTING OF HOSPITAL SPECIFIC ALL PATIENT READMISSION RATES.—The Secretary

shall make information on all patient readmission rates calculated under subparagraph (A) available on the CMS Hospital Compare website in a form and manner determined appropriate by the Secretary. The Secretary may also make other information determined appropriate by the Secretary available on such website.

"(C) HOSPITAL SUBMISSION OF ALL PATIENT DATA.—

"(i) Except as provided for in clause (ii), each specified hospital (as defined in subparagraph (D)(ii)) shall submit to the Secretary, in a form, manner and time specified by the Secretary, data and information determined necessary by the Secretary for the Secretary to calculate the all patient readmission rates described in subparagraph (A).

"(ii) Instead of a specified hospital submitting to the Secretary the data and information described in clause (i), such data and information may be submitted to the Secretary, on behalf of such a specified hospital, by a state or an entity determined appropriate by the Secretary.

"(D) DEFINITIONS.—For purposes of this paragraph:

"(i) The term 'all patients' means patients who are treated on an inpatient basis and discharged from a specified hospital (as defined in clause (ii)).

"(ii) The term 'specified hospital' means a subsection (d) hospital, hospitals described in clauses (i) through (v) of subsection (d)(1)(B) and, as determined feasible and appropriate by the Secretary, other hospitals not otherwise described in this subparagraph.".

(b) QUALITY IMPROVEMENT.—Part S of title III of the Public Health Service Act, as amended by section 3015, is further amended by adding at the end the following:

"SEC. 399KK. QUALITY IMPROVEMENT PROGRAM FOR HOSPITALS WITH A HIGH SEVERITY ADJUSTED READMISSION RATE.

"(a) ESTABLISHMENT.—

"(1) IN GENERAL.—Not later than 2 years after the date of enactment of this section, the Secretary shall make available a program for eligible hospitals to improve their readmission rates through the use of

patient safety organizations (as defined in section 921(4)).

"(2) ELIGIBLE HOSPITAL DEFINED.—In this subsection, the term 'eligible hospital' means a hospital that the Secretary determines has a high rate of risk adjusted readmissions for the conditions described in section 1886(q)(8)(A) of the Social Security Act and has not taken appropriate steps to reduce such readmissions and improve patient safety as evidenced through historically high rates of readmissions, as determined by the Secretary.

"(3) RISK ADJUSTMENT.—The Secretary shall utilize appropriate risk adjustment measures to determine eligible hospitals.

"(b) REPORT TO THE SECRETARY.—As determined appropriate by the Secretary, eligible hospitals and patient safety organizations working with those hospitals shall report to the Secretary on the processes employed by the hospital to improve readmission rates and the impact of such processes on readmission rates.".

SEC. 3026. COMMUNITY-BASED CARE TRANSITIONS PROGRAM.

(a) IN GENERAL.—The Secretary shall establish a Community-Based Care Transitions Program under which the Secretary provides funding to eligible entities that fur-

nish improved care transition services to high-risk Medicare beneficiaries.

(b) DEFINITIONS.—In this section:

(1) ELIGIBLE ENTITY.—The term "eligible entity" means the following:

(A) A subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))) identified by the Secretary as having a high readmission rate, such as under section 1886(q) of the Social Security Act, as added by section 3025.

(B) An appropriate community-based organization that provides care transition services under this section across a continuum of care through arrangements with subsection (d) hospitals (as so defined) to furnish the services described in subsection (c)(2)(B)(i) and whose governing body includes sufficient representation of multiple health care stakeholders (including consumers).

(2) HIGH-RISK MEDICARE BENEFICIARY.—The term "high-risk Medicare beneficiary" means a Medicare beneficiary who has attained a minimum hierarchical condition category score, as determined by the Secretary, based on a diagnosis of multiple chron-

ic conditions or other risk factors associated with a hospital readmission or substandard transition into post-hospitalization care, which may include 1 or more of the following:

(A) Cognitive impairment.

(B) Depression.

(C) A history of multiple readmissions.

(D) Any other chronic disease or risk factor as determined by the Secretary.

(3) MEDICARE BENEFICIARY.—The term "Medicare beneficiary" means an individual who is entitled to benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) and enrolled under part B of such title, but not enrolled under part C of such title.

(4) PROGRAM.—The term "program" means the program conducted under this section.

(5) READMISSION.—The term "readmission" has the meaning given such term in section 1886(q)(5)(E) of the Social Security Act, as added by section 3025.

(6) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

(c) REQUIREMENTS.—

(1) DURATION.—

(A) IN GENERAL.—The program shall be conducted for a 5-year period, beginning January 1, 2011.

(B) EXPANSION.—The Secretary may expand the duration and the scope of the program, to the extent determined appropriate by the Secretary, if the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services, with respect to spending under this title, certifies) that such expansion would reduce spending under this title without reducing quality.

(2) APPLICATION; PARTICIPATION.—

(A) IN GENERAL.—

(i) APPLICATION.—An eligible entity seeking to participate in the program shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(ii) PARTNERSHIP.—If an eligible entity is a hospital, such hospital shall enter into a partnership with a community-based organization to participate in the program.

(B) INTERVENTION PROPOSAL.—Subject to subparagraph (C), an application submitted under subparagraph (A)(i) shall include a detailed proposal for at least 1 care transition intervention, which may include the following:

(i) Initiating care transition services for a high-risk Medicare beneficiary not later than 24 hours prior to the discharge of the beneficiary from the eligible entity.

(ii) Arranging timely post-discharge follow-up services to the high-risk Medicare beneficiary to provide the beneficiary (and, as appropriate, the primary caregiver of the beneficiary) with information regarding responding to symptoms that may indicate additional health problems or a deteriorating condition.

(iii) Providing the high-risk Medicare beneficiary (and, as appropriate, the primary caregiver of the beneficiary) with assistance to ensure productive and timely interactions between patients and post-acute and outpatient providers.

(iv) Assessing and actively engaging with a high-risk Medicare beneficiary (and,

as appropriate, the primary caregiver of the beneficiary) through the provision of self-management support and relevant information that is specific to the beneficiary's condition.

(v) Conducting comprehensive medication review and management (including, if appropriate, counseling and self-management support).

(C) LIMITATION.—A care transition intervention proposed under subparagraph (B) may not include payment for services required under the discharge planning process described in section 1861(ee) of the Social Security Act (42 U.S.C. 1395x(ee)).

(3) SELECTION.—In selecting eligible entities to participate in the program, the Secretary shall give priority to eligible entities that—

(A) participate in a program administered by the Administration on Aging to provide concurrent care transitions interventions with multiple hospitals and practitioners; or

(B) provide services to medically underserved populations, small communities, and rural areas.

(d) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement the provisions of this section by program instruction or otherwise.

(e) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be necessary to carry out the program.

(f) FUNDING.—For purposes of carrying out this section, the Secretary of Health and Human Services shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines appropriate, of $500,000,000, to the Centers for Medicare & Medicaid Services Program Management Account for the period of fiscal years 2011 through 2015. Amounts transferred under the preceding sentence shall remain available until expended.

SEC. 3027. EXTENSION OF GAINSHARING DEMONSTRATION.

(a) IN GENERAL.—Subsection (d)(3) of section 5007 of the Deficit Reduction Act of 2005 (Public Law 109–171) is amended by inserting "(or September 30, 2011, in the case of a demonstration project in operation as of October 1, 2008)" after "December 31, 2009".

(b) FUNDING.—

(1) IN GENERAL.—Subsection (f)(1) of such section is amended by inserting "and for fiscal year 2010, $1,600,000," after "$6,000,000,".

(2) AVAILABILITY.—Subsection (f)(2) of such section is amended by striking "2010" and inserting "2014 or until expended".

(c) REPORTS.—

(1) QUALITY IMPROVEMENT AND SAVINGS.—Subsection (e)(3) of such section is amended by striking "December 1, 2008" and inserting "March 31, 2011".

(2) FINAL REPORT.—Subsection (e)(4) of such section is amended by striking "May 1, 2010" and inserting "March 31, 2013".

Subtitle B—Improving Medicare for Patients and Providers

PART I—ENSURING BENEFICIARY ACCESS TO PHYSICIAN CARE AND OTHER SERVICES

SEC. 3101. INCREASE IN THE PHYSICIAN PAYMENT UPDATE.

Section 1848(d) of the Social Security Act (42 U.S.C. 1395w–4(d)) is amended by adding at the end the following new paragraph:

"(10) UPDATE FOR 2010.—

"(A) IN GENERAL.—Subject to paragraphs (7)(B), (8)(B), and (9)(B), in lieu of the update to the single conversion factor established in

paragraph (1)(C) that would otherwise apply for 2010, the update to the single conversion factor shall be 0.5 percent.

"(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR 2011 AND SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2011 and subsequent years as if subparagraph (A) had never applied.".

SEC. 3102. EXTENSION OF THE WORK GEOGRAPHIC INDEX FLOOR AND REVISIONS TO THE PRACTICE EXPENSE GEOGRAPHIC ADJUSTMENT UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE.

(a) EXTENSION OF WORK GPCI FLOOR.—Section 1848(e)(1)(E) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)(E)) is amended by striking "before January 1, 2010" and inserting "before January 1, 2011".

(b) PRACTICE EXPENSE GEOGRAPHIC ADJUSTMENT FOR 2010 AND SUBSEQUENT YEARS.—Section 1848(e)(1) of the Social Security Act (42 U.S.C. 1395w4(e)(1)) is amended—

(1) in subparagraph (A), by striking "and (G)" and inserting "(G), and (H)"; and

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

"(H) PRACTICE EXPENSE GEOGRAPHIC ADJUSTMENT FOR 2010 AND SUBSEQUENT YEARS.—

"(i) FOR 2010.—Subject to clause (iii), for services furnished during 2010, the employee wage and rent portions of the practice expense geographic index described in subparagraph (A)(i) shall reflect ¾ of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national average of such employee wages and rents.

"(ii) FOR 2011.—Subject to clause (iii), for services furnished during 2011, the employee wage and rent portions of the practice expense geographic index described in subparagraph (A)(i) shall reflect ½ of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national average of such employee wages and rents.

"(iii) HOLD HARMLESS.—The practice expense portion of the geographic adjustment factor applied in a fee schedule area for services furnished in 2010 or 2011 shall not, as a result of the application of clause

(i) or (ii), be reduced below the practice expense portion of the geographic adjustment factor under subparagraph (A)(i) (as calculated prior to the application of such clause (i) or (ii), respectively) for such area for such year.

"(iv) ANALYSIS.—The Secretary shall analyze current methods of establishing practice expense geographic adjustments under subparagraph (A)(i) and evaluate data that fairly and reliably establishes distinctions in the costs of operating a medical practice in the different fee schedule areas. Such analysis shall include an evaluation of the following:

"(I) The feasibility of using actual data or reliable survey data developed by medical organizations on the costs of operating a medical practice, including office rents and non-physician staff wages, in different fee schedule areas.

"(II) The office expense portion of the practice expense geographic adjustment described in subparagraph (A)(i),

including the extent to which types of office expenses are determined in local markets instead of national markets.

"(III) The weights assigned to each of the categories within the practice expense geographic adjustment described in subparagraph (A)(i).

"(v) REVISION FOR 2012 AND SUBSEQUENT YEARS.—As a result of the analysis described in clause (iv), the Secretary shall, not later than January 1, 2012, make appropriate adjustments to the practice expense geographic adjustment described in subparagraph (A)(i) to ensure accurate geographic adjustments across fee schedule areas, including—

"(I) basing the office rents component and its weight on office expenses that vary among fee schedule areas; and

"(II) considering a representative range of professional and non-professional personnel employed in a medical office based on the use of the American Community Survey data or

other reliable data for wage adjustments.

Such adjustments shall be made without regard to adjustments made pursuant to clauses (i) and (ii) and shall be made in a budget neutral manner.".

SEC. 3103. EXTENSION OF EXCEPTIONS PROCESS FOR MEDICARE THERAPY CAPS.

Section 1833(g)(5) of the Social Security Act (42 U.S.C. 1395l(g)(5)) is amended by striking "December 31, 2009" and inserting "December 31, 2010".

SEC. 3104. EXTENSION OF PAYMENT FOR TECHNICAL COMPONENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES.

Section 542(c) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (as enacted into law by section 1(a)(6) of Public Law 106–554), as amended by section 732 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 U.S.C. 1395w–4 note), section 104 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395w–4 note), section 104 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), and section 136 of the Medicare Improvements for Patients and Pro-

viders Act of 2008 (Public Law 110–275), is amended by striking "and 2009" and inserting "2009, and 2010".

SEC. 3105. EXTENSION OF AMBULANCE ADD-ONS.

(a) GROUND AMBULANCE.—Section 1834(l)(13)(A) of the Social Security Act (42 U.S.C. 1395m(l)(13)(A)) is amended—

(1) in the matter preceding clause (i)—

(A) by striking "2007, and for" and inserting "2007, for"; and

(B) by striking "2010" and inserting "2010, and for such services furnished on or after April 1, 2010, and before January 1, 2011,"; and

(2) in each of clauses (i) and (ii), by inserting ", and on or after April 1, 2010, and before January 1, 2011" after "January 1, 2010" each place it appears.

(b) AIR AMBULANCE.—Section 146(b)(1) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275) is amended by striking "December 31, 2009" and inserting "December 31, 2009, and during the period beginning on April 1, 2010, and ending on January 1, 2011".

(c) SUPER RURAL AMBULANCE.—Section 1834(l)(12)(A) of the Social Security Act (42 U.S.C.

1395m(l)(12)(A)) is amended by striking "2010" and inserting "2010, and on or after April 1, 2010, and before January 1, 2011".

SEC. 3106. EXTENSION OF CERTAIN PAYMENT RULES FOR LONG-TERM CARE HOSPITAL SERVICES AND OF MORATORIUM ON THE ESTABLISHMENT OF CERTAIN HOSPITALS AND FACILITIES.

(a) EXTENSION OF CERTAIN PAYMENT RULES.—Section 114(c) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (42 U.S.C. 1395ww note), as amended by section 4302(a) of the American Recovery and Reinvestment Act (Public Law 111–5), is further amended by striking "3-year period" each place it appears and inserting "4-year period".

(b) EXTENSION OF MORATORIUM.—Section 114(d)(1) of such Act (42 U.S.C. 1395ww note), in the matter preceding subparagraph (A), is amended by striking "3-year period" and inserting "4-year period".

SEC. 3107. EXTENSION OF PHYSICIAN FEE SCHEDULE MENTAL HEALTH ADD-ON.

Section 138(a)(1) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275) is amended by striking "December 31, 2009" and inserting "December 31, 2010".

SEC. 3108. PERMITTING PHYSICIAN ASSISTANTS TO ORDER POST-HOSPITAL EXTENDED CARE SERVICES.

(a) ORDERING POST-HOSPITAL EXTENDED CARE SERVICES.—

(1) IN GENERAL.—Section 1814(a)(2) of the Social Security Act (42 U.S.C. 1395f(a)(2)), in the matter preceding subparagraph (A), is amended by striking "or clinical nurse specialist" and inserting ", a clinical nurse specialist, or a physician assistant (as those terms are defined in section 1861(aa)(5))" after "nurse practitioner".

(2) CONFORMING AMENDMENT.—Section 1814(a) of the Social Security Act (42 U.S.C. 1395f(a)) is amended, in the second sentence, by striking "or clinical nurse specialist" and inserting "clinical nurse specialist, or physician assistant" after "nurse practitioner,".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2011.

SEC. 3109. EXEMPTION OF CERTAIN PHARMACIES FROM ACCREDITATION REQUIREMENTS.

(a) IN GENERAL.—Section 1834(a)(20) of the Social Security Act (42 U.S.C. 1395m(a)(20)), as added by section 154(b)(1)(A) of the Medicare Improvements for Patients

and Providers Act of 2008 (Public Law 100–275), is amended—

(1) in subparagraph (F)(i)—

(A) by inserting "and subparagraph (G)" after "clause (ii)"; and

(B) by inserting ", except that the Secretary shall not require a pharmacy to have submitted to the Secretary such evidence of accreditation prior to January 1, 2011" before the semicolon at the end; and

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

"(G) APPLICATION OF ACCREDITATION REQUIREMENT TO CERTAIN PHARMACIES.—

"(i) IN GENERAL.—With respect to items and services furnished on or after January 1, 2011, in implementing quality standards under this paragraph—

"(I) subject to subclause (II), in applying such standards and the accreditation requirement of subparagraph (F)(i) with respect to pharmacies described in clause (ii) furnishing such items and services, such standards and accreditation require-

ment shall not apply to such pharmacies; and

"(II) the Secretary may apply to such pharmacies an alternative accreditation requirement established by the Secretary if the Secretary determines such alternative accreditation requirement is more appropriate for such pharmacies.

"(ii) PHARMACIES DESCRIBED.—A pharmacy described in this clause is a pharmacy that meets each of the following criteria:

"(I) The total billings by the pharmacy for such items and services under this title are less than 5 percent of total pharmacy sales, as determined based on the average total pharmacy sales for the previous 3 calendar years, 3 fiscal years, or other yearly period specified by the Secretary.

"(II) The pharmacy has been enrolled under section 1866(j) as a supplier of durable medical equipment, prosthetics, orthotics, and supplies, has

been issued (which may include the renewal of) a provider number for at least 5 years, and for which a final adverse action (as defined in section 424.57(a) of title 42, Code of Federal Regulations) has not been imposed in the past 5 years.

"(III) The pharmacy submits to the Secretary an attestation, in a form and manner, and at a time, specified by the Secretary, that the pharmacy meets the criteria described in subclauses (I) and (II). Such attestation shall be subject to section 1001 of title 18, United States Code.

"(IV) The pharmacy agrees to submit materials as requested by the Secretary, or during the course of an audit conducted on a random sample of pharmacies selected annually, to verify that the pharmacy meets the criteria described in subclauses (I) and (II). Materials submitted under the preceding sentence shall include a certification by an accountant on behalf

of the pharmacy or the submission of tax returns filed by the pharmacy during the relevant periods, as requested by the Secretary.".

(b) ADMINISTRATION.—Notwithstanding any other provision of law, the Secretary may implement the amendments made by subsection (a) by program instruction or otherwise.

(c) RULE OF CONSTRUCTION.—Nothing in the provisions of or amendments made by this section shall be construed as affecting the application of an accreditation requirement for pharmacies to qualify for bidding in a competitive acquisition area under section 1847 of the Social Security Act (42 U.S.C. 1395w–3).

SEC. 3110. PART B SPECIAL ENROLLMENT PERIOD FOR DISABLED TRICARE BENEFICIARIES.

(a) IN GENERAL.—

(1) IN GENERAL.—Section 1837 of the Social Security Act (42 U.S.C. 1395p) is amended by adding at the end the following new subsection:

"(l)(1) In the case of any individual who is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code) at the time the individual is entitled to part A under section 226(b) or section 226A and who is eligible to enroll but who has elected not to enroll (or to be deemed

enrolled) during the individual's initial enrollment period, there shall be a special enrollment period described in paragraph (2).

"(2) The special enrollment period described in this paragraph, with respect to an individual, is the 12-month period beginning on the day after the last day of the initial enrollment period of the individual or, if later, the 12-month period beginning with the month the individual is notified of enrollment under this section.

"(3) In the case of an individual who enrolls during the special enrollment period provided under paragraph (1), the coverage period under this part shall begin on the first day of the month in which the individual enrolls, or, at the option of the individual, the first month after the end of the individual's initial enrollment period.

"(4) An individual may only enroll during the special enrollment period provided under paragraph (1) one time during the individual's lifetime.

"(5) The Secretary shall ensure that the materials relating to coverage under this part that are provided to an individual described in paragraph (1) prior to the individual's initial enrollment period contain information concerning the impact of not enrolling under this part, including the impact on health care benefits under the TRICARE program under chapter 55 of title 10, United States Code.

"(6) The Secretary of Defense shall collaborate with the Secretary of Health and Human Services and the Commissioner of Social Security to provide for the accurate identification of individuals described in paragraph (1). The Secretary of Defense shall provide such individuals with notification with respect to this subsection. The Secretary of Defense shall collaborate with the Secretary of Health and Human Services and the Commissioner of Social Security to ensure appropriate follow up pursuant to any notification provided under the preceding sentence.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to elections made with respect to initial enrollment periods that end after the date of the enactment of this Act.

(b) WAIVER OF INCREASE OF PREMIUM.—Section 1839(b) of the Social Security Act (42 U.S.C. 1395r(b)) is amended by striking "section 1837(i)(4)" and inserting "subsection (i)(4) or (l) of section 1837".

SEC. 3111. PAYMENT FOR BONE DENSITY TESTS.

(a) PAYMENT.—

(1) IN GENERAL.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(A) in subsection (b)—

(i) in paragraph (4)(B), by inserting ", and for 2010 and 2011, dual-energy x-

ray absorptiometry services (as described in paragraph (6))" before the period at the end; and

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

"(6) TREATMENT OF BONE MASS SCANS.—For dual-energy x-ray absorptiometry services (identified in 2006 by HCPCS codes 76075 and 76077 (and any succeeding codes)) furnished during 2010 and 2011, instead of the payment amount that would otherwise be determined under this section for such years, the payment amount shall be equal to 70 percent of the product of—

"(A) the relative value for the service (as determined in subsection (c)(2)) for 2006;

"(B) the conversion factor (established under subsection (d)) for 2006; and

"(C) the geographic adjustment factor (established under subsection (e)(2)) for the service for the fee schedule area for 2010 and 2011, respectively."; and

(B) in subsection (c)(2)(B)(iv)—

(i) in subclause (II), by striking "and" at the end;

(ii) in subclause (III), by striking the period at the end and inserting "; and"; and

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

"(IV) subsection (b)(6) shall not be taken into account in applying clause (ii)(II) for 2010 or 2011.".

(2) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement the amendments made by paragraph (1) by program instruction or otherwise.

(b) STUDY AND REPORT BY THE INSTITUTE OF MEDICINE.—

(1) IN GENERAL.—The Secretary of Health and Human Services is authorized to enter into an agreement with the Institute of Medicine of the National Academies to conduct a study on the ramifications of Medicare payment reductions for dual-energy x-ray absorptiometry (as described in section 1848(b)(6) of the Social Security Act, as added by subsection (a)(1)) during 2007, 2008, and 2009 on beneficiary access to bone mass density tests.

(2) REPORT.—An agreement entered into under paragraph (1) shall provide for the Institute of Medi-

cine to submit to the Secretary and to Congress a report containing the results of the study conducted under such paragraph.

SEC. 3112. REVISION TO THE MEDICARE IMPROVEMENT FUND.

Section 1898(b)(1)(A) of the Social Security Act (42 U.S.C. 1395iii) is amended by striking "$22,290,000,000" and inserting "$0".

SEC. 3113. TREATMENT OF CERTAIN COMPLEX DIAGNOSTIC LABORATORY TESTS.

(a) DEMONSTRATION PROJECT.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall conduct a demonstration project under part B title XVIII of the Social Security Act under which separate payments are made under such part for complex diagnostic laboratory tests provided to individuals under such part. Under the demonstration project, the Secretary shall establish appropriate payment rates for such tests.

(2) COVERED COMPLEX DIAGNOSTIC LABORATORY TEST DEFINED.—In this section, the term "complex diagnostic laboratory test" means a diagnostic laboratory test—

(A) that is an analysis of gene protein expression, topographic genotyping, or a cancer chemotherapy sensitivity assay;

(B) that is determined by the Secretary to be a laboratory test for which there is not an alternative test having equivalent performance characteristics;

(C) which is billed using a Health Care Procedure Coding System (HCPCS) code other than a not otherwise classified code under such Coding System;

(D) which is approved or cleared by the Food and Drug Administration or is covered under title XVIII of the Social Security Act; and

(E) is described in section 1861(s)(3) of the Social Security Act (42 U.S.C. 1395x(s)(3)).

(3) SEPARATE PAYMENT DEFINED.—In this section, the term "separate payment" means direct payment to a laboratory (including a hospital-based or independent laboratory) that performs a complex diagnostic laboratory test with respect to a specimen collected from an individual during a period in which the individual is a patient of a hospital if the test is performed after such period of hospitalization and if separate payment would not otherwise be made under

title XVIII of the Social Security Act by reason of sections 1862(a)(14) and 1866(a)(1)(H)(i) of the such Act (42 U.S.C. 1395y(a)(14); 42 U.S.C. 1395cc(a)(1)(H)(i)).

(b) DURATION.—Subject to subsection (c)(2), the Secretary shall conduct the demonstration project under this section for the 2-year period beginning on July 1, 2011.

(c) PAYMENTS AND LIMITATION.—Payments under the demonstration project under this section shall—

(1) be made from the Federal Supplemental Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t); and

(2) may not exceed $100,000,000.

(d) REPORT.—Not later than 2 years after the completion of the demonstration project under this section, the Secretary shall submit to Congress a report on the project. Such report shall include—

(1) an assessment of the impact of the demonstration project on access to care, quality of care, health outcomes, and expenditures under title XVIII of the Social Security Act (including any savings under such title); and

(2) such recommendations as the Secretary determines appropriate.

(e) IMPLEMENTATION FUNDING.—For purposes of administering this section (including preparing and submitting the report under subsection (d)), the Secretary shall provide for the transfer, from the Federal Supplemental Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t), to the Centers for Medicare & Medicaid Services Program Management Account, of $5,000,000. Amounts transferred under the preceding sentence shall remain available until expended.

SEC. 3114. IMPROVED ACCESS FOR CERTIFIED NURSE-MIDWIFE SERVICES.

Section 1833(a)(1)(K) of the Social Security Act (42 U.S.C. 1395l(a)(1)(K)) is amended by inserting "(or 100 percent for services furnished on or after January 1, 2011)" after "1992, 65 percent".

PART II—RURAL PROTECTIONS

SEC. 3121. EXTENSION OF OUTPATIENT HOLD HARMLESS PROVISION.

(a) IN GENERAL.—Section 1833(t)(7)(D)(i) of the Social Security Act (42 U.S.C. 1395l(t)(7)(D)(i)) is amended—

(1) in subclause (II)—

(A) in the first sentence, by striking "2010"and inserting "2011"; and

(B) in the second sentence, by striking "or 2009" and inserting ", 2009, or 2010"; and

(2) in subclause (III), by striking "January 1, 2010" and inserting "January 1, 2011".

(b) PERMITTING ALL SOLE COMMUNITY HOSPITALS TO BE ELIGIBLE FOR HOLD HARMLESS.—Section 1833(t)(7)(D)(i)(III) of the Social Security Act (42 U.S.C. 1395l(t)(7)(D)(i)(III)) is amended by adding at the end the following new sentence: "In the case of covered OPD services furnished on or after January 1, 2010, and before January 1, 2011, the preceding sentence shall be applied without regard to the 100-bed limitation.".

SEC. 3122. EXTENSION OF MEDICARE REASONABLE COSTS PAYMENTS FOR CERTAIN CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED TO HOSPITAL PATIENTS IN CERTAIN RURAL AREAS.

Section 416(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 U.S.C. 1395l–4), as amended by section 105 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395l note) and section 107 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (42 U.S.C. 1395l note), is amended by inserting "or during the 1-year period beginning on July 1, 2010" before the period at the end.

SEC. 3123. EXTENSION OF THE RURAL COMMUNITY HOSPITAL DEMONSTRATION PROGRAM.

(a) ONE-YEAR EXTENSION.—Section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2272) is amended by adding at the end the following new subsection:

"(g) ONE-YEAR EXTENSION OF DEMONSTRATION PROGRAM.—

"(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall conduct the demonstration program under this section for an additional 1-year period (in this section referred to as the '1-year extension period') that begins on the date immediately following the last day of the initial 5-year period under subsection (a)(5).

"(2) EXPANSION OF DEMONSTRATION STATES.—Notwithstanding subsection (a)(2), during the 1-year extension period, the Secretary shall expand the number of States with low population densities determined by the Secretary under such subsection to 20. In determining which States to include in such expansion, the Secretary shall use the same criteria and data that the Secretary used to determine the States under such subsection for purposes of the initial 5-year period.

"(3) INCREASE IN MAXIMUM NUMBER OF HOSPITALS PARTICIPATING IN THE DEMONSTRATION PROGRAM.—Notwithstanding subsection (a)(4), during the 1-year extension period, not more than 30 rural community hospitals may participate in the demonstration program under this section.

"(4) NO AFFECT ON HOSPITALS IN DEMONSTRATION PROGRAM ON DATE OF ENACTMENT.—In the case of a rural community hospital that is participating in the demonstration program under this section as of the last day of the initial 5-year period, the Secretary shall provide for the continued participation of such rural community hospital in the demonstration program during the 1-year extension period unless the rural community hospital makes an election, in such form and manner as the Secretary may specify, to discontinue such participation.".

(b) CONFORMING AMENDMENTS.—Subsection (a)(5) of section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2272) is amended by inserting "(in this section referred to as the 'initial 5-year period') and, as provided in subsection (g), for the 1-year extension period" after "5-year period".

(c) TECHNICAL AMENDMENTS.—

(1) Subsection (b) of section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2272) is amended—

(A) in paragraph (1)(B)(ii), by striking "2)" and inserting "2))"; and

(B) in paragraph (2), by inserting "cost" before "reporting period" the first place such term appears in each of subparagraphs (A) and (B).

(2) Subsection (f)(1) of section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2272) is amended—

(A) in subparagraph (A)(ii), by striking "paragraph (2)" and inserting "subparagraph (B)"; and

(B) in subparagraph (B), by striking "paragraph (1)(B)" and inserting "subparagraph (A)(ii)".

SEC. 3124. EXTENSION OF THE MEDICARE-DEPENDENT HOSPITAL (MDH) PROGRAM.

(a) EXTENSION OF PAYMENT METHODOLOGY.—Section 1886(d)(5)(G) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(G)) is amended—

(1) in clause (i), by striking "October 1, 2011" and inserting "October 1, 2012"; and

(2) in clause (ii)(II), by striking "October 1, 2011" and inserting "October 1, 2012".

(b) CONFORMING AMENDMENTS.—

(1) EXTENSION OF TARGET AMOUNT.—Section 1886(b)(3)(D) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(D)) is amended—

(A) in the matter preceding clause (i), by striking "October 1, 2011" and inserting "October 1, 2012"; and

(B) in clause (iv), by striking "through fiscal year 2011" and inserting "through fiscal year 2012".

(2) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—Section 13501(e)(2) of the Omnibus Budget Reconciliation Act of 1993 (42 U.S.C. 1395ww note) is amended by striking "through fiscal year 2011" and inserting "through fiscal year 2012".

SEC. 3125. TEMPORARY IMPROVEMENTS TO THE MEDICARE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.

Section 1886(d)(12) of the Social Security Act (42 U.S.C. 1395ww(d)(12)) is amended—

(1) in subparagraph (A), by inserting "or (D)" after "subparagraph (B)";

(2) in subparagraph (B), in the matter preceding clause (i), by striking "The Secretary" and inserting "For discharges occurring in fiscal years 2005 through 2010 and for discharges occurring in fiscal year 2013 and subsequent fiscal years, the Secretary";

(3) in subparagraph (C)(i)—

(A) by inserting "(or, with respect to fiscal years 2011 and 2012, 15 road miles)" after "25 road miles"; and

(B) by inserting "(or, with respect to fiscal years 2011 and 2012, 1,500 discharges of individuals entitled to, or enrolled for, benefits under part A)" after "800 discharges"; and

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

"(D) TEMPORARY APPLICABLE PERCENTAGE INCREASE.—For discharges occurring in fiscal years 2011 and 2012, the Secretary shall determine an applicable percentage increase for purposes of subparagraph (A) using a continuous linear sliding scale ranging from 25 percent for low-volume hospitals with 200 or fewer discharges of individuals entitled to, or enrolled for,

benefits under part A in the fiscal year to 0 percent for low-volume hospitals with greater than 1,500 discharges of such individuals in the fiscal year.".

SEC. 3126. IMPROVEMENTS TO THE DEMONSTRATION PROJECT ON COMMUNITY HEALTH INTEGRATION MODELS IN CERTAIN RURAL COUNTIES.

(a) REMOVAL OF LIMITATION ON NUMBER OF ELIGIBLE COUNTIES SELECTED.—Subsection (d)(3) of section 123 of the Medicare Improvements for Patients and Providers Act of 2008 (42 U.S.C. 1395i–4 note) is amended by striking "not more than 6".

(b) REMOVAL OF REFERENCES TO RURAL HEALTH CLINIC SERVICES AND INCLUSION OF PHYSICIANS' SERVICES IN SCOPE OF DEMONSTRATION PROJECT.—Such section 123 is amended—

(1) in subsection (d)(4)(B)(i)(3), by striking subclause (III); and

(2) in subsection (j)—

(A) in paragraph (8), by striking subparagraph (B) and inserting the following:

"(B) Physicians' services (as defined in section 1861(q) of the Social Security Act (42 U.S.C. 1395x(q)).";

(B) by striking paragraph (9); and

(C) by redesignating paragraph (10) as paragraph (9).

SEC. 3127. MEDPAC STUDY ON ADEQUACY OF MEDICARE PAYMENTS FOR HEALTH CARE PROVIDERS SERVING IN RURAL AREAS.

(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the adequacy of payments for items and services furnished by providers of services and suppliers in rural areas under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.). Such study shall include an analysis of—

(1) any adjustments in payments to providers of services and suppliers that furnish items and services in rural areas;

(2) access by Medicare beneficiaries to items and services in rural areas;

(3) the adequacy of payments to providers of services and suppliers that furnish items and services in rural areas; and

(4) the quality of care furnished in rural areas.

(b) REPORT.—Not later than January 1, 2011, the Medicare Payment Advisory Commission shall submit to Congress a report containing the results of the study conducted under subsection (a). Such report shall include recommendations on appropriate modifications to any adjust-

ments in payments to providers of services and suppliers that furnish items and services in rural areas, together with recommendations for such legislation and administrative action as the Medicare Payment Advisory Commission determines appropriate.

SEC. 3128. TECHNICAL CORRECTION RELATED TO CRITICAL ACCESS HOSPITAL SERVICES.

(a) IN GENERAL.—Subsections (g)(2)(A) and (l)(8) of section 1834 of the Social Security Act (42 U.S.C. 1395m) are each amended by inserting "101 percent of" before "the reasonable costs".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect as if included in the enactment of section 405(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2266).

SEC. 3129. EXTENSION OF AND REVISIONS TO MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM.

(a) AUTHORIZATION.—Section 1820(j) of the Social Security Act (42 U.S.C. 1395i–4(j)) is amended—

(1) by striking "2010, and for" and inserting "2010, for"; and

(2) by inserting "and for making grants to all States under subsection (g), such sums as may be necessary in each of fiscal years 2011 and 2012, to re-

main available until expended'' before the period at the end.

(b) USE OF FUNDS.—Section 1820(g)(3) of the Social Security Act (42 U.S.C. 1395i–4(g)(3)) is amended—

(1) in subparagraph (A), by inserting ''and to assist such hospitals in participating in delivery system reforms under the provisions of and amendments made by the Patient Protection and Affordable Care Act, such as value-based purchasing programs, accountable care organizations under section 1899, the National pilot program on payment bundling under section 1866D, and other delivery system reform programs determined appropriate by the Secretary'' before the period at the end; and

(2) in subparagraph (E)—

(A) by striking '', and to offset'' and inserting '', to offset''; and

(B) by inserting ''and to participate in delivery system reforms under the provisions of and amendments made by the Patient Protection and Affordable Care Act, such as value-based purchasing programs, accountable care organizations under section 1899, the National pilot program on payment bundling under section 1866D, and other delivery system reform pro-

grams determined appropriate by the Secretary" before the period at the end.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to grants made on or after January 1, 2010.

PART III—IMPROVING PAYMENT ACCURACY

SEC. 3131. PAYMENT ADJUSTMENTS FOR HOME HEALTH CARE.

(a) REBASING HOME HEALTH PROSPECTIVE PAYMENT AMOUNT.—

(1) IN GENERAL.—Section 1895(b)(3)(A) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(A)) is amended—

(A) in clause (i)(III), by striking "For periods" and inserting "Subject to clause (iii), for periods"; and

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

"(iii) ADJUSTMENT FOR 2013 AND SUBSEQUENT YEARS.—

"(I) IN GENERAL.—Subject to subclause (II), for 2013 and subsequent years, the amount (or amounts) that would otherwise be applicable under clause (i)(III) shall be adjusted by a

percentage determined appropriate by the Secretary to reflect such factors as changes in the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other factors that the Secretary considers to be relevant. In conducting the analysis under the preceding sentence, the Secretary may consider differences between hospital-based and freestanding agencies, between for-profit and nonprofit agencies, and between the resource costs of urban and rural agencies. Such adjustment shall be made before the update under subparagraph (B) is applied for the year.

"(II) TRANSITION.—The Secretary shall provide for a 4-year phase-in (in equal increments) of the adjustment under subclause (I), with such adjustment being fully implemented for 2016. During each year of such phase-in, the amount of any adjustment

under subclause (I) for the year may not exceed 3.5 percent of the amount (or amounts) applicable under clause (i)(III) as of the date of enactment of the Patient Protection and Affordable Care Act.".

(2) MEDPAC STUDY AND REPORT.—

(A) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the implementation of the amendments made by paragraph (1). Such study shall include an analysis of the impact of such amendments on—

(i) access to care;

(ii) quality outcomes;

(iii) the number of home health agencies; and

(iv) rural agencies, urban agencies, for-profit agencies, and nonprofit agencies.

(B) REPORT.—Not later than January 1, 2015, the Medicare Payment Advisory Commission shall submit to Congress a report on the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Commission determines appropriate.

(b) PROGRAM-SPECIFIC OUTLIER CAP.—Section 1895(b) of the Social Security Act (42 U.S.C. 1395fff(b)) is amended—

(1) in paragraph (3)(C), by striking "the aggregate" and all that follows through the period at the end and inserting "5 percent of the total payments estimated to be made based on the prospective payment system under this subsection for the period."; and

(2) in paragraph (5)—

(A) by striking "OUTLIERS.—The Secretary" and inserting the following: "OUTLIERS.—

"(A) IN GENERAL.—Subject to subparagraph (B), the Secretary";

(B) in subparagraph (A), as added by subparagraph (A), by striking "5 percent" and inserting "2.5 percent"; and

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

"(B) PROGRAM SPECIFIC OUTLIER CAP.—The estimated total amount of additional payments or payment adjustments made under subparagraph (A) with respect to a home health agency for a year (beginning with 2011) may not exceed an amount equal to 10 percent of the

estimated total amount of payments made under this section (without regard to this paragraph) with respect to the home health agency for the year.".

(c) APPLICATION OF THE MEDICARE RURAL HOME HEALTH ADD-ON POLICY.—Section 421 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2283), as amended by section 5201(b) of the Deficit Reduction Act of 2005 (Public Law 109–171; 120 Stat. 46), is amended—

*(1) in the section heading, by striking "**ONE-YEAR**" and inserting "**TEMPORARY**"; and*

(2) in subsection (a)—

(A) by striking ", and episodes" and inserting ", episodes";

(B) by inserting "and episodes and visits ending on or after April 1, 2010, and before January 1, 2016," after "January 1, 2007,"; and

(C) by inserting "(or, in the case of episodes and visits ending on or after April 1, 2010, and before January 1, 2016, 3 percent)" before the period at the end.

(d) STUDY AND REPORT ON THE DEVELOPMENT OF HOME HEALTH PAYMENT REFORMS IN ORDER TO ENSURE ACCESS TO CARE AND QUALITY SERVICES.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall conduct a study to evaluate the costs and quality of care among efficient home health agencies relative to other such agencies in providing ongoing access to care and in treating Medicare beneficiaries with varying severity levels of illness. Such study shall include an analysis of the following:

(A) Methods to revise the home health prospective payment system under section 1895 of the Social Security Act (42 U.S.C. 1395fff) to more accurately account for the costs related to patient severity of illness or to improving beneficiary access to care, including—

(i) payment adjustments for services that may be under- or over-valued;

(ii) necessary changes to reflect the resource use relative to providing home health services to low-income Medicare beneficiaries or Medicare beneficiaries living in medically underserved areas;

(iii) ways the outlier payment may be improved to more accurately reflect the cost of treating Medicare beneficiaries with high severity levels of illness;

(iv) the role of quality of care incentives and penalties in driving provider and patient behavior;

(v) improvements in the application of a wage index; and

(vi) other areas determined appropriate by the Secretary.

(B) The validity and reliability of responses on the OASIS instrument with particular emphasis on questions that relate to higher payment under the home health prospective payment system and higher outcome scores under Home Care Compare.

(C) Additional research or payment revisions under the home health prospective payment system that may be necessary to set the payment rates for home health services based on costs of high-quality and efficient home health agencies or to improve Medicare beneficiary access to care.

(D) A timetable for implementation of any appropriate changes based on the analysis of the matters described in subparagraphs (A), (B), and (C).

(E) Other areas determined appropriate by the Secretary.

(2) CONSIDERATIONS.—In conducting the study under paragraph (1), the Secretary shall consider whether certain factors should be used to measure patient severity of illness and access to care, such as—

(A) population density and relative patient access to care;

(B) variations in service costs for providing care to individuals who are dually eligible under the Medicare and Medicaid programs;

(C) the presence of severe or chronic diseases, as evidenced by multiple, discontinuous home health episodes;

(D) poverty status, as evidenced by the receipt of Supplemental Security Income under title XVI of the Social Security Act;

(E) the absence of caregivers;

(F) language barriers;

(G) atypical transportation costs;

(H) security costs; and

(I) other factors determined appropriate by the Secretary.

(3) REPORT.—Not later than March 1, 2011, the Secretary shall submit to Congress a report on the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(4) CONSULTATIONS.—In conducting the study under paragraph (1) and preparing the report under paragraph (3), the Secretary shall consult with—

(A) stakeholders representing home health agencies;

(B) groups representing Medicare beneficiaries;

(C) the Medicare Payment Advisory Commission;

(D) the Inspector General of the Department of Health and Human Services; and

(E) the Comptroller General of the United States.

SEC. 3132. HOSPICE REFORM.

(a) HOSPICE CARE PAYMENT REFORMS.—

(1) IN GENERAL.—Section 1814(i) of the Social Security Act (42 U.S.C. 1395f(i)), as amended by section 3004(c), is amended—

(A) by redesignating paragraph (6) as paragraph (7); and

(B) by inserting after paragraph (5) the following new paragraph:

"(6)(A) The Secretary shall collect additional data and information as the Secretary determines appropriate to revise payments for hospice care under this subsection pursuant to subparagraph (D) and for other purposes as determined appropriate by the Secretary. The Secretary shall begin to collect such data by not later than January 1, 2011.

"(B) The additional data and information to be collected under subparagraph (A) may include data and information on—

"(i) charges and payments;

"(ii) the number of days of hospice care which are attributable to individuals who are entitled to, or enrolled for, benefits under part A; and

"(iii) with respect to each type of service included in hospice care—

"(I) the number of days of hospice care attributable to the type of service;

"(II) the cost of the type of service; and

"(III) the amount of payment for the type of service;

"(iv) charitable contributions and other revenue of the hospice program;

"(v) the number of hospice visits;

"(vi) the type of practitioner providing the visit; and

"(vii) the length of the visit and other basic information with respect to the visit.

"(C) The Secretary may collect the additional data and information under subparagraph (A) on cost reports, claims, or other mechanisms as the Secretary determines to be appropriate.

"(D)(i) Notwithstanding the preceding paragraphs of this subsection, not earlier than October 1, 2013, the Secretary shall, by regulation, implement revisions to the methodology for determining the payment rates for routine home care and other services included in hospice care under this part, as the Secretary determines to be appropriate. Such revisions may be based on an analysis of data and information collected under subparagraph (A). Such revisions may include adjustments to per diem payments that reflect changes in resource intensity in providing such care

and services during the course of the entire episode of hospice care.

"(ii) Revisions in payment implemented pursuant to clause (i) shall result in the same estimated amount of aggregate expenditures under this title for hospice care furnished in the fiscal year in which such revisions in payment are implemented as would have been made under this title for such care in such fiscal year if such revisions had not been implemented.

"(E) The Secretary shall consult with hospice programs and the Medicare Payment Advisory Commission regarding the additional data and information to be collected under subparagraph (A) and the payment revisions under subparagraph (D).".

(2) CONFORMING AMENDMENTS.—Section 1814(i)(1)(C) of the Social Security Act (42 U.S.C. 1395f(i)(1)(C)) is amended—

(A) in clause (ii)—

(i) in the matter preceding subclause (I), by inserting "(before the first fiscal year in which the payment revisions described in paragraph (6)(D) are implemented)" after "subsequent fiscal year"; and

(ii) in subclause (VII), by inserting "(before the first fiscal year in which the payment revisions described in paragraph (6)(D) are implemented), subject to clause (iv)," after "subsequent fiscal year"; and

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

"(iii) With respect to routine home care and other services included in hospice care furnished during fiscal years subsequent to the first fiscal year in which payment revisions described in paragraph (6)(D) are implemented, the payment rates for such care and services shall be the payment rates in effect under this clause during the preceding fiscal year increased by, subject to clause (iv), the market basket percentage increase (as defined in section 1886(b)(3)(B)(iii)) for the fiscal year.".

(b) ADOPTION OF MEDPAC HOSPICE PROGRAM ELIGIBILITY RECERTIFICATION RECOMMENDATIONS.—Section 1814(a)(7) of the Social Security Act (42 U.S.C. 1395f(a)(7)) is amended—

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

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

"(D) on and after January 1, 2011—

"(i) a hospice physician or nurse practitioner has a face-to-face encounter with the individual to determine continued eligibility of the individual for hospice care prior to the 180th-day recertification and each subsequent recertification under subparagraph (A)(ii) and attests that such visit took place (in accordance with procedures established by the Secretary); and

"(ii) in the case of hospice care provided an individual for more than 180 days by a hospice program for which the number of such cases for such program comprises more than a percent (specified by the Secretary) of the total number of such cases for all programs under this title, the hospice care provided to such individual is medically reviewed (in accordance with procedures established by the Secretary); and".

SEC. 3133. IMPROVEMENT TO MEDICARE DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS.

Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by sections 3001, 3008, and 3025, is amended—

(1) in subsection (d)(5)(F)(i), by striking "For" and inserting "Subject to subsection (r), for"; and

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

"(r) ADJUSTMENTS TO MEDICARE DSH PAYMENTS.—

"(1) EMPIRICALLY JUSTIFIED DSH PAYMENTS.—For fiscal year 2015 and each subsequent fiscal year, instead of the amount of disproportionate share hospital payment that would otherwise be made under subsection (d)(5)(F) to a subsection (d) hospital for the fiscal year, the Secretary shall pay to the subsection (d) hospital 25 percent of such amount (which represents the empirically justified amount for such payment, as determined by the Medicare Payment Advisory Commission in its March 2007 Report to the Congress).

"(2) ADDITIONAL PAYMENT.—In addition to the payment made to a subsection (d) hospital under paragraph (1), for fiscal year 2015 and each subsequent fiscal year, the Secretary shall pay to such sub-

section (d) hospitals an additional amount equal to the product of the following factors:

"(A) FACTOR ONE.—A factor equal to the difference between—

"(i) the aggregate amount of payments that would be made to subsection (d) hospitals under subsection (d)(5)(F) if this subsection did not apply for such fiscal year (as estimated by the Secretary); and

"(ii) the aggregate amount of payments that are made to subsection (d) hospitals under paragraph (1) for such fiscal year (as so estimated).

"(B) FACTOR TWO.—

"(i) FISCAL YEARS 2015, 2016, AND 2017.—For each of fiscal years 2015, 2016, and 2017, a factor equal to 1 minus the percent change (divided by 100) in the percent of individuals under the age of 65 who are uninsured, as determined by comparing the percent of such individuals—

"(I) who are uninsured in 2012, the last year before coverage expansion under the Patient Protection and Affordable Care Act (as calculated by the

Secretary based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on such Act that, if determined in the affirmative, would clear such Act for enrollment); and

"(II) who are uninsured in the most recent period for which data is available (as so calculated).

"(ii) 2018 AND SUBSEQUENT YEARS.—For fiscal year 2018 and each subsequent fiscal year, a factor equal to 1 minus the percent change (divided by 100) in the percent of individuals who are uninsured, as determined by comparing the percent of individuals—

"(I) who are uninsured in 2012 (as estimated by the Secretary, based on data from the Census Bureau or other sources the Secretary determines appropriate, and certified by the Chief Actuary of the Centers for Medicare & Medicaid Services); and

"(II) who are uninsured in the most recent period for which data is available (as so estimated and certified).

"(C) FACTOR THREE.—A factor equal to the percent, for each subsection (d) hospital, that represents the quotient of—

"(i) the amount of uncompensated care for such hospital for a period selected by the Secretary (as estimated by the Secretary, based on appropriate data (including, in the case where the Secretary determines that alternative data is available which is a better proxy for the costs of subsection (d) hospitals for treating the uninsured, the use of such alternative data)); and

"(ii) the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment under this subsection for such period (as so estimated, based on such data).

"(3) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

"(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).

"(B) Any period selected by the Secretary for such purposes.".

SEC. 3134. MISVALUED CODES UNDER THE PHYSICIAN FEE SCHEDULE.

(a) IN GENERAL.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)) is amended by adding at the end the following new subparagraphs:

"(K) POTENTIALLY MISVALUED CODES.—

"(i) IN GENERAL.—The Secretary shall—

"(I) periodically identify services as being potentially misvalued using criteria specified in clause (ii); and

"(II) review and make appropriate adjustments to the relative values established under this paragraph for services identified as being potentially misvalued under subclause (I).

"(ii) IDENTIFICATION OF POTENTIALLY MISVALUED CODES.—For purposes of identifying potentially misvalued services pursuant to clause (i)(I), the Secretary shall ex-

amine (as the Secretary determines to be appropriate) codes (and families of codes as appropriate) for which there has been the fastest growth; codes (and families of codes as appropriate) that have experienced substantial changes in practice expenses; codes for new technologies or services within an appropriate period (such as 3 years) after the relative values are initially established for such codes; multiple codes that are frequently billed in conjunction with furnishing a single service; codes with low relative values, particularly those that are often billed multiple times for a single treatment; codes which have not been subject to review since the implementation of the RBRVS (the so-called 'Harvard-valued codes'); and such other codes determined to be appropriate by the Secretary.

"(iii) REVIEW AND ADJUSTMENTS.—

"(I) The Secretary may use existing processes to receive recommendations on the review and appropriate adjustment of potentially misvalued services described in clause (i)(II).

"(II) The Secretary may conduct surveys, other data collection activities, studies, or other analyses as the Secretary determines to be appropriate to facilitate the review and appropriate adjustment described in clause (i)(II).

"(III) The Secretary may use analytic contractors to identify and analyze services identified under clause (i)(I), conduct surveys or collect data, and make recommendations on the review and appropriate adjustment of services described in clause (i)(II).

"(IV) The Secretary may coordinate the review and appropriate adjustment described in clause (i)(II) with the periodic review described in subparagraph (B).

"(V) As part of the review and adjustment described in clause (i)(II), including with respect to codes with low relative values described in clause (ii), the Secretary may make appropriate coding revisions (including using existing processes for consider-

ation of coding changes) which may include consolidation of individual services into bundled codes for payment under the fee schedule under subsection (b).

"(VI) The provisions of subparagraph (B)(ii)(II) shall apply to adjustments to relative value units made pursuant to this subparagraph in the same manner as such provisions apply to adjustments under subparagraph (B)(ii)(II).

"(L) VALIDATING RELATIVE VALUE UNITS.—

"(i) IN GENERAL.—The Secretary shall establish a process to validate relative value units under the fee schedule under subsection (b).

"(ii) COMPONENTS AND ELEMENTS OF WORK.—The process described in clause (i) may include validation of work elements (such as time, mental effort and professional judgment, technical skill and physical effort, and stress due to risk) involved with furnishing a service and may include

validation of the pre-, post-, and intra-service components of work.

"(iii) SCOPE OF CODES.—The validation of work relative value units shall include a sampling of codes for services that is the same as the codes listed under subparagraph (K)(ii).

"(iv) METHODS.—The Secretary may conduct the validation under this subparagraph using methods described in subclauses (I) through (V) of subparagraph (K)(iii) as the Secretary determines to be appropriate.

"(v) ADJUSTMENTS.—The Secretary shall make appropriate adjustments to the work relative value units under the fee schedule under subsection (b). The provisions of subparagraph (B)(ii)(II) shall apply to adjustments to relative value units made pursuant to this subparagraph in the same manner as such provisions apply to adjustments under subparagraph (B)(ii)(II).".

(b) IMPLEMENTATION.—

(1) ADMINISTRATION.—

(A) Chapter 35 of title 44, United States Code and the provisions of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to this section or the amendment made by this section.

(B) Notwithstanding any other provision of law, the Secretary may implement subparagraphs (K) and (L) of 1848(c)(2) of the Social Security Act, as added by subsection (a), by program instruction or otherwise.

(C) Section 4505(d) of the Balanced Budget Act of 1997 is repealed.

(D) Except for provisions related to confidentiality of information, the provisions of the Federal Acquisition Regulation shall not apply to this section or the amendment made by this section.

(2) FOCUSING CMS RESOURCES ON POTENTIALLY OVERVALUED CODES.—Section 1868(a) of the Social Security Act (42 U.S.C. 1395ee(a)) is repealed.

SEC. 3135. MODIFICATION OF EQUIPMENT UTILIZATION FACTOR FOR ADVANCED IMAGING SERVICES.

(a) ADJUSTMENT IN PRACTICE EXPENSE TO REFLECT HIGHER PRESUMED UTILIZATION.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(1) in subsection (b)(4)—

(A) in subparagraph (B), by striking "subparagraph (A)" and inserting "this paragraph"; and

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

"(C) ADJUSTMENT IN PRACTICE EXPENSE TO REFLECT HIGHER PRESUMED UTILIZATION.—Consistent with the methodology for computing the number of practice expense relative value units under subsection (c)(2)(C)(ii) with respect to advanced diagnostic imaging services (as defined in section 1834(e)(1)(B)) furnished on or after January 1, 2010, the Secretary shall adjust such number of units so it reflects—

"(i) in the case of services furnished on or after January 1, 2010, and before January 1, 2013, a 65 percent (rather than 50 percent) presumed rate of utilization of imaging equipment;

"(ii) in the case of services furnished on or after January 1, 2013, and before January 1, 2014, a 70 percent (rather than 50 percent) presumed rate of utilization of imaging equipment; and

"(iii) in the case of services furnished on or after January 1, 2014, a 75 percent (rather than 50 percent) presumed rate of utilization of imaging equipment."; and

(2) in subsection (c)(2)(B)(v), by adding at the end the following new subclauses:

"(III) CHANGE IN PRESUMED UTILIZATION LEVEL OF CERTAIN ADVANCED DIAGNOSTIC IMAGING SERVICES FOR 2010 THROUGH 2012.—Effective for fee schedules established beginning with 2010 and ending with 2012, reduced expenditures attributable to the presumed rate of utilization of imaging equipment of 65 percent under subsection (b)(4)(C)(i) instead of a presumed rate of utilization of such equipment of 50 percent.

"(IV) CHANGE IN PRESUMED UTILIZATION LEVEL OF CERTAIN ADVANCED DIAGNOSTIC IMAGING SERVICES FOR 2013.—Effective for fee schedules established for 2013, reduced expenditures attributable to the presumed rate of utilization of imaging equip-

ment of 70 percent under subsection (b)(4)(C)(ii) instead of a presumed rate of utilization of such equipment of 50 percent.

"(V) CHANGE IN PRESUMED UTILIZATION LEVEL OF CERTAIN ADVANCED DIAGNOSTIC IMAGING SERVICES FOR 2014 AND SUBSEQUENT YEARS.—Effective for fee schedules established beginning with 2014, reduced expenditures attributable to the presumed rate of utilization of imaging equipment of 75 percent under subsection (b)(4)(C)(iii) instead of a presumed rate of utilization of such equipment of 50 percent.".

(b) ADJUSTMENT IN TECHNICAL COMPONENT "DISCOUNT" ON SINGLE-SESSION IMAGING TO CONSECUTIVE BODY PARTS.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as amended by subsection (a), is amended—

(1) in subsection (b)(4), by adding at the end the following new subparagraph:

"(D) ADJUSTMENT IN TECHNICAL COMPONENT DISCOUNT ON SINGLE-SESSION IMAGING IN-

VOLVING CONSECUTIVE BODY PARTS.—For services furnished on or after July 1, 2010, the Secretary shall increase the reduction in payments attributable to the multiple procedure payment reduction applicable to the technical component for imaging under the final rule published by the Secretary in the Federal Register on November 21, 2005 (part 405 of title 42, Code of Federal Regulations) from 25 percent to 50 percent.''; and

(2) in subsection (c)(2)(B)(v), by adding at the end the following new subclause:

''(VI) ADDITIONAL REDUCED PAYMENT FOR MULTIPLE IMAGING PROCEDURES.—Effective for fee schedules established beginning with 2010 (but not applied for services furnished prior to July 1, 2010), reduced expenditures attributable to the increase in the multiple procedure payment reduction from 25 to 50 percent (as described in subsection (b)(4)(D)).''.

(c) ANALYSIS BY THE CHIEF ACTUARY OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES.—Not later than January 1, 2013, the Chief Actuary of the Centers for

Medicare & Medicaid Services shall make publicly available an analysis of whether, for the period of 2010 through 2019, the cumulative expenditure reductions under title XVIII of the Social Security Act that are attributable to the adjustments under the amendments made by this section are projected to exceed $3,000,000,000.

SEC. 3136. REVISION OF PAYMENT FOR POWER-DRIVEN WHEELCHAIRS.

(a) IN GENERAL.—Section 1834(a)(7)(A) of the Social Security Act (42 U.S.C. 1395m(a)(7)(A)) is amended—

(1) in clause (i)—

(A) in subclause (II), by inserting "subclause (III) and" after "Subject to"; and

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

"(III) SPECIAL RULE FOR POWER-DRIVEN WHEELCHAIRS.—For purposes of payment for power-driven wheelchairs, subclause (II) shall be applied by substituting '15 percent' and '6 percent' for '10 percent' and '7.5 percent', respectively."; and

(2) in clause (iii)—

(A) in the heading, by inserting "COMPLEX, REHABILITATIVE" before "POWER-DRIVEN"; and

(B) by inserting "complex, rehabilitative" before "power-driven".

(b) TECHNICAL AMENDMENT.—Section 1834(a)(7)(C)(ii)(II) of the Social Security Act (42 U.S.C. 1395m(a)(7)(C)(ii)(II)) is amended by striking "(A)(ii) or".

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by subsection (a) shall take effect on January 1, 2011, and shall apply to power-driven wheelchairs furnished on or after such date.

(2) APPLICATION TO COMPETITIVE BIDDING.—The amendments made by subsection (a) shall not apply to payment made for items and services furnished pursuant to contracts entered into under section 1847 of the Social Security Act (42 U.S.C. 1395w–3) prior to January 1, 2011, pursuant to the implementation of subsection (a)(1)(B)(i)(I) of such section 1847.

SEC. 3137. HOSPITAL WAGE INDEX IMPROVEMENT.

(a) EXTENSION OF SECTION 508 HOSPITAL RECLASSIFICATIONS.—

(1) IN GENERAL.—Subsection (a) of section 106 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395 note), as amended by section

117 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173) and section 124 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275), is amended by striking "September 30, 2009" and inserting "September 30, 2010".

(2) USE OF PARTICULAR WAGE INDEX IN FISCAL YEAR 2010.—For purposes of implementation of the amendment made by this subsection during fiscal year 2010, the Secretary shall use the hospital wage index that was promulgated by the Secretary in the Federal Register on August 27, 2009 (74 Fed. Reg. 43754), and any subsequent corrections.

(b) PLAN FOR REFORMING THE MEDICARE HOSPITAL WAGE INDEX SYSTEM.—

(1) IN GENERAL.—Not later than December 31, 2011, the Secretary of Health and Human Services (in this section referred to as the "Secretary") shall submit to Congress a report that includes a plan to reform the hospital wage index system under section 1886 of the Social Security Act.

(2) DETAILS.—In developing the plan under paragraph (1), the Secretary shall take into account the goals for reforming such system set forth in the Medicare Payment Advisory Commission June 2007

report entitled "Report to Congress: Promoting Greater Efficiency in Medicare", including establishing a new hospital compensation index system that—

(A) uses Bureau of Labor Statistics data, or other data or methodologies, to calculate relative wages for each geographic area involved;

(B) minimizes wage index adjustments between and within metropolitan statistical areas and statewide rural areas;

(C) includes methods to minimize the volatility of wage index adjustments that result from implementation of policy, while maintaining budget neutrality in applying such adjustments;

(D) takes into account the effect that implementation of the system would have on health care providers and on each region of the country;

(E) addresses issues related to occupational mix, such as staffing practices and ratios, and any evidence on the effect on quality of care or patient safety as a result of the implementation of the system; and

(F) provides for a transition.

(3) CONSULTATION.—In developing the plan under paragraph (1), the Secretary shall consult with relevant affected parties.

(c) USE OF PARTICULAR CRITERIA FOR DETERMINING RECLASSIFICATIONS.—Notwithstanding any other provision of law, in making decisions on applications for reclassification of a subsection (d) hospital (as defined in paragraph (1)(B) of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) for the purposes described in paragraph (10)(D)(v) of such section for fiscal year 2011 and each subsequent fiscal year (until the first fiscal year beginning on or after the date that is 1 year after the Secretary of Health and Human Services submits the report to Congress under subsection (b)), the Geographic Classification Review Board established under paragraph (10) of such section shall use the average hourly wage comparison criteria used in making such decisions as of September 30, 2008. The preceding sentence shall be effected in a budget neutral manner.

SEC. 3138. TREATMENT OF CERTAIN CANCER HOSPITALS.

Section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)) is amended by adding at the end the following new paragraph:

"(18) AUTHORIZATION OF ADJUSTMENT FOR CANCER HOSPITALS.—

"(A) STUDY.—The Secretary shall conduct a study to determine if, under the system under this subsection, costs incurred by hospitals de-

scribed in section 1886(d)(1)(B)(v) with respect to ambulatory payment classification groups exceed those costs incurred by other hospitals furnishing services under this subsection (as determined appropriate by the Secretary). In conducting the study under this subparagraph, the Secretary shall take into consideration the cost of drugs and biologicals incurred by such hospitals.

"(B) AUTHORIZATION OF ADJUSTMENT.—Insofar as the Secretary determines under subparagraph (A) that costs incurred by hospitals described in section 1886(d)(1)(B)(v) exceed those costs incurred by other hospitals furnishing services under this subsection, the Secretary shall provide for an appropriate adjustment under paragraph (2)(E) to reflect those higher costs effective for services furnished on or after January 1, 2011.".

SEC. 3139. PAYMENT FOR BIOSIMILAR BIOLOGICAL PRODUCTS.

(a) IN GENERAL.—Section 1847A of the Social Security Act (42 U.S.C. 1395w–3a) is amended—

(1) in subsection (b)—

(A) in paragraph (1)—

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

(ii) in subparagraph (B), by striking the period at the end and inserting "; or"; and

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

"(C) in the case of a biosimilar biological product (as defined in subsection (c)(6)(H)), the amount determined under paragraph (8)."; and

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

"(8) BIOSIMILAR BIOLOGICAL PRODUCT.—The amount specified in this paragraph for a biosimilar biological product described in paragraph (1)(C) is the sum of—

"(A) the average sales price as determined using the methodology described under paragraph (6) applied to a biosimilar biological product for all National Drug Codes assigned to such product in the same manner as such paragraph is applied to drugs described in such paragraph; and

"(B) 6 percent of the amount determined under paragraph (4) for the reference biological

product (as defined in subsection (c)(6)(I)).''; and

(2) in subsection (c)(6), by adding at the end the following new subparagraph:

''(H) BIOSIMILAR BIOLOGICAL PRODUCT.—The term 'biosimilar biological product' means a biological product approved under an abbreviated application for a license of a biological product that relies in part on data or information in an application for another biological product licensed under section 351 of the Public Health Service Act.

''(I) REFERENCE BIOLOGICAL PRODUCT.—The term 'reference biological product' means the biological product licensed under such section 351 that is referred to in the application described in subparagraph (H) of the biosimilar biological product.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to payments for biosimilar biological products beginning with the first day of the second calendar quarter after enactment of legislation providing for a biosimilar pathway (as determined by the Secretary).

SEC. 3140. MEDICARE HOSPICE CONCURRENT CARE DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall establish a Medicare Hospice Concurrent Care demonstration program at participating hospice programs under which Medicare beneficiaries are furnished, during the same period, hospice care and any other items or services covered under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) from funds otherwise paid under such title to such hospice programs.

(2) DURATION.—The demonstration program under this section shall be conducted for a 3-year period.

(3) SITES.—The Secretary shall select not more than 15 hospice programs at which the demonstration program under this section shall be conducted. Such hospice programs shall be located in urban and rural areas.

(b) INDEPENDENT EVALUATION AND REPORTS.—

(1) INDEPENDENT EVALUATION.—The Secretary shall provide for the conduct of an independent evaluation of the demonstration program under this section. Such independent evaluation shall determine

whether the demonstration program has improved patient care, quality of life, and cost-effectiveness for Medicare beneficiaries participating in the demonstration program.

(2) REPORTS.—The Secretary shall submit to Congress a report containing the results of the evaluation conducted under paragraph (1), together with such recommendations as the Secretary determines appropriate.

(c) BUDGET NEUTRALITY.—With respect to the 3-year period of the demonstration program under this section, the Secretary shall ensure that the aggregate expenditures under title XVIII for such period shall not exceed the aggregate expenditures that would have been expended under such title if the demonstration program under this section had not been implemented.

SEC. 3141. APPLICATION OF BUDGET NEUTRALITY ON A NATIONAL BASIS IN THE CALCULATION OF THE MEDICARE HOSPITAL WAGE INDEX FLOOR.

In the case of discharges occurring on or after October 1, 2010, for purposes of applying section 4410 of the Balanced Budget Act of 1997 (42 U.S.C. 1395ww note) and paragraph (h)(4) of section 412.64 of title 42, Code of Federal Regulations, the Secretary of Health and Human Services shall administer subsection (b) of such section 4410 and

paragraph (e) of such section 412.64 in the same manner as the Secretary administered such subsection (b) and paragraph (e) for discharges occurring during fiscal year 2008 (through a uniform, national adjustment to the area wage index).

SEC. 3142. HHS STUDY ON URBAN MEDICARE-DEPENDENT HOSPITALS.

(a) STUDY.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall conduct a study on the need for an additional payment for urban Medicare-dependent hospitals for inpatient hospital services under section 1886 of the Social Security Act (42 U.S.C. 1395ww). Such study shall include an analysis of—

(A) the Medicare inpatient margins of urban Medicare-dependent hospitals, as compared to other hospitals which receive 1 or more additional payments or adjustments under such section (including those payments or adjustments described in paragraph (2)(A)); and

(B) whether payments to medicare-dependent, small rural hospitals under subsection (d)(5)(G) of such section should be applied to urban Medicare-dependent hospitals.

(2) URBAN MEDICARE-DEPENDENT HOSPITAL DEFINED.—For purposes of this section, the term "urban Medicare-dependent hospital" means a subsection (d) hospital (as defined in subsection (d)(1)(B) of such section) that—

(A) does not receive any additional payment or adjustment under such section, such as payments for indirect medical education costs under subsection (d)(5)(B) of such section, disproportionate share payments under subsection (d)(5)(A) of such section, payments to a rural referral center under subsection (d)(5)(C) of such section, payments to a critical access hospital under section 1814(l) of such Act (42 U.S.C. 1395f(l)), payments to a sole community hospital under subsection (d)(5)(D) of such section 1886, or payments to a medicare-dependent, small rural hospital under subsection (d)(5)(G) of such section 1886; and

(B) for which more than 60 percent of its inpatient days or discharges during 2 of the 3 most recently audited cost reporting periods for which the Secretary has a settled cost report were attributable to inpatients entitled to benefits under part A of title XVIII of such Act.

(b) REPORT.—Not later than 9 months after the date of enactment of this Act, the Secretary shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

SEC. 3143. PROTECTING HOME HEALTH BENEFITS.

Nothing in the provisions of, or amendments made by, this Act shall result in the reduction of guaranteed home health benefits under title XVIII of the Social Security Act.

Subtitle C—Provisions Relating to Part C

SEC. 3201. MEDICARE ADVANTAGE PAYMENT.

(a) MA BENCHMARK BASED ON PLAN'S COMPETITIVE BIDS.—

(1) IN GENERAL.—Section 1853(j) of the Social Security Act (42 U.S.C. 1395w–23(j)) is amended—

(A) by striking "AMOUNTS.—For purposes" and inserting "AMOUNTS.—

"(1) IN GENERAL.—For purposes";

(B) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively, and indenting the subparagraphs appropriately;

(C) in subparagraph (A), as redesignated by subparagraph (B)—

(i) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively, and indenting the clauses appropriately; and

(ii) in clause (i), as redesignated by clause (i), by striking "an amount equal to" and all that follows through the end and inserting "an amount equal to—

"(I) for years before 2007, 1/12 of the annual MA capitation rate under section 1853(c)(1) for the area for the year, adjusted as appropriate for the purpose of risk adjustment;

"(II) for 2007 through 2011, 1/12 of the applicable amount determined under subsection (k)(1) for the area for the year;

"(III) for 2012, the sum of—

"(aa) 2/3 of the quotient of—

"(AA) the applicable amount determined under subsection (k)(1) for the area for the year; and

"(BB) 12; and

"(bb) 1/3 of the MA competitive benchmark amount (determined under paragraph (2)) for the area for the month;

"(IV) for 2013, the sum of—

"(aa) 1/3 of the quotient of—

"(AA) the applicable amount determined under subsection (k)(1) for the area for the year; and

"(BB) 12; and

"(bb) 2/3 of the MA competitive benchmark amount (as so determined) for the area for the month;

"(V) for 2014, the MA competitive benchmark amount for the area for a month in 2013 (as so determined), increased by the national per capita MA growth percentage, described in subsection (c)(6) for 2014, but not taking into account any adjustment under subparagraph (C) of such subsection for a year before 2004; and

"(VI) for 2015 and each subsequent year, the MA competitive benchmark amount (as so determined) for the area for the month; or";

(iii) in clause (ii), as redesignated by clause (i), by striking "subparagraph (A)" and inserting "clause (i)";

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

"(2) COMPUTATION OF MA COMPETITIVE BENCHMARK AMOUNT.—

"(A) IN GENERAL.—Subject to subparagraph (B) and paragraph (3), for months in each year (beginning with 2012) for each MA payment area the Secretary shall compute an MA competitive benchmark amount equal to the weighted average of the unadjusted MA statutory non-drug monthly bid amount (as defined in section 1854(b)(2)(E)) for each MA plan in the area, with the weight for each plan being equal to the average number of beneficiaries enrolled under such plan in the reference month (as defined in section 1858(f)(4), except that, in applying such definition for purposes of this paragraph, 'to compute the MA competitive bench-

mark amount under section 1853(j)(2)' shall be substituted for 'to compute the percentage specified in subparagraph (A) and other relevant percentages under this part').

"(B) WEIGHTING RULES.—

"(i) SINGLE PLAN RULE.—In the case of an MA payment area in which only a single MA plan is being offered, the weight under subparagraph (A) shall be equal to 1.

"(ii) USE OF SIMPLE AVERAGE AMONG MULTIPLE PLANS IF NO PLANS OFFERED IN PREVIOUS YEAR.—In the case of an MA payment area in which no MA plan was offered in the previous year and more than 1 MA plan is offered in the current year, the Secretary shall use a simple average of the unadjusted MA statutory non-drug monthly bid amount (as so defined) for purposes of computing the MA competitive benchmark amount under subparagraph (A).

"(3) CAP ON MA COMPETITIVE BENCHMARK AMOUNT.—In no case shall the MA competitive benchmark amount for an area for a month in a year be greater than the applicable amount that would (but for the application of this subsection) be determined

under subsection (k)(1) for the area for the month in the year."; and

(E) in subsection (k)(2)(B)(ii)(III), by striking "(j)(1)(A)" and inserting "(j)(1)(A)(i)".

(2) CONFORMING AMENDMENTS.—

(A) Section 1853(k)(2) of the Social Security Act (42 U.S.C. 1395w–23(k)(2)) is amended—

(i) in subparagraph (A), by striking "through 2010" and inserting "and subsequent years"; and

(ii) in subparagraph (C)—

(I) in clause (iii), by striking "and" at the end;

(II) in clause (iv), by striking the period at the end and inserting "; and"; and

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

"(v) for 2011 and subsequent years, 0.00.".

(B) Section 1854(b) of the Social Security Act (42 U.S.C. 1395w–24(b)) is amended—

(i) in paragraph (3)(B)(i), by striking "1853(j)(1)" and inserting "1853(j)(1)(A)"; and

(ii) in paragraph (4)(B)(i), by striking "1853(j)(2)" and inserting "1853(j)(1)(B)".

(C) Section 1858(f) of the Social Security Act (42 U.S.C. 1395w–27(f)) is amended—

(i) in paragraph (1), by striking "1853(j)(2)" and inserting "1853(j)(1)(B)"; and

(ii) in paragraph (3)(A), by striking "1853(j)(1)(A)" and inserting "1853(j)(1)(A)(i)".

(D) Section 1860C–1(d)(1)(A) of the Social Security Act (42 U.S.C. 1395w–29(d)(1)(A)) is amended by striking "1853(j)(1)(A)" and inserting "1853(j)(1)(A)(i)".

(b) REDUCTION OF NATIONAL PER CAPITA GROWTH PERCENTAGE FOR 2011.—Section 1853(c)(6) of the Social Security Act (42 U.S.C. 1395w–23(c)(6)) is amended—

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

(2) in clause (vi)—

(A) by striking "for a year after 2002" and inserting "for 2003 through 2010"; and

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

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

"(vii) for 2011, 3 percentage points; and

"(viii) for a year after 2011, 0 percentage points.".

(c) ENHANCEMENT OF BENEFICIARY REBATES.—Section 1854(b)(1)(C)(i) of the Social Security Act (42 U.S.C. 1395w–24(b)(1)(C)(i)) is amended by inserting "(or 100 percent in the case of plan years beginning on or after January 1, 2014)" after "75 percent".

(d) BIDDING RULES.—

(1) REQUIREMENTS FOR INFORMATION SUBMITTED.—Section 1854(a)(6)(A) of the Social Security Act (42 U.S.C. 1395w–24(a)(6)(A)) is amended, in the flush matter following clause (v), by adding at the end the following sentence: "Information to be submitted under this paragraph shall be certified by a qualified member of the American Academy of Actuaries and shall meet actuarial guidelines and rules established by the Secretary under subparagraph (B)(v).".

(2) ESTABLISHMENT OF ACTUARIAL GUIDELINES.—Section 1854(a)(6)(B) of the Social Security Act (42 U.S.C. 1395w–24(a)(6)(B)) is amended—

(A) in clause (i), by striking "(iii) and (iv)" and inserting "(iii), (iv), and (v)"; and

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

"(v) ESTABLISHMENT OF ACTUARIAL GUIDELINES.—

"(I) IN GENERAL.—In order to establish fair MA competitive benchmarks under section 1853(j)(1)(A)(i), the Secretary, acting through the Chief Actuary of the Centers for Medicare & Medicaid Services (in this clause referred to as the 'Chief Actuary'), shall establish—

"(aa) actuarial guidelines for the submission of bid information under this paragraph; and

"(bb) bidding rules that are appropriate to ensure accurate bids and fair competition among MA plans.

"(II) DENIAL OF BID AMOUNTS.—The Secretary shall deny monthly bid amounts submitted under subparagraph (A) that do not meet the actuarial guidelines and rules established under subclause (I).

"(III) REFUSAL TO ACCEPT CERTAIN BIDS DUE TO MISREPRESENTATIONS AND FAILURES TO ADEQUATELY MEET REQUIREMENTS.—In the case where the Secretary determines that information submitted by an MA organization under subparagraph (A) contains consistent misrepresentations and failures to adequately meet requirements of the organization, the Secretary may refuse to accept any additional such bid amounts from the organization for the plan year and the Chief Actuary shall, if the Chief Actuary determines that the actuaries of the organization were complicit in those misrepresentations and failures, report those actuaries to the Actuarial Board for Counseling and Discipline.".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to bid amounts submitted on or after January 1, 2012.

(e) MA LOCAL PLAN SERVICE AREAS.—

(1) IN GENERAL.—Section 1853(d) of the Social Security Act (42 U.S.C. 1395w–23(d)) is amended—

(A) in the subsection heading, by striking "MA REGION" and inserting "MA REGION; MA LOCAL PLAN SERVICE AREA";

(B) in paragraph (1), by striking subparagraph (A) and inserting the following:

"(A) with respect to an MA local plan—

"(i) for years before 2012, an MA local area (as defined in paragraph (2)); and

"(ii) for 2012 and succeeding years, a service area that is an entire urban or rural area, as applicable (as described in paragraph (5)); and"; and

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

"(5) MA LOCAL PLAN SERVICE AREA.—For 2012 and succeeding years, the service area for an MA local plan shall be an entire urban or rural area in each State as follows:

"(A) URBAN AREAS.—

"(i) IN GENERAL.—Subject to clause (ii) and subparagraphs (C) and (D), the service area for an MA local plan in an urban area shall be the Core Based Statistical Area (in this paragraph referred to as a 'CBSA') or, if applicable, a conceptually similar alternative classification, as defined by the Director of the Office of Management and Budget.

"(ii) CBSA COVERING MORE THAN ONE STATE.—In the case of a CBSA (or alternative classification) that covers more than one State, the Secretary shall divide the CBSA (or alternative classification) into separate service areas with respect to each State covered by the CBSA (or alternative classification).

"(B) RURAL AREAS.—Subject to subparagraphs (C) and (D), the service area for an MA local plan in a rural area shall be a county that does not qualify for inclusion in a CBSA (or alternative classification), as defined by the Director of the Office of Management and Budget.

"(C) REFINEMENTS TO SERVICE AREAS.—For 2015 and succeeding years, in order to re-

flect actual patterns of health care service utilization, the Secretary may adjust the boundaries of service areas for MA local plans in urban areas and rural areas under subparagraphs (A) and (B), respectively, but may only do so based on recent analyses of actual patterns of care.

"(D) ADDITIONAL AUTHORITY TO MAKE LIMITED EXCEPTIONS TO SERVICE AREA REQUIREMENTS FOR MA LOCAL PLANS.—The Secretary may, in addition to any adjustments under subparagraph (C), make limited exceptions to service area requirements otherwise applicable under this part for MA local plans that have in effect (as of the date of enactment of the Patient Protection and Affordable Care Act)—

"(i) agreements with another MA organization or MA plan that preclude the offering of benefits throughout an entire service area; or

"(ii) limitations in their structural capacity to support adequate networks throughout an entire service area as a result of the delivery system model of the MA local plan.".

(2) CONFORMING AMENDMENTS.—

(A) IN GENERAL.—

(i) Section 1851(b)(1) of the Social Security Act (42 U.S.C. 1395w–21(b)(1)) is amended by striking subparagraph (C).

(ii) Section 1853(b)(1)(B)(i) of such Act (42 U.S.C. 1395w–23(b)(1)(B)(i))—

(I) in the matter preceding subclause (I), by striking "MA payment area" and inserting "MA local area (as defined in subsection (d)(2))"; and

(II) in subclause (I), by striking "MA payment area" and inserting "MA local area (as so defined)".

(iii) Section 1853(b)(4) of such Act (42 U.S.C. 1395w–23(b)(4)) is amended by striking "Medicare Advantage payment area" and inserting "MA local area (as so defined)".

(iv) Section 1853(c)(1) of such Act (42 U.S.C. 1395w–23(c)(1)) is amended—

(I) in the matter preceding subparagraph (A), by striking "a Medicare Advantage payment area that is"; and

(II) in subparagraph (D)(i), by striking "MA payment area" and inserting "MA local area (as defined in subsection (d)(2))".

(v) Section 1854 of such Act (42 U.S.C. 1395w–24) is amended by striking subsection (h).

(B) EFFECTIVE DATE.—The amendments made by this paragraph shall take effect on January 1, 2012.

(f) PERFORMANCE BONUSES.—

(1) MA PLANS.—

(A) IN GENERAL.—Section 1853 of the Social Security Act (42 U.S.C. 1395w–23) is amended by adding at the end the following new subsection:

"(n) PERFORMANCE BONUSES.—

"(1) CARE COORDINATION AND MANAGEMENT PERFORMANCE BONUS.—

"(A) IN GENERAL.—For years beginning with 2014, subject to subparagraph (B), in the case of an MA plan that conducts 1 or more programs described in subparagraph (C) with respect to the year, the Secretary shall, in addition to any other payment provided under this part,

make monthly payments, with respect to coverage of an individual under this part, to the MA plan in an amount equal to the product of—

"(i) 0.5 percent of the national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year; and

"(ii) the total number of programs described in clauses (i) through (ix) of subparagraph (C) that the Secretary determines the plan is conducting for the year under such subparagraph.

"(B) LIMITATION.—In no case may the total amount of payment with respect to a year under subparagraph (A) be greater than 2 percent of the national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year, as determined prior to the application of risk adjustment under paragraph (4).

"(C) PROGRAMS DESCRIBED.—The following programs are described in this paragraph:

"(i) Care management programs that—

"(I) target individuals with 1 or more chronic conditions;

"(II) identify gaps in care; and

"(III) facilitate improved care by using additional resources like nurses, nurse practitioners, and physician assistants.

"(ii) Programs that focus on patient education and self-management of health conditions, including interventions that—

"(I) help manage chronic conditions;

"(II) reduce declines in health status; and

"(III) foster patient and provider collaboration.

"(iii) Transitional care interventions that focus on care provided around a hospital inpatient episode, including programs that target post-discharge patient care in order to reduce unnecessary health complications and readmissions.

"(iv) Patient safety programs, including provisions for hospital-based patient safety programs in contracts that the Medi-

care Advantage organization offering the MA plan has with hospitals.

"(v) Financial policies that promote systematic coordination of care by primary care physicians across the full spectrum of specialties and sites of care, such as medical homes, capitation arrangements, or pay-for-performance programs.

"(vi) Programs that address, identify, and ameliorate health care disparities among principal at-risk subpopulations.

"(vii) Medication therapy management programs that are more extensive than is required under section 1860D–4(c) (as determined by the Secretary).

"(viii) Health information technology programs, including clinical decision support and other tools to facilitate data collection and ensure patient-centered, appropriate care.

"(ix) Such other care management and coordination programs as the Secretary determines appropriate.

"(D) CONDUCT OF PROGRAM IN URBAN AND RURAL AREAS.—An MA plan may conduct a

program described in subparagraph (C) in a manner appropriate for an urban or rural area, as applicable.

"(E) REPORTING OF DATA.—Each Medicare Advantage organization shall provide to the Secretary the information needed to determine whether they are eligible for a care coordination and management performance bonus at a time and in a manner specified by the Secretary.

"(F) PERIODIC AUDITING.—The Secretary shall provide for the annual auditing of programs described in subparagraph (C) for which an MA plan receives a care coordination and management performance bonus under this paragraph. The Comptroller General shall monitor auditing activities conducted under this subparagraph.

"(2) QUALITY PERFORMANCE BONUSES.—

"(A) QUALITY BONUS.—For years beginning with 2014, the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to an MA plan that achieves at least a 3 star rating (or

comparable rating) on a rating system described in subparagraph (C) in an amount equal to—

"(i) in the case of a plan that achieves a 3 star rating (or comparable rating) on such system 2 percent of the national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year; and

"(ii) in the case of a plan that achieves a 4 or 5 star rating (or comparable rating on such system, 4 percent of such national monthly per capita cost for the year.

"(B) IMPROVED QUALITY BONUS.—For years beginning with 2014, in the case of an MA plan that does not receive a quality bonus under subparagraph (A) and is an improved quality MA plan with respect to the year (as identified by the Secretary), the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to the MA plan in an amount equal to 1 percent of such national monthly per capita cost for the year.

"(C) USE OF RATING SYSTEM.—For purposes of subparagraph (A), a rating system described in this paragraph is—

"(i) a rating system that uses up to 5 stars to rate clinical quality and enrollee satisfaction and performance at the Medicare Advantage contract or MA plan level; or

"(ii) such other system established by the Secretary that provides for the determination of a comparable quality performance rating to the rating system described in clause (i).

"(D) DATA USED IN DETERMINING SCORE.—

"(i) IN GENERAL.—The rating of an MA plan under the rating system described in subparagraph (C) with respect to a year shall be based on based on the most recent data available.

"(ii) PLANS THAT FAIL TO REPORT DATA.—An MA plan which does not report data that enables the Secretary to rate the plan for purposes of subparagraph (A) or identify the plan for purposes of subpara-

graph (B) shall be counted, for purposes of such rating or identification, as having the lowest plan performance rating and the lowest percentage improvement, respectively.

"(3) QUALITY BONUS FOR NEW AND LOW ENROLLMENT MA PLANS.—

"(A) NEW MA PLANS.—For years beginning with 2014, in the case of an MA plan that first submits a bid under section 1854(a)(1)(A) for 2012 or a subsequent year, only receives enrollments made during the coverage election periods described in section 1851(e), and is not able to receive a bonus under subparagraph (A) or (B) of paragraph (2) for the year, the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to the MA plan in an amount equal to 2 percent of national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year. In its fourth year of operation, the MA plan shall be paid in the same manner as other MA plans with comparable enrollment.

"(B) LOW ENROLLMENT PLANS.—For years beginning with 2014, in the case of an MA plan that has low enrollment (as defined by the Secretary) and would not otherwise be able to receive a bonus under subparagraph (A) or (B) of paragraph (2) or subparagraph (A) of this paragraph for the year (referred to in this subparagraph as a 'low enrollment plan'), the Secretary shall use a regional or local mean of the rating of all MA plans in the region or local area, as determined appropriate by the Secretary, on measures used to determine whether MA plans are eligible for a quality or an improved quality bonus, as applicable, to determine whether the low enrollment plan is eligible for a bonus under such a subparagraph.

"(4) RISK ADJUSTMENT.—The Secretary shall risk adjust a performance bonus under this subsection in the same manner as the Secretary risk adjusts beneficiary rebates described in section 1854(b)(1)(C).

"(5) NOTIFICATION.—The Secretary, in the annual announcement required under subsection (b)(1)(B) for 2014 and each succeeding year, shall notify the Medicare Advantage organization of any performance bonus (including a care coordination and

management performance bonus under paragraph (1), a quality performance bonus under paragraph (2), and a quality bonus for new and low enrollment plans under paragraph (3)) that the organization will receive under this subsection with respect to the year. The Secretary shall provide for the publication of the information described in the previous sentence on the Internet website of the Centers for Medicare & Medicaid Services.''

(B) CONFORMING AMENDMENT.—Section 1853(a)(1)(B) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(B)) is amended—

(i) in clause (i), by inserting ''and any performance bonus under subsection (n)'' before the period at the end; and

(ii) in clause (ii), by striking ''(G)'' and inserting ''(G), plus the amount (if any) of any performance bonus under subsection (n)''.

(2) APPLICATION OF PERFORMANCE BONUSES TO MA REGIONAL PLANS.—Section 1858 of the Social Security Act (42 U.S.C. 1395w–27a) is amended—

(A) in subsection (f)(1), by striking ''subsection (e)'' and inserting ''subsections (e) and (i)''; and

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

"(i) APPLICATION OF PERFORMANCE BONUSES TO MA REGIONAL PLANS.—For years beginning with 2014, the Secretary shall apply the performance bonuses under section 1853(n) (relating to bonuses for care coordination and management, quality performance, and new and low enrollment MA plans) to MA regional plans in a similar manner as such performance bonuses apply to MA plans under such subsection.".

(g) GRANDFATHERING SUPPLEMENTAL BENEFITS FOR CURRENT ENROLLEES AFTER IMPLEMENTATION OF COMPETITIVE BIDDING.—Section 1853 of the Social Security Act (42 U.S.C. 1395w–23), as amended by subsection (f), is amended by adding at the end the following new subsection:

"(o) GRANDFATHERING SUPPLEMENTAL BENEFITS FOR CURRENT ENROLLES AFTER IMPLEMENTATION OF COMPETITIVE BIDDING.—

"(1) IDENTIFICATION OF AREAS.—The Secretary shall identify MA local areas in which, with respect to 2009, average bids submitted by an MA organization under section 1854(a) for MA local plans in the area are not greater than 75 percent of the adjusted average per capita cost for the year involved, deter-

mined under section 1876(a)(4), for the area for individuals who are not enrolled in an MA plan under this part for the year, but adjusted to exclude costs attributable to payments under section 1848(o), 1886(n), and 1886(h).

"(2) ELECTION TO PROVIDE REBATES TO GRANDFATHERED ENROLLEES.—

"(A) IN GENERAL.—For years beginning with 2012, each Medicare Advantage organization offering an MA local plan in an area identified by the Secretary under paragraph (1) may elect to provide rebates to grandfathered enrollees under section 1854(b)(1)(C). In the case where an MA organization makes such an election, the monthly per capita dollar amount of such rebates shall not exceed the applicable amount for the year (as defined in subparagraph (B)).

"(B) APPLICABLE AMOUNT.—For purposes of this subsection, the term 'applicable amount' means—

"(i) for 2012, the monthly per capita dollar amount of such rebates provided to enrollees under the MA local plan with respect to 2011; and

"(ii) for a subsequent year, 95 percent of the amount determined under this subparagraph for the preceding year.

"(3) SPECIAL RULES FOR PLANS IN IDENTIFIED AREAS.—Notwithstanding any other provision of this part, the following shall apply with respect to each Medicare Advantage organization offering an MA local plan in an area identified by the Secretary under paragraph (1) that makes an election described in paragraph (2):

"(A) PAYMENTS.—The amount of the monthly payment under this section to the Medicare Advantage organization, with respect to coverage of a grandfathered enrollee under this part in the area for a month, shall be equal to—

"(i) for 2012 and 2013, the sum of—

"(I) the bid amount under section 1854(a) for the MA local plan; and

"(II) the applicable amount (as defined in paragraph (2)(B)) for the MA local plan for the year.

"(ii) for 2014 and subsequent years, the sum of—

"(I) the MA competitive benchmark amount under subsection

(j)(1)(A)(i) for the area for the month, adjusted, only to the extent the Secretary determines necessary, to account for induced utilization as a result of rebates provided to grandfathered enrollees (except that such adjustment shall not exceed 0.5 percent of such MA competitive benchmark amount); and

"(II) the applicable amount (as so defined) for the MA local plan for the year.

"(B) REQUIREMENT TO SUBMIT BIDS UNDER COMPETITIVE BIDDING.—The Medicare Advantage organization shall submit a single bid amount under section 1854(a) for the MA local plan. The Medicare Advantage organization shall remove from such bid amount any effects of induced demand for care that may result from the higher rebates available to grandfathered enrollees under this subsection.

"(C) NONAPPLICATION OF BONUS PAYMENTS AND ANY OTHER REBATES.—The Medicare Advantage organization offering the MA local plan shall not be eligible for any bonus payment under subsection (n) or any rebate under this

part (other than as provided under this subsection) with respect to grandfathered enrollees.

"(D) NONAPPLICATION OF UNIFORM BID AND PREMIUM AMOUNTS TO GRANDFATHERED ENROLLEES.—Section 1854(c) shall not apply with respect to the MA local plan.

"(E) NONAPPLICATION OF LIMITATION ON APPLICATION OF PLAN REBATES TOWARD PAYMENT OF PART B PREMIUM.—Notwithstanding clause (iii) of section 1854(b)(1)(C), in the case of a grandfathered enrollee, a rebate under such section may be used for the purpose described in clause (ii)(III) of such section.

"(F) RISK ADJUSTMENT.—The Secretary shall risk adjust rebates to grandfathered enrollees under this subsection in the same manner as the Secretary risk adjusts beneficiary rebates described in section 1854(b)(1)(C).

"(4) DEFINITION OF GRANDFATHERED ENROLLEE.—In this subsection, the term 'grandfathered enrollee' means an individual who is enrolled (effective as of the date of enactment of this subsection) in an MA local plan in an area that is identified by the Secretary under paragraph (1).".

(h) TRANSITIONAL EXTRA BENEFITS.—Section 1853 of the Social Security Act (42 U.S.C. 1395w–23), as amended by subsections (f) and (g), is amended by adding at the end the following new subsection:

"(p) TRANSITIONAL EXTRA BENEFITS.—

"(1) IN GENERAL.—For years beginning with 2012, the Secretary shall provide transitional rebates under section 1854(b)(1)(C) for the provision of extra benefits (as specified by the Secretary) to enrollees described in paragraph (2).

"(2) ENROLLEES DESCRIBED.—An enrollee described in this paragraph is an individual who—

"(A) enrolls in an MA local plan in an applicable area; and

"(B) experiences a significant reduction in extra benefits described in clause (ii) of section 1854(b)(1)(C) as a result of competitive bidding under this part (as determined by the Secretary).

"(3) APPLICABLE AREAS.—In this subsection, the term 'applicable area' means the following:

"(A) The 2 largest metropolitan statistical areas, if the Secretary determines that the total amount of such extra benefits for each enrollee for the month in those areas is greater than $100.

"(B) A county where—

"(i) the MA area-specific non-drug monthly benchmark amount for a month in 2011 is equal to the legacy urban floor amount (as described in subsection (c)(1)(B)(iii)), as determined by the Secretary for the area for 2011;

"(ii) the percentage of Medicare Advantage eligible beneficiaries in the county who are enrolled in an MA plan for 2009 is greater than 30 percent (as determined by the Secretary); and

"(iii) average bids submitted by an MA organization under section 1854(a) for MA local plans in the county for 2011 are not greater than the adjusted average per capita cost for the year involved, determined under section 1876(a)(4), for the county for individuals who are not enrolled in an MA plan under this part for the year, but adjusted to exclude costs attributable to payments under section 1848(o), 1886(n), and 1886(h).

"(C) If the Secretary determines appropriate, a county contiguous to an area or county

described in subparagraph (A) or (B), respectively.

"(4) REVIEW OF PLAN BIDS.—In the case of a bid submitted by an MA organization under section 1854(a) for an MA local plan in an applicable area, the Secretary shall review such bid in order to ensure that extra benefits (as specified by the Secretary) are provided to enrollees described in paragraph (2).

"(5) FUNDING.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund established under section 1841, in such proportion as the Secretary determines appropriate, of an amount not to exceed $5,000,000,000 for the period of fiscal years 2012 through 2019 for the purpose of providing transitional rebates under section 1854(b)(1)(C) for the provision of extra benefits under this subsection.".

(i) NONAPPLICATION OF COMPETITIVE BIDDING AND RELATED PROVISIONS AND CLARIFICATION OF MA PAYMENT AREA FOR PACE PROGRAMS.—

(1) NONAPPLICATION OF COMPETITIVE BIDDING AND RELATED PROVISIONS FOR PACE PROGRAMS.—Section 1894 of the Social Security Act (42 U.S.C. 1395eee) is amended—

(A) by redesignating subsections (h) and (i) as subsections (i) and (j), respectively;

(B) by inserting after subsection (g) the following new subsection:

"(h) NONAPPLICATION OF COMPETITIVE BIDDING AND RELATED PROVISIONS UNDER PART C.—With respect to a PACE program under this section, the following provisions (and regulations relating to such provisions) shall not apply:

"(1) Section 1853(j)(1)(A)(i), relating to MA area-specific non-drug monthly benchmark amount being based on competitive bids.

"(2) Section 1853(d)(5), relating to the establishment of MA local plan service areas.

"(3) Section 1853(n), relating to the payment of performance bonuses.

"(4) Section 1853(o), relating to grandfathering supplemental benefits for current enrollees after implementation of competitive bidding.

"(5) Section 1853(p), relating to transitional extra benefits.".

(2) SPECIAL RULE FOR MA PAYMENT AREA FOR PACE PROGRAMS.—Section 1853(d) of the Social Security Act (42 U.S.C. 1395w–23(d)), as amended by

subsection (e), is amended by adding at the end the following new paragraph:

"(6) SPECIAL RULE FOR MA PAYMENT AREA FOR PACE PROGRAMS.—For years beginning with 2012, in the case of a PACE program under section 1894, the MA payment area shall be the MA local area (as defined in paragraph (2)).".

SEC. 3202. BENEFIT PROTECTION AND SIMPLIFICATION.

(a) LIMITATION ON VARIATION OF COST SHARING FOR CERTAIN BENEFITS.—

(1) IN GENERAL.—Section 1852(a)(1)(B) of the Social Security Act (42 U.S.C. 1395w–22(a)(1)(B)) is amended—

(A) in clause (i), by inserting ", subject to clause (iii)," after "and B or"; and

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

"(iii) LIMITATION ON VARIATION OF COST SHARING FOR CERTAIN BENEFITS.—Subject to clause (v), cost-sharing for services described in clause (iv) shall not exceed the cost-sharing required for those services under parts A and B.

"(iv) SERVICES DESCRIBED.—The following services are described in this clause:

"(I) Chemotherapy administration services.

"(II) Renal dialysis services (as defined in section 1881(b)(14)(B)).

"(III) Skilled nursing care.

"(IV) Such other services that the Secretary determines appropriate (including services that the Secretary determines require a high level of predictability and transparency for beneficiaries).

"(v) EXCEPTION.—In the case of services described in clause (iv) for which there is no cost-sharing required under parts A and B, cost-sharing may be required for those services in accordance with clause (i).".

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to plan years beginning on or after January 1, 2011.

(b) APPLICATION OF REBATES, PERFORMANCE BONUSES, AND PREMIUMS.—

(1) APPLICATION OF REBATES.—Section 1854(b)(1)(C) of the Social Security Act (42 U.S.C. 1395w–24(b)(1)(C)) is amended—

(A) in clause (ii), by striking "REBATE.—A rebate" and inserting "REBATE FOR PLAN YEARS BEFORE 2012.—For plan years before 2012, a rebate";

(B) by redesignating clauses (iii) and (iv) as clauses (iv) and (v); and

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

"(iii) FORM OF REBATE FOR PLAN YEAR 2012 AND SUBSEQUENT PLAN YEARS.—For plan years beginning on or after January 1, 2012, a rebate required under this subparagraph may not be used for the purpose described in clause (ii)(III) and shall be provided through the application of the amount of the rebate in the following priority order:

"(I) First, to use the most significant share to meaningfully reduce cost-sharing otherwise applicable for benefits under the original medicare fee-for-service program under parts A and B and for qualified prescription drug coverage under part D, including the reduction of any deductibles, copay-

ments, and maximum limitations on out-of-pocket expenses otherwise applicable. Any reduction of maximum limitations on out-of-pocket expenses under the preceding sentence shall apply to all benefits under the original medicare fee-for-service program option. The Secretary may provide guidance on meaningfully reducing cost-sharing under this subclause, except that such guidance may not require a particular amount of cost-sharing or reduction in cost-sharing.

"(II) Second, to use the next most significant share to meaningfully provide coverage of preventive and wellness health care benefits (as defined by the Secretary) which are not benefits under the original medicare fee-for-service program, such as smoking cessation, a free flu shot, and an annual physical examination.

"(III) Third, to use the remaining share to meaningfully provide coverage of other health care benefits which are

not benefits under the original medicare fee-for-service program, such as eye examinations and dental coverage, and are not benefits described in subclause (II).".

(2) APPLICATION OF PERFORMANCE BONUSES.—Section 1853(n) of the Social Security Act, as added by section 3201(f), is amended by adding at the end the following new paragraph:

"(6) APPLICATION OF PERFORMANCE BONUSES.—For plan years beginning on or after January 1, 2014, any performance bonus paid to an MA plan under this subsection shall be used for the purposes, and in the priority order, described in subclauses (I) through (III) of section 1854(b)(1)(C)(iii).".

(3) APPLICATION OF MA MONTHLY SUPPLEMENTARY BENEFICIARY PREMIUM.—Section 1854(b)(2)(C) of the Social Security Act (42 U.S.C. 1395w–24(b)(2)(C)) is amended—

(A) by striking "PREMIUM.—The term" and inserting "PREMIUM.—

"(i) IN GENERAL.—The term"; and

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

"(ii) APPLICATION OF MA MONTHLY SUPPLEMENTARY BENEFICIARY PREMIUM.—For plan years beginning on or after January 1, 2012, any MA monthly supplementary beneficiary premium charged to an individual enrolled in an MA plan shall be used for the purposes, and in the priority order, described in subclauses (I) through (III) of paragraph (1)(C)(iii).".

SEC. 3203. APPLICATION OF CODING INTENSITY ADJUSTMENT DURING MA PAYMENT TRANSITION.

Section 1853(a)(1)(C) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(C)) is amended by adding at the end the following new clause:

"(iii) APPLICATION OF CODING INTENSITY ADJUSTMENT FOR 2011 AND SUBSEQUENT YEARS.—

"(I) REQUIREMENT TO APPLY IN 2011 THROUGH 2013.—In order to ensure payment accuracy, the Secretary shall conduct an analysis of the differences described in clause (ii)(I). The Secretary shall ensure that the results of such analysis are incorporated into

the risk scores for 2011, 2012, and 2013.

"(II) AUTHORITY TO APPLY IN 2014 AND SUBSEQUENT YEARS.—The Secretary may, as appropriate, incorporate the results of such analysis into the risk scores for 2014 and subsequent years.".

SEC. 3204. SIMPLIFICATION OF ANNUAL BENEFICIARY ELECTION PERIODS.

(a) ANNUAL 45-DAY PERIOD FOR DISENROLLMENT FROM MA PLANS TO ELECT TO RECEIVE BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM.—

(1) IN GENERAL.—Section 1851(e)(2)(C) of the Social Security Act (42 U.S.C. 1395w–1(e)(2)(C)) is amended to read as follows:

"(C) ANNUAL 45-DAY PERIOD FOR DISENROLLMENT FROM MA PLANS TO ELECT TO RECEIVE BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM.—Subject to subparagraph (D), at any time during the first 45 days of a year (beginning with 2011), an individual who is enrolled in a Medicare Advantage plan may change the election under sub-

section (a)(1), but only with respect to coverage under the original medicare fee-for-service program under parts A and B, and may elect qualified prescription drug coverage in accordance with section 1860D–1.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to 2011 and succeeding years.

(b) TIMING OF THE ANNUAL, COORDINATED ELECTION PERIOD UNDER PARTS C AND D.—Section 1851(e)(3)(B) of the Social Security Act (42 U.S.C. 1395w–1(e)(3)(B)) is amended—

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

(2) in clause (iv)—

(A) by striking "and succeeding years" and inserting ", 2008, 2009, and 2010"; and

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

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

"(v) with respect to 2012 and succeeding years, the period beginning on October 15 and ending on December 7 of the year before such year.".

SEC. 3205. EXTENSION FOR SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.

(a) EXTENSION OF SNP AUTHORITY.—Section 1859(f)(1) of the Social Security Act (42 U.S.C. 1395w–28(f)(1)), as amended by section 164(a) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275), is amended by striking "2011" and inserting "2014".

(b) AUTHORITY TO APPLY FRAILTY ADJUSTMENT UNDER PACE PAYMENT RULES.—Section 1853(a)(1)(B) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(B)) is amended by adding at the end the following new clause:

"(iv) AUTHORITY TO APPLY FRAILTY ADJUSTMENT UNDER PACE PAYMENT RULES FOR CERTAIN SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.—

"(I) IN GENERAL.—Notwithstanding the preceding provisions of this paragraph, for plan year 2011 and subsequent plan years, in the case of a plan described in subclause (II), the Secretary may apply the payment rules under section 1894(d) (other than paragraph (3) of such section) rather than the payment rules that would otherwise apply under this part, but only

to the extent necessary to reflect the costs of treating high concentrations of frail individuals.

"(II) PLAN DESCRIBED.—A plan described in this subclause is a specialized MA plan for special needs individuals described in section 1859(b)(6)(B)(ii) that is fully integrated with capitated contracts with States for Medicaid benefits, including long-term care, and that have similar average levels of frailty (as determined by the Secretary) as the PACE program.".

(c) TRANSITION AND EXCEPTION REGARDING RESTRICTION ON ENROLLMENT.—Section 1859(f) of the Social Security Act (42 U.S.C. 1395w–28(f)) is amended by adding at the end the following new paragraph:

"(6) TRANSITION AND EXCEPTION REGARDING RESTRICTION ON ENROLLMENT.—

"(A) IN GENERAL.—Subject to subparagraph (C), the Secretary shall establish procedures for the transition of applicable individuals to—

"(i) a Medicare Advantage plan that is not a specialized MA plan for special needs individuals (as defined in subsection (b)(6)); or

"(ii) the original medicare fee-for-service program under parts A and B.

"(B) APPLICABLE INDIVIDUALS.—For purposes of clause (i), the term 'applicable individual' means an individual who—

"(i) is enrolled under a specialized MA plan for special needs individuals (as defined in subsection (b)(6)); and

"(ii) is not within the 1 or more of the classes of special needs individuals to which enrollment under the plan is restricted to.

"(C) EXCEPTION.—The Secretary shall provide for an exception to the transition described in subparagraph (A) for a limited period of time for individuals enrolled under a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(ii) who are no longer eligible for medical assistance under title XIX.

"(D) TIMELINE FOR INITIAL TRANSITION.—The Secretary shall ensure that applicable individuals enrolled in a specialized MA plan for

special needs individuals (as defined in subsection (b)(6)) prior to January 1, 2010, are transitioned to a plan or the program described in subparagraph (A) by not later than January 1, 2013.".

(d) TEMPORARY EXTENSION OF AUTHORITY TO OPERATE BUT NO SERVICE AREA EXPANSION FOR DUAL SPECIAL NEEDS PLANS THAT DO NOT MEET CERTAIN REQUIREMENTS.—Section 164(c)(2) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275) is amended by striking "December 31, 2010" and inserting "December 31, 2012".

(e) AUTHORITY TO REQUIRE SPECIAL NEEDS PLANS BE NCQA APPROVED.—Section 1859(f) of the Social Security Act (42 U.S.C. 1395w–28(f)), as amended by subsections (a) and (c), is amended—

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

"(C) If applicable, the plan meets the requirement described in paragraph (7).";

(2) in paragraph (3), by adding at the end the following new subparagraph:

"(E) If applicable, the plan meets the requirement described in paragraph (7).";

(3) in paragraph (4), by adding at the end the following new subparagraph:

"(C) If applicable, the plan meets the requirement described in paragraph (7)."; and

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

"(7) AUTHORITY TO REQUIRE SPECIAL NEEDS PLANS BE NCQA APPROVED.—For 2012 and subsequent years, the Secretary shall require that a Medicare Advantage organization offering a specialized MA plan for special needs individuals be approved by the National Committee for Quality Assurance (based on standards established by the Secretary).".

(f) RISK ADJUSTMENT.—Section 1853(a)(1)(C) of the Social Security Act (42 U.S.C. 1395i–23(a)(1)(C)) is amended by adding at the end the following new clause:

"(iii) IMPROVEMENTS TO RISK ADJUSTMENT FOR SPECIAL NEEDS INDIVIDUALS WITH CHRONIC HEALTH CONDITIONS.—

"(I) IN GENERAL.—For 2011 and subsequent years, for purposes of the adjustment under clause (i) with respect to individuals described in subclause (II), the Secretary shall use a

risk score that reflects the known underlying risk profile and chronic health status of similar individuals. Such risk score shall be used instead of the default risk score for new enrollees in Medicare Advantage plans that are not specialized MA plans for special needs individuals (as defined in section 1859(b)(6)).

"(II) INDIVIDUALS DESCRIBED.—An individual described in this subclause is a special needs individual described in subsection (b)(6)(B)(iii) who enrolls in a specialized MA plan for special needs individuals on or after January 1, 2011.

"(III) EVALUATION.—For 2011 and periodically thereafter, the Secretary shall evaluate and revise the risk adjustment system under this subparagraph in order to, as accurately as possible, account for higher medical and care coordination costs associated with frailty, individuals with multiple, comorbid chronic conditions, and indi-

viduals with a diagnosis of mental illness, and also to account for costs that may be associated with higher concentrations of beneficiaries with those conditions.

"(IV) PUBLICATION OF EVALUATION AND REVISIONS.—The Secretary shall publish, as part of an announcement under subsection (b), a description of any evaluation conducted under subclause (III) during the preceding year and any revisions made under such subclause as a result of such evaluation.".

(g) TECHNICAL CORRECTION.—Section 1859(f)(5) of the Social Security Act (42 U.S.C. 1395w–28(f)(5)) is amended, in the matter preceding subparagraph (A), by striking "described in subsection (b)(6)(B)(i)".

SEC. 3206. EXTENSION OF REASONABLE COST CONTRACTS.

Section 1876(h)(5)(C)(ii) of the Social Security Act (42 U.S.C. 1395mm(h)(5)(C)(ii)) is amended, in the matter preceding subclause (I), by striking "January 1, 2010" and inserting "January 1, 2013".

SEC. 3207. TECHNICAL CORRECTION TO MA PRIVATE FEE-FOR-SERVICE PLANS.

For plan year 2011 and subsequent plan years, to the extent that the Secretary of Health and Human Services is applying the 2008 service area extension waiver policy (as modified in the April 11, 2008, Centers for Medicare & Medicaid Services' memorandum with the subject "2009 Employer Group Waiver-Modification of the 2008 Service Area Extension Waiver Granted to Certain MA Local Coordinated Care Plans") to Medicare Advantage coordinated care plans, the Secretary shall extend the application of such waiver policy to employers who contract directly with the Secretary as a Medicare Advantage private fee-for-service plan under section 1857(i)(2) of the Social Security Act (42 U.S.C. 1395w–27(i)(2)) and that had enrollment as of October 1, 2009.

SEC. 3208. MAKING SENIOR HOUSING FACILITY DEMONSTRATION PERMANENT.

(a) IN GENERAL.—Section 1859 of the Social Security Act (42 U.S.C. 1395w–28) is amended by adding at the end the following new subsection:

"(g) SPECIAL RULES FOR SENIOR HOUSING FACILITY PLANS.—

"(1) IN GENERAL.—In the case of a Medicare Advantage senior housing facility plan described in paragraph (2), notwithstanding any other provision

of this part to the contrary and in accordance with regulations of the Secretary, the service area of such plan may be limited to a senior housing facility in a geographic area.

"(2) MEDICARE ADVANTAGE SENIOR HOUSING FACILITY PLAN DESCRIBED.—For purposes of this subsection, a Medicare Advantage senior housing facility plan is a Medicare Advantage plan that—

"(A) restricts enrollment of individuals under this part to individuals who reside in a continuing care retirement community (as defined in section 1852(l)(4)(B));

"(B) provides primary care services onsite and has a ratio of accessible physicians to beneficiaries that the Secretary determines is adequate;

"(C) provides transportation services for beneficiaries to specialty providers outside of the facility; and

"(D) has participated (as of December 31, 2009) in a demonstration project established by the Secretary under which such a plan was offered for not less than 1 year.".

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect on January 1, 2010, and shall apply to plan years beginning on or after such date.

SEC. 3209. AUTHORITY TO DENY PLAN BIDS.

(a) IN GENERAL.—Section 1854(a)(5) of the Social Security Act (42 U.S.C. 1395w–24(a)(5)) is amended by adding at the end the following new subparagraph:

"(C) REJECTION OF BIDS.—

"(i) IN GENERAL.—Nothing in this section shall be construed as requiring the Secretary to accept any or every bid submitted by an MA organization under this subsection.

"(ii) AUTHORITY TO DENY BIDS THAT PROPOSE SIGNIFICANT INCREASES IN COST SHARING OR DECREASES IN BENEFITS.—The Secretary may deny a bid submitted by an MA organization for an MA plan if it proposes significant increases in cost sharing or decreases in benefits offered under the plan.".

(b) APPLICATION UNDER PART D.—Section 1860D–11(d) of such Act (42 U.S.C. 1395w–111(d)) is amended by adding at the end the following new paragraph:

"(3) REJECTION OF BIDS.—Paragraph (5)(C) of section 1854(a) shall apply with respect to bids submitted by a PDP sponsor under subsection (b) in the same manner as such paragraph applies to bids submitted by an MA organization under such section 1854(a).".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to bids submitted for contract years beginning on or after January 1, 2011.

SEC. 3210. DEVELOPMENT OF NEW STANDARDS FOR CERTAIN MEDIGAP PLANS.

(a) IN GENERAL.—Section 1882 of the Social Security Act (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:

"(y) DEVELOPMENT OF NEW STANDARDS FOR CERTAIN MEDICARE SUPPLEMENTAL POLICIES.—

"(1) IN GENERAL.—The Secretary shall request the National Association of Insurance Commissioners to review and revise the standards for benefit packages described in paragraph (2) under subsection (p)(1), to otherwise update standards to include requirements for nominal cost sharing to encourage the use of appropriate physicians' services under part B. Such revisions shall be based on evidence published in peer-reviewed journals or current examples used by

integrated delivery systems and made consistent with the rules applicable under subsection (p)(1)(E) with the reference to the '1991 NAIC Model Regulation' deemed a reference to the NAIC Model Regulation as published in the Federal Register on December 4, 1998, and as subsequently updated by the National Association of Insurance Commissioners to reflect previous changes in law and the reference to 'date of enactment of this subsection' deemed a reference to the date of enactment of the Patient Protection and Affordable Care Act. To the extent practicable, such revision shall provide for the implementation of revised standards for benefit packages as of January 1, 2015.

"(2) BENEFIT PACKAGES DESCRIBED.—The benefit packages described in this paragraph are benefit packages classified as 'C' and 'F'.".

(b) CONFORMING AMENDMENT.—Section 1882(o)(1) of the Social Security Act (42 U.S.C. 1395ss(o)(1)) is amended by striking ", and (w)" and inserting "(w), and (y)".

Subtitle D—Medicare Part D Improvements for Prescription Drug Plans and MA–PD Plans

SEC. 3301. MEDICARE COVERAGE GAP DISCOUNT PROGRAM.

(a) CONDITION FOR COVERAGE OF DRUGS UNDER PART D.—Part D of Title XVIII of the Social Security Act

(42 U.S.C. 1395w–101 et seq.), is amended by adding at the end the following new section:

"CONDITION FOR COVERAGE OF DRUGS UNDER THIS PART

"SEC. 1860D–43. (a) IN GENERAL.—In order for coverage to be available under this part for covered part D drugs (as defined in section 1860D–2(e)) of a manufacturer, the manufacturer must—

"(1) participate in the Medicare coverage gap discount program under section 1860D–14A;

"(2) have entered into and have in effect an agreement described in subsection (b) of such section with the Secretary; and

"(3) have entered into and have in effect, under terms and conditions specified by the Secretary, a contract with a third party that the Secretary has entered into a contract with under subsection (d)(3) of such section.

"(b) EFFECTIVE DATE.—Subsection (a) shall apply to covered part D drugs dispensed under this part on or after July 1, 2010.

"(c) AUTHORIZING COVERAGE FOR DRUGS NOT COVERED UNDER AGREEMENTS.—Subsection (a) shall not apply to the dispensing of a covered part D drug if—

"(1) the Secretary has made a determination that the availability of the drug is essential to the health of beneficiaries under this part; or

"(2) the Secretary determines that in the period beginning on July 1, 2010, and ending on December 31, 2010, there were extenuating circumstances.

"(d) DEFINITION OF MANUFACTURER.—In this section, the term 'manufacturer' has the meaning given such term in section 1860D–14A(g)(5).".

(b) MEDICARE COVERAGE GAP DISCOUNT PROGRAM.—Part D of title XVIII of the Social Security Act (42 U.S.C. 1395w–101) is amended by inserting after section 1860D–14 the following new section:

"MEDICARE COVERAGE GAP DISCOUNT PROGRAM

"SEC. 1860D–14A. (a) ESTABLISHMENT.—The Secretary shall establish a Medicare coverage gap discount program (in this section referred to as the 'program') by not later than July 1, 2010. Under the program, the Secretary shall enter into agreements described in subsection (b) with manufacturers and provide for the performance of the duties described in subsection (c)(1). The Secretary shall establish a model agreement for use under the program by not later than April 1, 2010, in consultation with manufacturers, and allow for comment on such model agreement.

"(b) TERMS OF AGREEMENT.—

"(1) IN GENERAL.—

"(A) AGREEMENT.—An agreement under this section shall require the manufacturer to provide applicable beneficiaries access to dis-

counted prices for applicable drugs of the manufacturer.

"(B) PROVISION OF DISCOUNTED PRICES AT THE POINT-OF-SALE.—Except as provided in subsection (c)(1)(A)(iii), such discounted prices shall be provided to the applicable beneficiary at the pharmacy or by the mail order service at the point-of-sale of an applicable drug.

"(C) TIMING OF AGREEMENT.—

"(i) SPECIAL RULE FOR 2010 AND 2011.—In order for an agreement with a manufacturer to be in effect under this section with respect to the period beginning on July 1, 2010, and ending on December 31, 2011, the manufacturer shall enter into such agreement not later than May 1, 2010.

"(ii) 2012 AND SUBSEQUENT YEARS.—In order for an agreement with a manufacturer to be in effect under this section with respect to plan year 2012 or a subsequent plan year, the manufacturer shall enter into such agreement (or such agreement shall be renewed under paragraph (4)(A)) not later than January 30 of the preceding year.

"(2) PROVISION OF APPROPRIATE DATA.—Each manufacturer with an agreement in effect under this section shall collect and have available appropriate data, as determined by the Secretary, to ensure that it can demonstrate to the Secretary compliance with the requirements under the program.

"(3) COMPLIANCE WITH REQUIREMENTS FOR ADMINISTRATION OF PROGRAM.—Each manufacturer with an agreement in effect under this section shall comply with requirements imposed by the Secretary or a third party with a contract under subsection (d)(3), as applicable, for purposes of administering the program, including any determination under clause (i) of subsection (c)(1)(A) or procedures established under such subsection (c)(1)(A).

"(4) LENGTH OF AGREEMENT.—

"(A) IN GENERAL.—An agreement under this section shall be effective for an initial period of not less than 18 months and shall be automatically renewed for a period of not less than 1 year unless terminated under subparagraph (B).

"(B) TERMINATION.—

"(i) BY THE SECRETARY.—The Secretary may provide for termination of an

agreement under this section for a knowing and willful violation of the requirements of the agreement or other good cause shown. Such termination shall not be effective earlier than 30 days after the date of notice to the manufacturer of such termination. The Secretary shall provide, upon request, a manufacturer with a hearing concerning such a termination, and such hearing shall take place prior to the effective date of the termination with sufficient time for such effective date to be repealed if the Secretary determines appropriate.

"(ii) BY A MANUFACTURER.—A manufacturer may terminate an agreement under this section for any reason. Any such termination shall be effective, with respect to a plan year—

"(I) if the termination occurs before January 30 of a plan year, as of the day after the end of the plan year; and

"(II) if the termination occurs on or after January 30 of a plan year, as

of the day after the end of the succeeding plan year.

"(iii) EFFECTIVENESS OF TERMINATION.—Any termination under this subparagraph shall not affect discounts for applicable drugs of the manufacturer that are due under the agreement before the effective date of its termination.

"(iv) NOTICE TO THIRD PARTY.—The Secretary shall provide notice of such termination to a third party with a contract under subsection (d)(3) within not less than 30 days before the effective date of such termination.

"(c) DUTIES DESCRIBED AND SPECIAL RULE FOR SUPPLEMENTAL BENEFITS.—

"(1) DUTIES DESCRIBED.—The duties described in this subsection are the following:

"(A) ADMINISTRATION OF PROGRAM.—Administering the program, including—

"(i) the determination of the amount of the discounted price of an applicable drug of a manufacturer;

"(ii) except as provided in clause (iii), the establishment of procedures under which

discounted prices are provided to applicable beneficiaries at pharmacies or by mail order service at the point-of-sale of an applicable drug;

"(iii) in the case where, during the period beginning on July 1, 2010, and ending on December 31, 2011, it is not practicable to provide such discounted prices at the point-of-sale (as described in clause (ii)), the establishment of procedures to provide such discounted prices as soon as practicable after the point-of-sale;

"(iv) the establishment of procedures to ensure that, not later than the applicable number of calendar days after the dispensing of an applicable drug by a pharmacy or mail order service, the pharmacy or mail order service is reimbursed for an amount equal to the difference between—

"(I) the negotiated price of the applicable drug; and

"(II) the discounted price of the applicable drug;

"(v) the establishment of procedures to ensure that the discounted price for an ap-

plicable drug under this section is applied before any coverage or financial assistance under other health benefit plans or programs that provide coverage or financial assistance for the purchase or provision of prescription drug coverage on behalf of applicable beneficiaries as the Secretary may specify;

"(vi) the establishment of procedures to implement the special rule for supplemental benefits under paragraph (2); and

"(vii) providing a reasonable dispute resolution mechanism to resolve disagreements between manufacturers, applicable beneficiaries, and the third party with a contract under subsection (d)(3).

"(B) MONITORING COMPLIANCE.—

"(i) IN GENERAL.—The Secretary shall monitor compliance by a manufacturer with the terms of an agreement under this section.

"(ii) NOTIFICATION.—If a third party with a contract under subsection (d)(3) determines that the manufacturer is not in compliance with such agreement, the third

party shall notify the Secretary of such noncompliance for appropriate enforcement under subsection (e).

"(C) COLLECTION OF DATA FROM PRESCRIPTION DRUG PLANS AND MA–PD PLANS.—The Secretary may collect appropriate data from prescription drug plans and MA–PD plans in a timeframe that allows for discounted prices to be provided for applicable drugs under this section.

"(2) SPECIAL RULE FOR SUPPLEMENTAL BENEFITS.—For plan year 2010 and each subsequent plan year, in the case where an applicable beneficiary has supplemental benefits with respect to applicable drugs under the prescription drug plan or MA–PD plan that the applicable beneficiary is enrolled in, the applicable beneficiary shall not be provided a discounted price for an applicable drug under this section until after such supplemental benefits have been applied with respect to the applicable drug.

"(d) ADMINISTRATION.—

"(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall provide for the implementation of this section, including the performance of the duties described in subsection (c)(1).

"(2) LIMITATION.—

"(A) IN GENERAL.—Subject to subparagraph (B), in providing for such implementation, the Secretary shall not receive or distribute any funds of a manufacturer under the program.

"(B) EXCEPTION.—The limitation under subparagraph (A) shall not apply to the Secretary with respect to drugs dispensed during the period beginning on July 1, 2010, and ending on December 31, 2010, but only if the Secretary determines that the exception to such limitation under this subparagraph is necessary in order for the Secretary to begin implementation of this section and provide applicable beneficiaries timely access to discounted prices during such period.

"(3) CONTRACT WITH THIRD PARTIES.—The Secretary shall enter into a contract with 1 or more third parties to administer the requirements established by the Secretary in order to carry out this section. At a minimum, the contract with a third party under the preceding sentence shall require that the third party—

"(A) receive and transmit information between the Secretary, manufacturers, and other individuals or entities the Secretary determines appropriate;

"(B) receive, distribute, or facilitate the distribution of funds of manufacturers to appropriate individuals or entities in order to meet the obligations of manufacturers under agreements under this section;

"(C) provide adequate and timely information to manufacturers, consistent with the agreement with the manufacturer under this section, as necessary for the manufacturer to fulfill its obligations under this section; and

"(D) permit manufacturers to conduct periodic audits, directly or through contracts, of the data and information used by the third party to determine discounts for applicable drugs of the manufacturer under the program.

"(4) PERFORMANCE REQUIREMENTS.—The Secretary shall establish performance requirements for a third party with a contract under paragraph (3) and safeguards to protect the independence and integrity of the activities carried out by the third party under the program under this section.

"(5) IMPLEMENTATION.—The Secretary may implement the program under this section by program instruction or otherwise.

"(6) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the program under this section.

"(e) ENFORCEMENT.—

"(1) AUDITS.—Each manufacturer with an agreement in effect under this section shall be subject to periodic audit by the Secretary.

"(2) CIVIL MONEY PENALTY.—

"(A) IN GENERAL.—The Secretary shall impose a civil money penalty on a manufacturer that fails to provide applicable beneficiaries discounts for applicable drugs of the manufacturer in accordance with such agreement for each such failure in an amount the Secretary determines is commensurate with the sum of—

"(i) the amount that the manufacturer would have paid with respect to such discounts under the agreement, which will then be used to pay the discounts which the manufacturer had failed to provide; and

"(ii) 25 percent of such amount.

"(B) APPLICATION.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provi-

sions apply to a penalty or proceeding under section 1128A(a).

"(f) CLARIFICATION REGARDING AVAILABILITY OF OTHER COVERED PART D DRUGS.—Nothing in this section shall prevent an applicable beneficiary from purchasing a covered part D drug that is not an applicable drug (including a generic drug or a drug that is not on the formulary of the prescription drug plan or MA–PD plan that the applicable beneficiary is enrolled in).

"(g) DEFINITIONS.—In this section:

"(1) APPLICABLE BENEFICIARY.—The term 'applicable beneficiary' means an individual who, on the date of dispensing an applicable drug—

"(A) is enrolled in a prescription drug plan or an MA–PD plan;

"(B) is not enrolled in a qualified retiree prescription drug plan;

"(C) is not entitled to an income-related subsidy under section 1860D–14(a);

"(D) is not subject to a reduction in premium subsidy under section 1839(i); and

"(E) who—

"(i) has reached or exceeded the initial coverage limit under section 1860D–2(b)(3) during the year; and

"(ii) has not incurred costs for covered part D drugs in the year equal to the annual out-of-pocket threshold specified in section 1860D–2(b)(4)(B).

"(2) APPLICABLE DRUG.—The term 'applicable drug' means, with respect to an applicable beneficiary, a covered part D drug—

"(A) approved under a new drug application under section 505(b) of the Federal Food, Drug, and Cosmetic Act or, in the case of a biologic product, licensed under section 351 of the Public Health Service Act (other than a product licensed under subsection (k) of such section 351); and

"(B)(i) if the PDP sponsor of the prescription drug plan or the MA organization offering the MA–PD plan uses a formulary, which is on the formulary of the prescription drug plan or MA–PD plan that the applicable beneficiary is enrolled in;

"(ii) if the PDP sponsor of the prescription drug plan or the MA organization offering the MA–PD plan does not use a formulary, for which benefits are available under the prescrip-

tion drug plan or MA–PD plan that the applicable beneficiary is enrolled in; or

"(iii) is provided through an exception or appeal.

"(3) APPLICABLE NUMBER OF CALENDAR DAYS.—The term 'applicable number of calendar days' means—

"(A) with respect to claims for reimbursement submitted electronically, 14 days; and

"(B) with respect to claims for reimbursement submitted otherwise, 30 days.

"(4) DISCOUNTED PRICE.—

"(A) IN GENERAL.—The term 'discounted price' means 50 percent of the negotiated price of the applicable drug of a manufacturer.

"(B) CLARIFICATION.—Nothing in this section shall be construed as affecting the responsibility of an applicable beneficiary for payment of a dispensing fee for an applicable drug.

"(C) SPECIAL CASE FOR CERTAIN CLAIMS.—In the case where the entire amount of the negotiated price of an individual claim for an applicable drug with respect to an applicable beneficiary does not fall at or above the initial coverage limit under section 1860D–2(b)(3) and

below the annual out-of-pocket threshold specified in section 1860D–2(b)(4)(B) for the year, the manufacturer of the applicable drug shall provide the discounted price under this section on only the portion of the negotiated price of the applicable drug that falls at or above such initial coverage limit and below such annual out-of-pocket threshold.

"(5) MANUFACTURER.—The term 'manufacturer' means any entity which is engaged in the production, preparation, propagation, compounding, conversion, or processing of prescription drug products, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis. Such term does not include a wholesale distributor of drugs or a retail pharmacy licensed under State law.

"(6) NEGOTIATED PRICE.—The term 'negotiated price' has the meaning given such term in section 423.100 of title 42, Code of Federal Regulations (as in effect on the date of enactment of this section), except that such negotiated price shall not include any dispensing fee for the applicable drug.

"(7) QUALIFIED RETIREE PRESCRIPTION DRUG PLAN.—The term 'qualified retiree prescription drug plan' has the meaning given such term in section 1860D–22(a)(2).".

(c) INCLUSION IN INCURRED COSTS.—

(1) IN GENERAL.—Section 1860D–2(b)(4) of the Social Security Act (42 U.S.C. 1395w–102(b)(4)) is amended—

(A) in subparagraph (C), in the matter preceding clause (i), by striking "In applying" and inserting "Except as provided in subparagraph (E), in applying"; and

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

"(E) INCLUSION OF COSTS OF APPLICABLE DRUGS UNDER MEDICARE COVERAGE GAP DISCOUNT PROGRAM.—In applying subparagraph (A), incurred costs shall include the negotiated price (as defined in paragraph (6) of section 1860D–14A(g)) of an applicable drug (as defined in paragraph (2) of such section) of a manufacturer that is furnished to an applicable beneficiary (as defined in paragraph (1) of such section) under the Medicare coverage gap discount program under section 1860D–14A, regardless of

whether part of such costs were paid by a manufacturer under such program.".

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to costs incurred on or after July 1, 2010.

(d) CONFORMING AMENDMENT PERMITTING PRESCRIPTION DRUG DISCOUNTS.—

(1) IN GENERAL.—Section 1128B(b)(3) of the Social Security Act (42 U.S.C. 1320a–7b(b)(3)) is amended—

(A) by striking "and" at the end of subparagraph (G);

(B) in the subparagraph (H) added by section 237(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2213)—

(i) by moving such subparagraph 2 ems to the left; and

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

(C) in the subparagraph (H) added by section 431(a) of such Act (117 Stat. 2287)—

(i) by redesignating such subparagraph as subparagraph (I);

(ii) by moving such subparagraph 2 ems to the left; and

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

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

"(J) a discount in the price of an applicable drug (as defined in paragraph (2) of section 1860D–14A(g)) of a manufacturer that is furnished to an applicable beneficiary (as defined in paragraph (1) of such section) under the Medicare coverage gap discount program under section 1860D–14A.".

(2) CONFORMING AMENDMENT TO DEFINITION OF BEST PRICE UNDER MEDICAID.—Section 1927(c)(1)(C)(i)(VI) of the Social Security Act (42 U.S.C. 1396r–8(c)(1)(C)(i)(VI)) is amended by inserting ", or any discounts provided by manufacturers under the Medicare coverage gap discount program under section 1860D–14A" before the period at the end.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to drugs dispensed on or after July 1, 2010.

SEC. 3302. IMPROVEMENT IN DETERMINATION OF MEDICARE PART D LOW-INCOME BENCHMARK PREMIUM.

(a) IN GENERAL.—Section 1860D–14(b)(2)(B)(iii) of the Social Security Act (42 U.S.C. 1395w–114(b)(2)(B)(iii)) is amended by inserting ", determined without regard to any reduction in such premium as a result of any beneficiary rebate under section 1854(b)(1)(C) or bonus payment under section 1853(n)" before the period at the end.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to premiums for months beginning on or after January 1, 2011.

SEC. 3303. VOLUNTARY DE MINIMIS POLICY FOR SUBSIDY ELIGIBLE INDIVIDUALS UNDER PRESCRIPTION DRUG PLANS AND MA–PD PLANS.

(a) IN GENERAL.—Section 1860D–14(a) of the Social Security Act (42 U.S.C. 1395w–114(a)) is amended by adding at the end the following new paragraph:

"(5) WAIVER OF DE MINIMIS PREMIUMS.—The Secretary shall, under procedures established by the Secretary, permit a prescription drug plan or an MA–PD plan to waive the monthly beneficiary premium for a subsidy eligible individual if the amount of such premium is de minimis. If such premium is waived under the plan, the Secretary shall not reas-

sign subsidy eligible individuals enrolled in the plan to other plans based on the fact that the monthly beneficiary premium under the plan was greater than the low-income benchmark premium amount.".

(b) AUTHORIZING THE SECRETARY TO AUTO-ENROLL SUBSIDY ELIGIBLE INDIVIDUALS IN PLANS THAT WAIVE DE MINIMIS PREMIUMS.—Section 1860D–1(b)(1) of the Social Security Act (42 U.S.C. 1395w–101(b)(1)) is amended—

(1) in subparagraph (C), by inserting "except as provided in subparagraph (D)," after "shall include,"

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

"(D) SPECIAL RULE FOR PLANS THAT WAIVE DE MINIMIS PREMIUMS.—The process established under subparagraph (A) may include, in the case of a part D eligible individual who is a subsidy eligible individual (as defined in section 1860D–14(a)(3)) who has failed to enroll in a prescription drug plan or an MA–PD plan, for the enrollment in a prescription drug plan or MA–PD plan that has waived the monthly beneficiary premium for such subsidy eligible individual under section 1860D–14(a)(5). If there is more than one such plan available, the Secretary

shall enroll such an individual under the preceding sentence on a random basis among all such plans in the PDP region. Nothing in the previous sentence shall prevent such an individual from declining or changing such enrollment.".

(c) EFFECTIVE DATE.—The amendments made by this subsection shall apply to premiums for months, and enrollments for plan years, beginning on or after January 1, 2011.

SEC. 3304. SPECIAL RULE FOR WIDOWS AND WIDOWERS REGARDING ELIGIBILITY FOR LOW-INCOME ASSISTANCE.

(a) IN GENERAL.—Section 1860D–14(a)(3)(B) of the Social Security Act (42 U.S.C. 1395w–114(a)(3)(B)) is amended by adding at the end the following new clause:

"(vi) SPECIAL RULE FOR WIDOWS AND WIDOWERS.—Notwithstanding the preceding provisions of this subparagraph, in the case of an individual whose spouse dies during the effective period for a determination or redetermination that has been made under this subparagraph, such effective period shall be extended through the date that is 1 year after the date on which the determina-

tion or redetermination would (but for the application of this clause) otherwise cease to be effective.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on January 1, 2011.

SEC. 3305. IMPROVED INFORMATION FOR SUBSIDY ELIGIBLE INDIVIDUALS REASSIGNED TO PRESCRIPTION DRUG PLANS AND MA–PD PLANS.

Section 1860D–14 of the Social Security Act (42 U.S.C. 1395w–114) is amended—

(1) by redesignating subsection (d) as subsection (e); and

(2) by inserting after subsection (c) the following new subsection:

''(d) FACILITATION OF REASSIGNMENTS.—Beginning not later than January 1, 2011, the Secretary shall, in the case of a subsidy eligible individual who is enrolled in one prescription drug plan and is subsequently reassigned by the Secretary to a new prescription drug plan, provide the individual, within 30 days of such reassignment, with—

''(1) information on formulary differences between the individual's former plan and the plan to which the individual is reassigned with respect to the individual's drug regimens; and

"(2) a description of the individual's right to request a coverage determination, exception, or reconsideration under section 1860D–4(g), bring an appeal under section 1860D–4(h), or resolve a grievance under section 1860D–4(f).".

SEC. 3306. FUNDING OUTREACH AND ASSISTANCE FOR LOW-INCOME PROGRAMS.

(a) ADDITIONAL FUNDING FOR STATE HEALTH INSURANCE PROGRAMS.—Subsection (a)(1)(B) of section 119 of the Medicare Improvements for Patients and Providers Act of 2008 (42 U.S.C. 1395b–3 note) is amended by striking "(42 U.S.C. 1395w–23(f))" and all that follows through the period at the end and inserting "(42 U.S.C. 1395w–23(f)), to the Centers for Medicare & Medicaid Services Program Management Account—

"(i) for fiscal year 2009, of $7,500,000; and

"(ii) for the period of fiscal years 2010 through 2012, of $15,000,000.

Amounts appropriated under this subparagraph shall remain available until expended.".

(b) ADDITIONAL FUNDING FOR AREA AGENCIES ON AGING.—Subsection (b)(1)(B) of such section 119 is amended by striking "(42 U.S.C. 1395w–23(f))" and all that fol-

lows through the period at the end and inserting "(42 U.S.C. 1395w–23(f)), to the Administration on Aging—

"(i) for fiscal year 2009, of $7,500,000; and

"(ii) for the period of fiscal years 2010 through 2012, of $15,000,000.

Amounts appropriated under this subparagraph shall remain available until expended.".

(c) ADDITIONAL FUNDING FOR AGING AND DISABILITY RESOURCE CENTERS.—Subsection (c)(1)(B) of such section 119 is amended by striking "(42 U.S.C. 1395w–23(f))" and all that follows through the period at the end and inserting "(42 U.S.C. 1395w–23(f)), to the Administration on Aging—

"(i) for fiscal year 2009, of $5,000,000; and

"(ii) for the period of fiscal years 2010 through 2012, of $10,000,000.

Amounts appropriated under this subparagraph shall remain available until expended.".

(d) ADDITIONAL FUNDING FOR CONTRACT WITH THE NATIONAL CENTER FOR BENEFITS AND OUTREACH ENROLLMENT.—Subsection (d)(2) of such section 119 is amended by striking "(42 U.S.C. 1395w–23(f))" and all that follows through the period at the end and inserting

"(42 U.S.C. 1395w–23(f)), to the Administration on Aging—

"(i) for fiscal year 2009, of $5,000,000; and

"(ii) for the period of fiscal years 2010 through 2012, of $5,000,000.

Amounts appropriated under this subparagraph shall remain available until expended.".

(e) SECRETARIAL AUTHORITY TO ENLIST SUPPORT IN CONDUCTING CERTAIN OUTREACH ACTIVITIES.—Such section 119 is amended by adding at the end the following new subsection:

"(g) SECRETARIAL AUTHORITY TO ENLIST SUPPORT IN CONDUCTING CERTAIN OUTREACH ACTIVITIES.—The Secretary may request that an entity awarded a grant under this section support the conduct of outreach activities aimed at preventing disease and promoting wellness. Notwithstanding any other provision of this section, an entity may use a grant awarded under this subsection to support the conduct of activities described in the preceding sentence.".

SEC. 3307. IMPROVING FORMULARY REQUIREMENTS FOR PRESCRIPTION DRUG PLANS AND MA–PD PLANS WITH RESPECT TO CERTAIN CATEGORIES OR CLASSES OF DRUGS.

(a) IMPROVING FORMULARY REQUIREMENTS.—Section 1860D–4(b)(3)(G) of the Social Security Act is amended to read as follows:

"(G) REQUIRED INCLUSION OF DRUGS IN CERTAIN CATEGORIES AND CLASSES.—

"(i) FORMULARY REQUIREMENTS.—

"(I) IN GENERAL.—Subject to subclause (II), a PDP sponsor offering a prescription drug plan shall be required to include all covered part D drugs in the categories and classes identified by the Secretary under clause (ii)(I).

"(II) EXCEPTIONS.—The Secretary may establish exceptions that permit a PDP sponsor offering a prescription drug plan to exclude from its formulary a particular covered part D drug in a category or class that is otherwise required to be included in the formulary under subclause (I) (or to otherwise limit access to such a drug,

including through prior authorization or utilization management).

"(ii) IDENTIFICATION OF DRUGS IN CERTAIN CATEGORIES AND CLASSES.—

"(I) IN GENERAL.—Subject to clause (iv), the Secretary shall identify, as appropriate, categories and classes of drugs for which the Secretary determines are of clinical concern.

"(II) CRITERIA.—The Secretary shall use criteria established by the Secretary in making any determination under subclause (I).

"(iii) IMPLEMENTATION.—The Secretary shall establish the criteria under clause (ii)(II) and any exceptions under clause (i)(II) through the promulgation of a regulation which includes a public notice and comment period.

"(iv) REQUIREMENT FOR CERTAIN CATEGORIES AND CLASSES UNTIL CRITERIA ESTABLISHED.—Until such time as the Secretary establishes the criteria under clause (ii)(II) the following categories and classes

of drugs shall be identified under clause (ii)(I):

"(I) Anticonvulsants.

"(II) Antidepressants.

"(III) Antineoplastics.

"(IV) Antipsychotics.

"(V) Antiretrovirals.

"(VI) Immunosuppressants for the treatment of transplant rejection.".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to plan year 2011 and subsequent plan years.

SEC. 3308. REDUCING PART D PREMIUM SUBSIDY FOR HIGH-INCOME BENEFICIARIES.

(a) INCOME-RELATED INCREASE IN PART D PREMIUM.—

(1) IN GENERAL.—Section 1860D–13(a) of the Social Security Act (42 U.S.C. 1395w–113(a)) is amended by adding at the end the following new paragraph:

"(7) INCREASE IN BASE BENEFICIARY PREMIUM BASED ON INCOME.—

"(A) IN GENERAL.—In the case of an individual whose modified adjusted gross income exceeds the threshold amount applicable under

paragraph (2) of section 1839(i) (including application of paragraph (5) of such section) for the calendar year, the monthly amount of the beneficiary premium applicable under this section for a month after December 2010 shall be increased by the monthly adjustment amount specified in subparagraph (B).

"(B) MONTHLY ADJUSTMENT AMOUNT.—The monthly adjustment amount specified in this subparagraph for an individual for a month in a year is equal to the product of—

"(i) the quotient obtained by dividing—

"(I) the applicable percentage determined under paragraph (3)(C) of section 1839(i) (including application of paragraph (5) of such section) for the individual for the calendar year reduced by 25.5 percent; by

"(II) 25.5 percent; and

"(ii) the base beneficiary premium (as computed under paragraph (2)).

"(C) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this paragraph, the term 'modified adjusted gross income' has the

meaning given such term in subparagraph (A) of section 1839(i)(4), determined for the taxable year applicable under subparagraphs (B) and (C) of such section.

"(D) DETERMINATION BY COMMISSIONER OF SOCIAL SECURITY.—The Commissioner of Social Security shall make any determination necessary to carry out the income-related increase in the base beneficiary premium under this paragraph.

"(E) PROCEDURES TO ASSURE CORRECT INCOME-RELATED INCREASE IN BASE BENEFICIARY PREMIUM.—

"(i) DISCLOSURE OF BASE BENEFICIARY PREMIUM.—Not later than September 15 of each year beginning with 2010, the Secretary shall disclose to the Commissioner of Social Security the amount of the base beneficiary premium (as computed under paragraph (2)) for the purpose of carrying out the income-related increase in the base beneficiary premium under this paragraph with respect to the following year.

"(ii) ADDITIONAL DISCLOSURE.—Not later than October 15 of each year begin-

ning with 2010, the Secretary shall disclose to the Commissioner of Social Security the following information for the purpose of carrying out the income-related increase in the base beneficiary premium under this paragraph with respect to the following year:

"(I) The modified adjusted gross income threshold applicable under paragraph (2) of section 1839(i) (including application of paragraph (5) of such section).

"(II) The applicable percentage determined under paragraph (3)(C) of section 1839(i) (including application of paragraph (5) of such section).

"(III) The monthly adjustment amount specified in subparagraph (B).

"(IV) Any other information the Commissioner of Social Security determines necessary to carry out the income-related increase in the base beneficiary premium under this paragraph.

"(F) RULE OF CONSTRUCTION.—The formula used to determine the monthly adjustment

amount specified under subparagraph (B) shall only be used for the purpose of determining such monthly adjustment amount under such subparagraph.".

(2) COLLECTION OF MONTHLY ADJUSTMENT AMOUNT.—Section 1860D–13(c) of the Social Security Act (42 U.S.C. 1395w–113(c)) is amended—

(A) in paragraph (1), by striking "(2) and (3)" and inserting "(2), (3), and (4)"; and

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

"(4) COLLECTION OF MONTHLY ADJUSTMENT AMOUNT.—

"(A) IN GENERAL.—Notwithstanding any provision of this subsection or section 1854(d)(2), subject to subparagraph (B), the amount of the income-related increase in the base beneficiary premium for an individual for a month (as determined under subsection (a)(7)) shall be paid through withholding from benefit payments in the manner provided under section 1840.

"(B) AGREEMENTS.—In the case where the monthly benefit payments of an individual that are withheld under subparagraph (A) are insufficient to pay the amount described in such sub-

paragraph, the Commissioner of Social Security shall enter into agreements with the Secretary, the Director of the Office of Personnel Management, and the Railroad Retirement Board as necessary in order to allow other agencies to collect the amount described in subparagraph (A) that was not withheld under such subparagraph.".

(b) CONFORMING AMENDMENTS.—

(1) MEDICARE.—Section 1860D–13(a)(1) of the Social Security Act (42 U.S.C. 1395w–113(a)(1)) is amended—

(A) by redesignating subparagraph (F) as subparagraph (G);

(B) in subparagraph (G), as redesignated by subparagraph (A), by striking "(D) and (E)" and inserting "(D), (E), and (F)"; and

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

"(F) INCREASE BASED ON INCOME.—The monthly beneficiary premium shall be increased pursuant to paragraph (7).".

(2) INTERNAL REVENUE CODE.—Section 6103(l)(20) of the Internal Revenue Code of 1986 (relating to disclosure of return information to carry out

Medicare part B premium subsidy adjustment) is amended—

(A) in the heading, by inserting "AND PART D BASE BENEFICIARY PREMIUM INCREASE" after "PART B PREMIUM SUBSIDY ADJUSTMENT";

(B) in subparagraph (A)—

(i) in the matter preceding clause (i), by inserting "or increase under section 1860D–13(a)(7)" after "1839(i)"; and

(ii) in clause (vii), by inserting after "subsection (i) of such section" the following: "or increase under section 1860D–13(a)(7) of such Act"; and

(C) in subparagraph (B)—

(i) by striking "Return information" and inserting the following:

"(i) IN GENERAL.—Return information";

(ii) by inserting "or increase under such section 1860D–13(a)(7)" before the period at the end;

(iii) as amended by clause (i), by inserting "or for the purpose of resolving taxpayer appeals with respect to any such pre-

mium 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 in-

serting "or, effective on a date specified by the Secretary (but in no case earlier than January 1, 2012), who would be such an institutionalized individual or couple, if the full-benefit dual eligible individual were not receiving services under a home and community-based waiver authorized for a State under section 1115 or subsection (c) or (d) of section 1915 or under a State plan amendment under subsection (i) of such section or services provided through enrollment in a medicaid managed care organization with a contract under section 1903(m) or under section 1932" after "1902(q)(1)(B))".

SEC. 3310. REDUCING WASTEFUL DISPENSING OF OUTPATIENT PRESCRIPTION DRUGS IN LONG-TERM CARE FACILITIES UNDER PRESCRIPTION DRUG PLANS AND MA–PD PLANS.

(a) IN GENERAL.—Section 1860D–4(c) of the Social Security Act (42 U.S.C. 1395w–104(c)) is amended by adding at the end the following new paragraph:

"(3) REDUCING WASTEFUL DISPENSING OF OUTPATIENT PRESCRIPTION DRUGS IN LONG-TERM CARE FACILITIES.—The Secretary shall require PDP sponsors of prescription drug plans to utilize specific, uniform dispensing techniques, as determined by the Secretary, in consultation with relevant stakeholders (including representatives of nursing facilities, residents

of nursing facilities, pharmacists, the pharmacy industry (including retail and long-term care pharmacy), prescription drug plans, MA–PD plans, and any other stakeholders the Secretary determines appropriate), such as weekly, daily, or automated dose dispensing, when dispensing covered part D drugs to enrollees who reside in a long-term care facility in order to reduce waste associated with 30-day fills.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to plan years beginning on or after January 1, 2012.

SEC. 3311. IMPROVED MEDICARE PRESCRIPTION DRUG PLAN AND MA–PD PLAN COMPLAINT SYSTEM.

(a) IN GENERAL.—The Secretary shall develop and maintain a complaint system, that is widely known and easy to use, to collect and maintain information on MA–PD plan and prescription drug plan complaints that are received (including by telephone, letter, e-mail, or any other means) by the Secretary (including by a regional office of the Department of Health and Human Services, the Medicare Beneficiary Ombudsman, a subcontractor, a carrier, a fiscal intermediary, and a Medicare administrative contractor under section 1874A of the Social Security Act (42 U.S.C. 1395kk)) through the date on which the complaint is resolved. The system shall be able to report and initiate

appropriate interventions and monitoring based on substantial complaints and to guide quality improvement.

(b) MODEL ELECTRONIC COMPLAINT FORM.—The Secretary shall develop a model electronic complaint form to be used for reporting plan complaints under the system. Such form shall be prominently displayed on the front page of the Medicare.gov Internet website and on the Internet website of the Medicare Beneficiary Ombudsman.

(c) ANNUAL REPORTS BY THE SECRETARY.—The Secretary shall submit to Congress annual reports on the system. Such reports shall include an analysis of the number and types of complaints reported in the system, geographic variations in such complaints, the timeliness of agency or plan responses to such complaints, and the resolution of such complaints.

(d) DEFINITIONS.—In this section:

(1) MA–PD PLAN.—The term "MA–PD plan" has the meaning given such term in section 1860D–41(a)(9) of such Act (42 U.S.C. 1395w–151(a)(9)).

(2) PRESCRIPTION DRUG PLAN.—The term "prescription drug plan" has the meaning given such term in section 1860D–41(a)(14) of such Act (42 U.S.C. 1395w–151(a)(14)).

(3) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

(4) SYSTEM.—The term "system" means the plan complaint system developed and maintained under subsection (a).

SEC. 3312. UNIFORM EXCEPTIONS AND APPEALS PROCESS FOR PRESCRIPTION DRUG PLANS AND MA–PD PLANS.

(a) IN GENERAL.—Section 1860D–4(b)(3) of the Social Security Act (42 U.S.C. 1395w–104(b)(3)) is amended by adding at the end the following new subparagraph:

"(H) USE OF SINGLE, UNIFORM EXCEPTIONS AND APPEALS PROCESS.—Notwithstanding any other provision of this part, each PDP sponsor of a prescription drug plan shall—

"(i) use a single, uniform exceptions and appeals process (including, to the extent the Secretary determines feasible, a single, uniform model form for use under such process) with respect to the determination of prescription drug coverage for an enrollee under the plan; and

"(ii) provide instant access to such process by enrollees through a toll-free telephone number and an Internet website.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to exceptions and appeals on or after January 1, 2012.

SEC. 3313. OFFICE OF THE INSPECTOR GENERAL STUDIES AND REPORTS.

(a) STUDY AND ANNUAL REPORT ON PART D FORMULARIES' INCLUSION OF DRUGS COMMONLY USED BY DUAL ELIGIBLES.—

(1) STUDY.—The Inspector General of the Department of Health and Human Services shall conduct a study of the extent to which formularies used by prescription drug plans and MA–PD plans under part D include drugs commonly used by full-benefit dual eligible individuals (as defined in section 1935(c)(6) of the Social Security Act (42 U.S.C. 1396u–5(c)(6))).

(2) ANNUAL REPORTS.—Not later than July 1 of each year (beginning with 2011), the Inspector General shall submit to Congress a report on the study conducted under paragraph (1), together with such recommendations as the Inspector General determines appropriate.

(b) STUDY AND REPORT ON PRESCRIPTION DRUG PRICES UNDER MEDICARE PART D AND MEDICAID.—

(1) STUDY.—

(A) IN GENERAL.—The Inspector General of the Department of Health and Human Services shall conduct a study on prices for covered part D drugs under the Medicare prescription drug program under part D of title XVIII of the Social Security Act and for covered outpatient drugs under title XIX. Such study shall include the following:

(i) A comparison, with respect to the 200 most frequently dispensed covered part D drugs under such program and covered outpatient drugs under such title (as determined by the Inspector General based on volume and expenditures), of—

(I) the prices paid for covered part D drugs by PDP sponsors of prescription drug plans and Medicare Advantage organizations offering MA–PD plans; and

(II) the prices paid for covered outpatient drugs by a State plan under title XIX.

(ii) An assessment of—

(I) the financial impact of any discrepancies in such prices on the Federal Government; and

(II) the financial impact of any such discrepancies on enrollees under part D or individuals eligible for medical assistance under a State plan under title XIX.

(B) PRICE.—For purposes of subparagraph (A), the price of a covered part D drug or a covered outpatient drug shall include any rebate or discount under such program or such title, respectively, including any negotiated price concession described in section 1860D–2(d)(1)(B) of the Social Security Act (42 U.S.C. 1395w–102(d)(1)(B)) or rebate under an agreement under section 1927 of the Social Security Act (42 U.S.C. 1396r–8).

(C) AUTHORITY TO COLLECT ANY NECESSARY INFORMATION.—Notwithstanding any other provision of law, the Inspector General of the Department of Health and Human Services shall be able to collect any information related to the prices of covered part D drugs under such program and covered outpatient drugs under

such title XIX necessary to carry out the comparison under subparagraph (A).

(2) REPORT.—

(A) IN GENERAL.—Not later than October 1, 2011, subject to subparagraph (B), the Inspector General shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Inspector General determines appropriate.

(B) LIMITATION ON INFORMATION CONTAINED IN REPORT.—The report submitted under subparagraph (A) shall not include any information that the Inspector General determines is proprietary or is likely to negatively impact the ability of a PDP sponsor or a State plan under title XIX to negotiate prices for covered part D drugs or covered outpatient drugs, respectively.

(3) DEFINITIONS.—In this section:

(A) COVERED PART D DRUG.—The term "covered part D drug" has the meaning given such term in section 1860D–2(e) of the Social Security Act (42 U.S.C. 1395w–102(e)).

(B) COVERED OUTPATIENT DRUG.—The term "covered outpatient drug" has the meaning

given such term in section 1927(k) of such Act (42 U.S.C. 1396r(k)).

(C) MA–PD PLAN.—The term "MA–PD plan" has the meaning given such term in section 1860D–41(a)(9) of such Act (42 U.S.C. 1395w–151(a)(9)).

(D) MEDICARE ADVANTAGE ORGANIZATION.—The term "Medicare Advantage organization" has the meaning given such term in section 1859(a)(1) of such Act (42 U.S.C. 1395w–28)(a)(1)).

(E) PDP SPONSOR.—The term "PDP sponsor" has the meaning given such term in section 1860D–41(a)(13) of such Act (42 U.S.C. 1395w–151(a)(13)).

(F) PRESCRIPTION DRUG PLAN.—The term "prescription drug plan" has the meaning given such term in section 1860D–41(a)(14) of such Act (42 U.S.C. 1395w–151(a)(14)).

SEC. 3314. INCLUDING COSTS INCURRED BY AIDS DRUG ASSISTANCE PROGRAMS AND INDIAN HEALTH SERVICE IN PROVIDING PRESCRIPTION DRUGS TOWARD THE ANNUAL OUT-OF-POCKET THRESHOLD UNDER PART D.

(a) IN GENERAL.—Section 1860D–2(b)(4)(C) of the Social Security Act (42 U.S.C. 1395w–102(b)(4)(C)) is amended—

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

(2) in clause (ii)—

(A) by striking "such costs shall be treated as incurred only if" and inserting "subject to clause (iii), such costs shall be treated as incurred only if";

(B) by striking ", under section 1860D–14, or under a State Pharmaceutical Assistance Program"; and

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

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

"(iii) such costs shall be treated as incurred and shall not be considered to be reimbursed under clause (ii) if such costs are borne or paid—

"(I) under section 1860D–14;

"(II) under a State Pharmaceutical Assistance Program;

"(III) by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act); or

"(IV) under an AIDS Drug Assistance Program under part B of title XXVI of the Public Health Service Act.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to costs incurred on or after January 1, 2011.

SEC. 3315. IMMEDIATE REDUCTION IN COVERAGE GAP IN 2010.

Section 1860D–2(b) of the Social Security Act (42 U.S.C. 1395w–102(b)) is amended—

(1) in paragraph (3)(A), by striking "paragraph (4)" and inserting "paragraphs (4) and (7)"; and

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

"(7) INCREASE IN INITIAL COVERAGE LIMIT IN 2010.—

"(A) IN GENERAL.—For the plan year beginning on January 1, 2010, the initial coverage limit described in paragraph (3)(B) otherwise applicable shall be increased by $500.

"(B) APPLICATION.—In applying subparagraph (A)—

"(i) except as otherwise provided in this subparagraph, there shall be no change in the premiums, bids, or any other parameters under this part or part C;

"(ii) costs that would be treated as incurred costs for purposes of applying paragraph (4) but for the application of subparagraph (A) shall continue to be treated as incurred costs;

"(iii) the Secretary shall establish procedures, which may include a reconciliation process, to fully reimburse PDP sponsors with respect to prescription drug plans and MA organizations with respect to MA–PD plans for the reduction in beneficiary cost sharing associated with the application of subparagraph (A);

"(iv) the Secretary shall develop an estimate of the additional increased costs at-

tributable to the application of this paragraph for increased drug utilization and financing and administrative costs and shall use such estimate to adjust payments to PDP sponsors with respect to prescription drug plans under this part and MA organizations with respect to MA–PD plans under part C; and

"(v) the Secretary shall establish procedures for retroactive reimbursement of part D eligible individuals who are covered under such a plan for costs which are incurred before the date of initial implementation of subparagraph (A) and which would be reimbursed under such a plan if such implementation occurred as of January 1, 2010.

"(C) NO EFFECT ON SUBSEQUENT YEARS.—The increase under subparagraph (A) shall only apply with respect to the plan year beginning on January 1, 2010, and the initial coverage limit for plan years beginning on or after January 1, 2011, shall be determined as if subparagraph (A) had never applied.".

Subtitle E—Ensuring Medicare Sustainability

SEC. 3401. REVISION OF CERTAIN MARKET BASKET UPDATES AND INCORPORATION OF PRODUCTIVITY IMPROVEMENTS INTO MARKET BASKET UPDATES THAT DO NOT ALREADY INCORPORATE SUCH IMPROVEMENTS.

(a) INPATIENT ACUTE HOSPITALS.—Section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)), as amended by section 3001(a)(3), is further amended—

(1) in clause (i)(XX), by striking "clause (viii)" and inserting "clauses (viii), (ix), (xi), and (xii)";

(2) in the first sentence of clause (viii), by inserting "of such applicable percentage increase (determined without regard to clause (ix), (xi), or (xii))" after "one-quarter";

(3) in the first sentence of clause (ix)(I), by inserting "(determined without regard to clause (viii), (xi), or (xii))" after "clause (i)" the second time it appears; and

(4) by adding at the end the following new clauses:

"(xi)(I) For 2012 and each subsequent fiscal year, after determining the applicable percentage increase de-

scribed in clause (i) and after application of clauses (viii) and (ix), such percentage increase shall be reduced by the productivity adjustment described in subclause (II).

"(II) The productivity adjustment described in this subclause, with respect to a percentage, factor, or update for a fiscal year, year, cost reporting period, or other annual period, is a productivity adjustment equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, year, cost reporting period, or other annual period).

"(III) The application of subclause (I) may result in the applicable percentage increase described in clause (i) being less than 0.0 for a fiscal year, and may result in payment rates under this section for a fiscal year being less than such payment rates for the preceding fiscal year.

"(xii) After determining the applicable percentage increase described in clause (i), and after application of clauses (viii), (ix), and (xi), the Secretary shall reduce such applicable percentage increase—

"(I) for each of fiscal years 2010 and 2011, by 0.25 percentage point; and

"(II) subject to clause (xiii), for each of fiscal years 2012 through 2019, by 0.2 percentage point.

The application of this clause may result in the applicable percentage increase described in clause (i) being less than 0.0 for a fiscal year, and may result in payment rates under this section for a fiscal year being less than such payment rates for the preceding fiscal year.

"(xiii) Clause (xii) shall be applied with respect to any of fiscal years 2014 through 2019 by substituting '0.0 percentage points' for '0.2 percentage point', if for such fiscal year—

"(I) the excess (if any) of—

"(aa) the total percentage of the non-elderly insured population for the preceding fiscal year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

"(bb) the total percentage of the non-elderly insured population for such preceding fiscal year (as estimated by the Secretary); exceeds

"(II) 5 percentage points.".

(b) SKILLED NURSING FACILITIES.—Section 1888(e)(5)(B) of the Social Security Act (42 U.S.C. 1395yy(e)(5)(B)) is amended—

(1) by striking "PERCENTAGE.—The term" and inserting "PERCENTAGE.—

"(i) IN GENERAL.—Subject to clause (ii), the term"; and

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

"(ii) ADJUSTMENT.—For fiscal year 2012 and each subsequent fiscal year, after determining the percentage described in clause (i), the Secretary shall reduce such percentage by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II). The application of the preceding sentence may result in such percentage being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.".

(c) LONG-TERM CARE HOSPITALS.—Section 1886(m) of the Social Security Act (42 U.S.C. 1395ww(m)) is amended by adding at the end the following new paragraphs:

"(3) IMPLEMENTATION FOR RATE YEAR 2010 AND SUBSEQUENT YEARS.—

"(A) IN GENERAL.—In implementing the system described in paragraph (1) for rate year 2010 and each subsequent rate year, any annual update to a standard Federal rate for discharges for the hospital during the rate year, shall be reduced—

"(i) for rate year 2012 and each subsequent rate year, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

"(ii) for each of rate years 2010 through 2019, by the other adjustment described in paragraph (4).

"(B) SPECIAL RULE.—The application of this paragraph may result in such annual update being less than 0.0 for a rate year, and may result in payment rates under the system described in paragraph (1) for a rate year being less than such payment rates for the preceding rate year.

"(4) OTHER ADJUSTMENT.—

"(A) IN GENERAL.—For purposes of paragraph (3)(A)(ii), the other adjustment described in this paragraph is—

"(i) for each of rate years 2010 and 2011, 0.25 percentage point; and

"(ii) subject to subparagraph (B), for each of rate years 2012 through 2019, 0.2 percentage point.

"(B) REDUCTION OF OTHER ADJUSTMENT.—Subparagraph (A)(ii) shall be applied with respect to any of rate years 2014 through 2019 by substituting '0.0 percentage points' for '0.2 percentage point', if for such rate year—

"(i) the excess (if any) of—

"(I) the total percentage of the non-elderly insured population for the preceding rate year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

"(II) the total percentage of the non-elderly insured population for such preceding rate year (as estimated by the Secretary); exceeds

"(ii) 5 percentage points.".

(d) INPATIENT REHABILITATION FACILITIES.—Section 1886(j)(3) of the Social Security Act (42 U.S.C. 1395ww(j)(3)) is amended—

(1) in subparagraph (C)—

(A) by striking "FACTOR.—For purposes" and inserting "FACTOR.—

"(i) IN GENERAL.—For purposes";

(B) by inserting "subject to clause (ii)" before the period at the end of the first sentence of clause (i), as added by paragraph (1); and

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

"(ii) PRODUCTIVITY AND OTHER ADJUSTMENT.—After establishing the increase factor described in clause (i) for a fiscal year, the Secretary shall reduce such increase factor—

"(I) for fiscal year 2012 and each subsequent fiscal year, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

"(II) for each of fiscal years 2010 through 2019, by the other adjustment described in subparagraph (D).

The application of this clause may result in the increase factor under this subparagraph being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.''; and

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

''(D) OTHER ADJUSTMENT.—

''(i) IN GENERAL.—For purposes of subparagraph (C)(ii)(II), the other adjustment described in this subparagraph is—

''(I) for each of fiscal years 2010 and 2011, 0.25 percentage point; and

''(II) subject to clause (ii), for each of fiscal years 2012 through 2019, 0.2 percentage point.

''(ii) REDUCTION OF OTHER ADJUSTMENT.—Clause (i)(II) shall be applied with respect to any of fiscal years 2014 through 2019 by substituting '0.0 percentage points' for '0.2 percentage point', if for such fiscal year—

''(I) the excess (if any) of—

"(aa) the total percentage of the non-elderly insured population for the preceding fiscal year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

"(bb) the total percentage of the non-elderly insured population for such preceding fiscal year (as estimated by the Secretary); exceeds

"(II) 5 percentage points.".

(e) HOME HEALTH AGENCIES.—Section 1895(b)(3)(B) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(B)) is amended—

(1) in clause (ii)(V), by striking "clause (v)" and inserting "clauses (v) and (vi)"; and

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

"(vi) ADJUSTMENTS.—After determining the home health market basket percentage increase under clause (iii), and after application of clause (v), the Secretary shall reduce such percentage—

"(I) for 2015 and each subsequent year, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

"(II) for each of 2011 and 2012, by 1 percentage point.

The application of this clause may result in the home health market basket percentage increase under clause (iii) being less than 0.0 for a year, and may result in payment rates under the system under this subsection for a year being less than such payment rates for the preceding year.".

(f) PSYCHIATRIC HOSPITALS.—Section 1886 of the Social Security Act, as amended by sections 3001, 3008, 3025, and 3133, is amended by adding at the end the following new subsection:

"(s) PROSPECTIVE PAYMENT FOR PSYCHIATRIC HOSPITALS.—

"(1) REFERENCE TO ESTABLISHMENT AND IMPLEMENTATION OF SYSTEM.—For provisions related to the establishment and implementation of a prospective payment system for payments under this title for inpatient hospital services furnished by psychiatric hospitals (as described in clause (i) of subsection (d)(1)(B)) and psychiatric units (as described in the matter following clause (v) of such subsection), see section 124 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999.

"(2) IMPLEMENTATION FOR RATE YEAR BEGINNING IN 2010 AND SUBSEQUENT RATE YEARS.—

"(A) IN GENERAL.—In implementing the system described in paragraph (1) for the rate year beginning in 2010 and any subsequent rate year, any update to a base rate for days during the rate year for a psychiatric hospital or unit, respectively, shall be reduced—

"(i) for the rate year beginning in 2012 and each subsequent rate year, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

"(ii) for each of the rate years beginning in 2010 through 2019, by the other adjustment described in paragraph (3).

"(B) SPECIAL RULE.—The application of this paragraph may result in such update being less than 0.0 for a rate year, and may result in payment rates under the system described in paragraph (1) for a rate year being less than such payment rates for the preceding rate year.

"(3) OTHER ADJUSTMENT.—

"(A) IN GENERAL.—For purposes of paragraph (2)(A)(ii), the other adjustment described in this paragraph is—

"(i) for each of the rate years beginning in 2010 and 2011, 0.25 percentage point; and

"(ii) subject to subparagraph (B), for each of the rate years beginning in 2012 through 2019, 0.2 percentage point.

"(B) REDUCTION OF OTHER ADJUSTMENT.—Subparagraph (A)(ii) shall be applied with respect to any of rate years 2014 through 2019 by substituting '0.0 percentage points' for '0.2 percentage point', if for such rate year—

"(i) the excess (if any) of—

"(I) the total percentage of the non-elderly insured population for the preceding rate year (based on the most

recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

"(II) the total percentage of the non-elderly insured population for such preceding rate year (as estimated by the Secretary); exceeds

"(ii) 5 percentage points.".

(g) HOSPICE CARE.—Section 1814(i)(1)(C) of the Social Security Act (42 U.S.C. 1395f(i)(1)(C)), as amended by section 3132, is amended by adding at the end the following new clauses:

"(iv) After determining the market basket percentage increase under clause (ii)(VII) or (iii), as applicable, with respect to fiscal year 2013 and each subsequent fiscal year, the Secretary shall reduce such percentage—

"(I) for 2013 and each subsequent fiscal year, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

"(II) subject to clause (v), for each of fiscal years 2013 through 2019, by 0.5 percentage point.

The application of this clause may result in the market basket percentage increase under clause (ii)(VII) or (iii), as applicable, being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.

"(v) Clause (iv)(II) shall be applied with respect to any of fiscal years 2014 through 2019 by substituting '0.0 percentage points' for '0.5 percentage point', if for such fiscal year—

"(I) the excess (if any) of—

"(aa) the total percentage of the non-elderly insured population for the preceding fiscal year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

"(bb) the total percentage of the non-elderly insured population for such preceding fiscal year (as estimated by the Secretary); exceeds

"(II) 5 percentage points.".

(h) DIALYSIS.—Section 1881(b)(14)(F) of the Social Security Act (42 U.S.C. 1395rr(b)(14)(F)) is amended—

(1) in clause (i)—

(A) by inserting "(I)" after "(F)(i)"

(B) in subclause (I), as inserted by subparagraph (A)—

(i) by striking "clause (ii)" and inserting "subclause (II) and clause (ii)"; and

(ii) by striking "minus 1.0 percentage point"; and

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

"(II) For 2012 and each subsequent year, after determining the increase factor described in subclause (I), the Secretary shall reduce such increase factor by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II). The application of the preceding sentence may result in such increase factor being less than 0.0 for a year, and may result in payment rates under the payment system under this paragraph for a year being less than such payment rates for the preceding year."; and

(2) in clause (ii)(II)—

(A) by striking "The" and inserting "Subject to clause (i)(II), the"; and

(B) by striking "clause (i) minus 1.0 percentage point" and inserting "clause (i)(I)".

(i) OUTPATIENT HOSPITALS.—Section 1833(t)(3) of the Social Security Act (42 U.S.C. 1395l(t)(3)) is amended—

(1) in subparagraph (C)(iv), by inserting "and subparagraph (F) of this paragraph" after "(17)"; and

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

"(F) PRODUCTIVITY AND OTHER ADJUSTMENT.—After determining the OPD fee schedule increase factor under subparagraph (C)(iv), the Secretary shall reduce such increase factor—

"(i) for 2012 and subsequent years, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

"(ii) for each of 2010 through 2019, by the adjustment described in subparagraph (G).

The application of this subparagraph may result in the increase factor under subparagraph (C)(iv) being less than 0.0 for a year, and may result in payment rates under the payment system under this subsection for a year being less than such payment rates for the preceding year.

"(G) OTHER ADJUSTMENT.—

"(i) ADJUSTMENT.—For purposes of subparagraph (F)(ii), the adjustment described in this subparagraph is—

"(I) for each of 2010 and 2011, 0.25 percentage point; and

"(II) subject to clause (ii), for each of 2012 through 2019, 0.2 percentage point.

"(ii) REDUCTION OF OTHER ADJUSTMENT.—Clause (i)(II) shall be applied with respect to any of 2014 through 2019 by substituting '0.0 percentage points' for '0.2 percentage point', if for such year—

"(I) the excess (if any) of—

"(aa) the total percentage of the non-elderly insured population for the preceding year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

"(bb) the total percentage of the non-elderly insured population for such preceding year (as estimated by the Secretary); exceeds

"(II) 5 percentage points.".

(j) AMBULANCE SERVICES.—Section 1834(l)(3) of the Social Security Act (42 U.S.C. 1395m(l)(3)) is amended—

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

(2) in subparagraph (B)—

(A) by inserting ", subject to subparagraph (C) and the succeeding sentence of this paragraph," after "increased"; and

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

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

"(C) for 2011 and each subsequent year, after determining the percentage increase under subparagraph (B) for the year, reduce such percentage increase by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II)."; and

(4) by adding at the end the following flush sentence:

"The application of subparagraph (C) may result in the percentage increase under subparagraph (B) being less than 0.0 for a year, and may result in payment rates under the fee schedule under this subsection for a year being less than such payment rates for the preceding year.".

(k) AMBULATORY SURGICAL CENTER SERVICES.—Section 1833(i)(2)(D) of the Social Security Act (42 U.S.C. 1395l(i)(2)(D)) is amended—

(1) by redesignating clause (v) as clause (vi); and

(2) by inserting after clause (iv) the following new clause:

"(v) In implementing the system described in clause (i) for 2011 and each subsequent year, any annual update under such system for the year, after application of clause (iv), shall be reduced by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II). The application of the preceding sentence may result in such update being less than 0.0 for a year, and may result in payment rates under the system described in clause (i) for a year being

less than such payment rates for the preceding year.".

(l) LABORATORY SERVICES.—Section 1833(h)(2)(A) of the Social Security Act (42 U.S.C. 1395l(h)(2)(A)) is amended—

(1) in clause (i)—

(A) by inserting ", subject to clause (iv)," after "year) by"; and

(B) by striking "through 2013" and inserting "and 2010"; and

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

"(iv) After determining the adjustment to the fee schedules under clause (i), the Secretary shall reduce such adjustment—

"(I) for 2011 and each subsequent year, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

"(II) for each of 2011 through 2015, by 1.75 percentage points.

Subclause (I) shall not apply in a year where the adjustment to the fee schedules determined under clause (i) is 0.0 or a percentage decrease for a year. The application

of the productivity adjustment under subclause (I) shall not result in an adjustment to the fee schedules under clause (i) being less than 0.0 for a year. The application of subclause (II) may result in an adjustment to the fee schedules under clause (i) being less than 0.0 for a year, and may result in payment rates for a year being less than such payment rates for the preceding year.''.

(m) CERTAIN DURABLE MEDICAL EQUIPMENT.—Section 1834(a)(14) of the Social Security Act (42 U.S.C. 1395m(a)(14)) is amended—

(1) in subparagraph (K)—

(A) by striking ''2011, 2012, and 2013,''; and

(B) by inserting ''and'' after the semicolon at the end;

(2) by striking subparagraphs (L) and (M) and inserting the following new subparagraph:

''(L) for 2011 and each subsequent year—

''(i) the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year, reduced by—

"(ii) the productivity adjustment described in section 1886(b)(3)(B)(xi)(II).";

and

(3) by adding at the end the following flush sentence:

"The application of subparagraph (L)(ii) may result in the covered item update under this paragraph being less than 0.0 for a year, and may result in payment rates under this subsection for a year being less than such payment rates for the preceding year.".

(n) PROSTHETIC DEVICES, ORTHOTICS, AND PROSTHETICS.—Section 1834(h)(4) of the Social Security Act (42 U.S.C. 1395m(h)(4)) is amended—

(1) in subparagraph (A)—

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

(B) in clause (x)—

(i) by striking "a subsequent year" and inserting "for each of 2007 through 2010"; and

(ii) by inserting "and" after the semicolon at the end;

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

"(xi) for 2011 and each subsequent year—

"(I) the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year, reduced by—

"(II) the productivity adjustment described in section 1886(b)(3)(B)(xi)(II)."; and

(D) by adding at the end the following flush sentence:

"The application of subparagraph (A)(xi)(II) may result in the applicable percentage increase under subparagraph (A) being less than 0.0 for a year, and may result in payment rates under this subsection for a year being less than such payment rates for the preceding year.".

(o) OTHER ITEMS.—Section 1842(s)(1) of the Social Security Act (42 U.S.C. 1395u(s)(1)) is amended—

(1) in the first sentence, by striking "Subject to" and inserting "(A) Subject to";

(2) by striking the second sentence and inserting the following new subparagraph:

"(B) Any fee schedule established under this paragraph for such item or service shall be updated—

"(i) for years before 2011—

"(I) subject to subclause (II), by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the preceding year; and

"(II) for items and services described in paragraph (2)(D) for 2009, section 1834(a)(14)(J) shall apply under this paragraph instead of the percentage increase otherwise applicable; and

"(ii) for 2011 and subsequent years—

"(I) the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year, reduced by—

"(II) the productivity adjustment described in section 1886(b)(3)(B)(xi)(II)."; and

(3) by adding at the end the following flush sentence:

"The application of subparagraph (B)(ii)(II) may result in the update under this paragraph being less than 0.0 for a year, and may result in payment rates under any fee schedule established under this paragraph for a year being less than such payment rates for the preceding year.".

(p) NO APPLICATION PRIOR TO APRIL 1, 2010.—Notwithstanding the preceding provisions of this section, the amendments made by subsections (a), (c), and (d) shall not apply to discharges occurring before April 1, 2010.

SEC. 3402. TEMPORARY ADJUSTMENT TO THE CALCULATION OF PART B PREMIUMS.

Section 1839(i) of the Social Security Act (42 U.S.C. 1395r(i)) is amended—

(1) in paragraph (2), in the matter preceding subparagraph (A), by inserting "subject to paragraph (6)," after "subsection,";

(2) in paragraph (3)(A)(i), by striking "The applicable" and inserting "Subject to paragraph (6), the applicable";

(3) by redesignating paragraph (6) as paragraph (7); and

(4) by inserting after paragraph (5) the following new paragraph:

"(6) TEMPORARY ADJUSTMENT TO INCOME THRESHOLDS.—Notwithstanding any other provision of this subsection, during the period beginning on January 1, 2011, and ending on December 31, 2019—

"(A) the threshold amount otherwise applicable under paragraph (2) shall be equal to such amount for 2010; and

"(B) the dollar amounts otherwise applicable under paragraph (3)(C)(i) shall be equal to such dollar amounts for 2010.".

SEC. 3403. INDEPENDENT MEDICARE ADVISORY BOARD.

(a) BOARD.—

(1) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 3022, is amended by adding at the end the following new section:

"INDEPENDENT MEDICARE ADVISORY BOARD

"SEC. 1899A. (a) ESTABLISHMENT.—There is established an independent board to be known as the 'Independent Medicare Advisory Board'.

"(b) PURPOSE.—It is the purpose of this section to, in accordance with the following provisions of this section, reduce the per capita rate of growth in Medicare spending—

"(1) by requiring the Chief Actuary of the Centers for Medicare & Medicaid Services to determine in each year to which this section applies (in this section referred to as 'a determination year') the projected per capita growth rate under Medicare for the second year following the determination year (in this section referred to as 'an implementation year');

"(2) if the projection for the implementation year exceeds the target growth rate for that year, by requiring the Board to develop and submit during the first year following the determination year (in this section referred to as 'a proposal year') a proposal containing recommendations to reduce the Medicare per capita growth rate to the extent required by this section; and

"(3) by requiring the Secretary to implement such proposals unless Congress enacts legislation pursuant to this section.

"(c) BOARD PROPOSALS.—

"(1) DEVELOPMENT.—

"(A) IN GENERAL.—The Board shall develop detailed and specific proposals related to the Medicare program in accordance with the succeeding provisions of this section.

"(B) ADVISORY REPORTS.—Beginning January 15, 2014, the Board may develop and submit to Congress advisory reports on matters related to the Medicare program, regardless of whether or not the Board submitted a proposal for such year. Such a report may, for years prior to 2020, include recommendations regarding improvements to payment systems for providers of services and suppliers who are not otherwise subject to the scope of the Board's recommendations in a proposal under this section. Any advisory report submitted under this subparagraph shall not be subject to the rules for congressional consideration under subsection (d).

"(2) PROPOSALS.—

"(A) REQUIREMENTS.—Each proposal submitted under this section in a proposal year shall meet each of the following requirements:

"(i) If the Chief Actuary of the Centers for Medicare & Medicaid Services has made a determination under paragraph (7)(A) in

the determination year, the proposal shall include recommendations so that the proposal as a whole (after taking into account recommendations under clause (v)) will result in a net reduction in total Medicare program spending in the implementation year that is at least equal to the applicable savings target established under paragraph (7)(B) for such implementation year. In determining whether a proposal meets the requirement of the preceding sentence, reductions in Medicare program spending during the 3-month period immediately preceding the implementation year shall be counted to the extent that such reductions are a result of the implementation of recommendations contained in the proposal for a change in the payment rate for an item or service that was effective during such period pursuant to subsection (e)(2)(A).

"(ii) The proposal shall not include any recommendation to ration health care, raise revenues or Medicare beneficiary premiums under section 1818, 1818A, or 1839, increase Medicare beneficiary cost-sharing

(including deductibles, coinsurance, and co-payments), or otherwise restrict benefits or modify eligibility criteria.

"(iii) In the case of proposals submitted prior to December 31, 2018, the proposal shall not include any recommendation that would reduce payment rates for items and services furnished, prior to December 31, 2019, by providers of services (as defined in section 1861(u)) and suppliers (as defined in section 1861(d)) scheduled, pursuant to the amendments made by section 3401 of the Patient Protection and Affordable Care Act, to receive a reduction to the inflationary payment updates of such providers of services and suppliers in excess of a reduction due to productivity in a year in which such recommendations would take effect.

"(iv) As appropriate, the proposal shall include recommendations to reduce Medicare payments under parts C and D, such as reductions in direct subsidy payments to Medicare Advantage and prescription drug plans specified under paragraph

(1) and (2) of section 1860D–15(a) that are related to administrative expenses (including profits) for basic coverage, denying high bids or removing high bids for prescription drug coverage from the calculation of the national average monthly bid amount under section 1860D–13(a)(4), and reductions in payments to Medicare Advantage plans under clauses (i) and (ii) of section 1853(a)(1)(B) that are related to administrative expenses (including profits) and performance bonuses for Medicare Advantage plans under section 1853(n). Any such recommendation shall not affect the base beneficiary premium percentage specified under 1860D–13(a).

"(v) The proposal shall include recommendations with respect to administrative funding for the Secretary to carry out the recommendations contained in the proposal.

"(vi) The proposal shall only include recommendations related to the Medicare program.

"(B) ADDITIONAL CONSIDERATIONS.—In developing and submitting each proposal under this section in a proposal year, the Board shall, to the extent feasible—

"(i) give priority to recommendations that extend Medicare solvency;

"(ii) include recommendations that—

"(I) improve the health care delivery system and health outcomes, including by promoting integrated care, care coordination, prevention and wellness, and quality and efficiency improvement; and

"(II) protect and improve Medicare beneficiaries' access to necessary and evidence-based items and services, including in rural and frontier areas;

"(iii) include recommendations that target reductions in Medicare program spending to sources of excess cost growth;

"(iv) consider the effects on Medicare beneficiaries of changes in payments to providers of services (as defined in section 1861(u)) and suppliers (as defined in section 1861(d));

"(v) consider the effects of the recommendations on providers of services and suppliers with actual or projected negative cost margins or payment updates; and

"(vi) consider the unique needs of Medicare beneficiaries who are dually eligible for Medicare and the Medicaid program under title XIX.

"(C) NO INCREASE IN TOTAL MEDICARE PROGRAM SPENDING.—Each proposal submitted under this section shall be designed in such a manner that implementation of the recommendations contained in the proposal would not be expected to result, over the 10-year period starting with the implementation year, in any increase in the total amount of net Medicare program spending relative to the total amount of net Medicare program spending that would have occurred absent such implementation.

"(D) CONSULTATION WITH MEDPAC.—The Board shall submit a draft copy of each proposal to be submitted under this section to the Medicare Payment Advisory Commission established under section 1805 for its review. The Board

shall submit such draft copy by not later than September 1 of the determination year.

"(E) REVIEW AND COMMENT BY THE SECRETARY.—The Board shall submit a draft copy of each proposal to be submitted to Congress under this section to the Secretary for the Secretary's review and comment. The Board shall submit such draft copy by not later than September 1 of the determination year. Not later than March 1 of the submission year, the Secretary shall submit a report to Congress on the results of such review, unless the Secretary submits a proposal under paragraph (5)(A) in that year.

"(F) CONSULTATIONS.—In carrying out its duties under this section, the Board shall engage in regular consultations with the Medicaid and CHIP Payment and Access Commission under section 1900.

"(3) TRANSMISSION OF BOARD PROPOSAL TO PRESIDENT.—

"(A) IN GENERAL.—

"(i) IN GENERAL.—Except as provided in clause (ii) and subsection (f)(3)(B), the Board shall transmit a proposal under this

section to the President on January 15 of each year (beginning with 2014).

"(ii) EXCEPTION.—The Board shall not submit a proposal under clause (i) in a proposal year if the year is—

"(I) a year for which the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination in the determination year under paragraph (6)(A) that the growth rate described in clause (i) of such paragraph does not exceed the growth rate described in clause (ii) of such paragraph;

"(II) a year in which the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination in the determination year that the projected percentage increase (if any) for the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average) for the implementation year is less than the projected percentage increase (if any) in the Consumer

Price Index for All Urban Consumers (all items; United States city average) for such implementation year; or

"(III) for proposal year 2019 and subsequent proposal years, a year in which the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination in the determination year that the growth rate described in paragraph (8) exceeds the growth rate described in paragraph (6)(A)(i).

"(iii) START-UP PERIOD.—The Board may not submit a proposal under clause (i) prior to January 15, 2014.

"(B) REQUIRED INFORMATION.—Each proposal submitted by the Board under subparagraph (A)(i) shall include—

"(i) the recommendations described in paragraph (2)(A)(i);

"(ii) an explanation of each recommendation contained in the proposal and the reasons for including such recommendation;

"(iii) an actuarial opinion by the Chief Actuary of the Centers for Medicare & Medicaid Services certifying that the proposal meets the requirements of subparagraphs (A)(i) and (C) of paragraph (2);

"(iv) a legislative proposal that implements the recommendations; and

"(v) other information determined appropriate by the Board.

"(4) PRESIDENTIAL SUBMISSION TO CONGRESS.—Upon receiving a proposal from the Board under paragraph (3)(A)(i) or the Secretary under paragraph (5), the President shall immediately submit such proposal to Congress.

"(5) CONTINGENT SECRETARIAL DEVELOPMENT OF PROPOSAL.—If, with respect to a proposal year, the Board is required, to but fails, to submit a proposal to the President by the deadline applicable under paragraph (3)(A)(i), the Secretary shall develop a detailed and specific proposal that satisfies the requirements of subparagraphs (A) and (C) (and, to the extent feasible, subparagraph (B)) of paragraph (2) and contains the information required paragraph (3)(B)). By not later than January 25 of the year, the Secretary shall transmit—

"(A) such proposal to the President; and

"(B) a copy of such proposal to the Medicare Payment Advisory Commission for its review.

"(6) PER CAPITA GROWTH RATE PROJECTIONS BY CHIEF ACTUARY.—

"(A) IN GENERAL.—Subject to subsection (f)(3)(A), not later than April 30, 2013, and annually thereafter, the Chief Actuary of the Centers for Medicare & Medicaid Services shall determine in each such year whether—

"(i) the projected Medicare per capita growth rate for the implementation year (as determined under subparagraph (B)); exceeds

"(ii) the projected Medicare per capita target growth rate for the implementation year (as determined under subparagraph (C)).

"(B) MEDICARE PER CAPITA GROWTH RATE.—

"(i) IN GENERAL.—For purposes of this section, the Medicare per capita growth rate for an implementation year shall be calculated as the projected 5-year average

(ending with such year) of the growth in Medicare program spending per unduplicated enrollee.

"(ii) REQUIREMENT.—The projection under clause (i) shall—

"(I) to the extent that there is projected to be a negative update to the single conversion factor applicable to payments for physicians' services under section 1848(d) furnished in the proposal year or the implementation year, assume that such update for such services is 0 percent rather than the negative percent that would otherwise apply; and

"(II) take into account any delivery system reforms or other payment changes that have been enacted or published in final rules but not yet implemented as of the making of such calculation.

"(C) MEDICARE PER CAPITA TARGET GROWTH RATE.—For purposes of this section, the Medicare per capita target growth rate for an implementation year shall be calculated as the

projected 5-year average (ending with such year) percentage increase in—

"(i) with respect to a determination year that is prior to 2018, the average of the projected percentage increase (if any) in—

"(I) the Consumer Price Index for All Urban Consumers (all items; United States city average); and

"(II) the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average); and

"(ii) with respect to a determination year that is after 2017, the nominal gross domestic product per capita plus 1.0 percentage point.

"(7) SAVINGS REQUIREMENT.—

"(A) IN GENERAL.—If, with respect to a determination year, the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination under paragraph (6)(A) that the growth rate described in clause (i) of such paragraph exceeds the growth rate described in clause (ii) of such paragraph, the Chief Actuary shall

establish an applicable savings target for the implementation year.

"(B) APPLICABLE SAVINGS TARGET.—For purposes of this section, the applicable savings target for an implementation year shall be an amount equal to the product of—

"(i) the total amount of projected Medicare program spending for the proposal year; and

"(ii) the applicable percent for the implementation year.

"(C) APPLICABLE PERCENT.—For purposes of subparagraph (B), the applicable percent for an implementation year is the lesser of—

"(i) in the case of—

"(I) implementation year 2015, 0.5 percent;

"(II) implementation year 2016, 1.0 percent;

"(III) implementation year 2017, 1.25 percent; and

"(IV) implementation year 2018 or any subsequent implementation year, 1.5 percent; and

"(ii) the projected excess for the implementation year (expressed as a percent) determined under subparagraph (A).

"(8) PER CAPITA RATE OF GROWTH IN NATIONAL HEALTH EXPENDITURES.—In each determination year (beginning in 2018), the Chief Actuary of the Centers for Medicare & Medicaid Services shall project the per capita rate of growth in national health expenditures for the implementation year. Such rate of growth for an implementation year shall be calculated as the projected 5-year average (ending with such year) percentage increase in national health care expenditures.

"(d) CONGRESSIONAL CONSIDERATION.—

"(1) INTRODUCTION.—

*"(A) IN GENERAL.—On the day on which a proposal is submitted by the President to the House of Representatives and the Senate under subsection (c)(4), the legislative proposal (described in subsection (c)(3)(B)(iv)) contained in the proposal shall be introduced (by request) in the Senate by the majority leader of the Senate or by Members of the Senate designated by the majority leader of the Senate and shall be introduced (by request) in the House by the majority

leader of the House or by Members of the House designated by the majority leader of the House.

"(B) NOT IN SESSION.—If either House is not in session on the day on which such legislative proposal is submitted, the legislative proposal shall be introduced in that House, as provided in subparagraph (A), on the first day thereafter on which that House is in session.

"(C) ANY MEMBER.—If the legislative proposal is not introduced in either House within 5 days on which that House is in session after the day on which the legislative proposal is submitted, then any Member of that House may introduce the legislative proposal.

"(D) REFERRAL.—The legislation introduced under this paragraph shall be referred by the Presiding Officers of the respective Houses to the Committee on Finance in the Senate and to the Committee on Energy and Commerce and the Committee on Ways and Means in the House of Representatives.

"(2) COMMITTEE CONSIDERATION OF PROPOSAL.—

"(A) REPORTING BILL.—Not later than April 1 of any proposal year in which a pro-

posal is submitted by the President to Congress under this section, the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate may report the bill referred to the Committee under paragraph (1)(D) with committee amendments related to the Medicare program.

"(B) CALCULATIONS.—In determining whether a committee amendment meets the requirement of subparagraph (A), the reductions in Medicare program spending during the 3-month period immediately preceding the implementation year shall be counted to the extent that such reductions are a result of the implementation provisions in the committee amendment for a change in the payment rate for an item or service that was effective during such period pursuant to such amendment.

"(C) COMMITTEE JURISDICTION.—Notwithstanding rule XV of the Standing Rules of the Senate, a committee amendment described in subparagraph (A) may include matter not within the jurisdiction of the Committee on Finance

if that matter is relevant to a proposal contained in the bill submitted under subsection (c)(3).

"(D) DISCHARGE.—If, with respect to the House involved, the committee has not reported the bill by the date required by subparagraph (A), the committee shall be discharged from further consideration of the proposal.

"(3) LIMITATION ON CHANGES TO THE BOARD RECOMMENDATIONS.—

"(A) IN GENERAL.—It shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, or amendment, pursuant to this subsection or conference report thereon, that fails to satisfy the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2).

"(B) LIMITATION ON CHANGES TO THE BOARD RECOMMENDATIONS IN OTHER LEGISLATION.—It shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, amendment, or conference report (other than pursuant to this section) that would repeal or otherwise change the recommendations of the Board if that change would fail to satisfy

the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2).

"(C) LIMITATION ON CHANGES TO THIS SUBSECTION.—It shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, amendment, or conference report that would repeal or otherwise change this subsection.

"(D) WAIVER.—This paragraph may be waived or suspended in the Senate only by the affirmative vote of three-fifths of the Members, duly chosen and sworn.

"(E) APPEALS.—An affirmative vote of three-fifths of the Members of the Senate, duly chosen and sworn, shall be required in the Senate to sustain an appeal of the ruling of the Chair on a point of order raised under this paragraph.

"(4) EXPEDITED PROCEDURE.—

"(A) CONSIDERATION.—A motion to proceed to the consideration of the bill in the Senate is not debatable.

"(B) AMENDMENT.—

"(i) TIME LIMITATION.—Debate in the Senate on any amendment to a bill under

this section shall be limited to 1 hour, to be equally divided between, and controlled by, the mover and the manager of the bill, and debate on any amendment to an amendment, debatable motion, or appeal shall be limited to 30 minutes, to be equally divided between, and controlled by, the mover and the manager of the bill, except that in the event the manager of the bill is in favor of any such amendment, motion, or appeal, the time in opposition thereto shall be controlled by the minority leader or such leader's designee.

"(ii) GERMANE.—No amendment that is not germane to the provisions of such bill shall be received.

"(iii) ADDITIONAL TIME.—The leaders, or either of them, may, from the time under their control on the passage of the bill, allot additional time to any Senator during the consideration of any amendment, debatable motion, or appeal.

"(iv) AMENDMENT NOT IN ORDER.—It shall not be in order to consider an amendment that would cause the bill to result in

a net reduction in total Medicare program spending in the implementation year that is less than the applicable savings target established under subsection (c)(7)(B) for such implementation year.

"(v) WAIVER AND APPEALS.—This paragraph may be waived or suspended in the Senate only by the affirmative vote of three-fifths of the Members, duly chosen and sworn. An affirmative vote of three-fifths of the Members of the Senate, duly chosen and sworn, shall be required in the Senate to sustain an appeal of the ruling of the Chair on a point of order raised under this section.

"(C) CONSIDERATION BY THE OTHER HOUSE.—

"(i) IN GENERAL.—The expedited procedures provided in this subsection for the consideration of a bill introduced pursuant to paragraph (1) shall not apply to such a bill that is received by one House from the other House if such a bill was not introduced in the receiving House.

"(ii) BEFORE PASSAGE.—If a bill that is introduced pursuant to paragraph (1) is received by one House from the other House, after introduction but before disposition of such a bill in the receiving House, then the following shall apply:

"(I) The receiving House shall consider the bill introduced in that House through all stages of consideration up to, but not including, passage.

"(II) The question on passage shall be put on the bill of the other House as amended by the language of the receiving House.

"(iii) AFTER PASSAGE.—If a bill introduced pursuant to paragraph (1) is received by one House from the other House, after such a bill is passed by the receiving House, then the vote on passage of the bill that originates in the receiving House shall be considered to be the vote on passage of the bill received from the other House as amended by the language of the receiving House.

"(iv) DISPOSITION.—Upon disposition of a bill introduced pursuant to paragraph (1) that is received by one House from the other House, it shall no longer be in order to consider the bill that originates in the receiving House.

"(v) LIMITATION.—Clauses (ii), (iii), and (iv) shall apply only to a bill received by one House from the other House if the bill—

"(I) is related only to the program under this title; and

"(II) satisfies the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2).

"(D) SENATE LIMITS ON DEBATE.—

"(i) IN GENERAL.—In the Senate, consideration of the bill and on all debatable motions and appeals in connection therewith shall not exceed a total of 30 hours, which shall be divided equally between the majority and minority leaders or their designees.

"(ii) MOTION TO FURTHER LIMIT DEBATE.—A motion to further limit debate on the bill is in order and is not debatable.

"(iii) MOTION OR APPEAL.—Any debatable motion or appeal is debatable for not to exceed 1 hour, to be divided equally between those favoring and those opposing the motion or appeal.

"(iv) FINAL DISPOSITION.—After 30 hours of consideration, the Senate shall proceed, without any further debate on any question, to vote on the final disposition thereof to the exclusion of all amendments not then pending before the Senate at that time and to the exclusion of all motions, except a motion to table, or to reconsider and one quorum call on demand to establish the presence of a quorum (and motions required to establish a quorum) immediately before the final vote begins.

"(E) CONSIDERATION IN CONFERENCE.—

"(i) IN GENERAL.—Consideration in the Senate and the House of Representatives on the conference report or any messages between Houses shall be limited to 10 hours,

equally divided and controlled by the majority and minority leaders of the Senate or their designees and the Speaker of the House of Representatives and the minority leader of the House of Representatives or their designees.

"(ii) TIME LIMITATION.—Debate in the Senate on any amendment under this subparagraph shall be limited to 1 hour, to be equally divided between, and controlled by, the mover and the manager of the bill, and debate on any amendment to an amendment, debatable motion, or appeal shall be limited to 30 minutes, to be equally divided between, and controlled by, the mover and the manager of the bill, except that in the event the manager of the bill is in favor of any such amendment, motion, or appeal, the time in opposition thereto shall be controlled by the minority leader or such leader's designee.

"(iii) FINAL DISPOSITION.—After 10 hours of consideration, the Senate shall proceed, without any further debate on any question, to vote on the final disposition

thereof to the exclusion of all motions not then pending before the Senate at that time or necessary to resolve the differences between the Houses and to the exclusion of all other motions, except a motion to table, or to reconsider and one quorum call on demand to establish the presence of a quorum (and motions required to establish a quorum) immediately before the final vote begins.

"(iv) LIMITATION.—Clauses (i) through (iii) shall only apply to a conference report, message or the amendments thereto if the conference report, message, or an amendment thereto—

"(I) is related only to the program under this title; and

"(II) satisfies the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2).

"(F) VETO.—If the President vetoes the bill debate on a veto message in the Senate under this subsection shall be 1 hour equally divided between the majority and minority leaders or their designees.

"(5) RULES OF THE SENATE AND HOUSE OF REPRESENTATIVES.—This subsection and subsection (f)(2) are enacted by Congress—

"(A) as an exercise of the rulemaking power of the Senate and the House of Representatives, respectively, and is deemed to be part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of bill under this section, and it supersedes other rules only to the extent that it is inconsistent with such rules; and

"(B) with full recognition of the constitutional right of either House to change the rules (so far as they relate to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

"(e) IMPLEMENTATION OF PROPOSAL.—

"(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary shall, except as provided in paragraph (3), implement the recommendations contained in a proposal submitted by the President to Congress pursuant to this section on August 15 of the year in which the proposal is so submitted.

"(2) APPLICATION.—

"(A) IN GENERAL.—A recommendation described in paragraph (1) shall apply as follows:

"(i) In the case of a recommendation that is a change in the payment rate for an item or service under Medicare in which payment rates change on a fiscal year basis (or a cost reporting period basis that relates to a fiscal year), on a calendar year basis (or a cost reporting period basis that relates to a calendar year), or on a rate year basis (or a cost reporting period basis that relates to a rate year), such recommendation shall apply to items and services furnished on the first day of the first fiscal year, calendar year, or rate year (as the case may be) that begins after such August 15.

"(ii) In the case of a recommendation relating to payments to plans under parts C and D, such recommendation shall apply to plan years beginning on the first day of the first calendar year that begins after such August 15.

"(iii) In the case of any other recommendation, such recommendation shall be addressed in the regular regulatory proc-

ess timeframe and shall apply as soon as practicable.

"(B) INTERIM FINAL RULEMAKING.—The Secretary may use interim final rulemaking to implement any recommendation described in paragraph (1).

"(3) EXCEPTION.—The Secretary shall not be required to implement the recommendations contained in a proposal submitted in a proposal year by the President to Congress pursuant to this section if—

"(A) prior to August 15 of the proposal year, Federal legislation is enacted that includes the following provision: 'This Act supercedes the recommendations of the Board contained in the proposal submitted, in the year which includes the date of enactment of this Act, to Congress under section 1899A of the Social Security Act.'; and

"(B) in the case of implementation year 2020 and subsequent implementation years, a joint resolution described in subsection (f)(1) is enacted not later than August 15, 2017.

"(4) NO AFFECT ON AUTHORITY TO IMPLEMENT CERTAIN PROVISIONS.—Nothing in paragraph (3) shall be construed to affect the authority of the Sec-

retary to implement any recommendation contained in a proposal or advisory report under this section to the extent that the Secretary otherwise has the authority to implement such recommendation administratively.

"(5) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the implementation by the Secretary under this subsection of the recommendations contained in a proposal.

"(f) JOINT RESOLUTION REQUIRED TO DISCONTINUE THE BOARD.—

"(1) IN GENERAL.—For purposes of subsection (e)(3)(B), a joint resolution described in this paragraph means only a joint resolution—

"(A) that is introduced in 2017 by not later than February 1 of such year;

"(B) which does not have a preamble;

"(C) the title of which is as follows: 'Joint resolution approving the discontinuation of the process for consideration and automatic implementation of the annual proposal of the Independent Medicare Advisory Board under section 1899A of the Social Security Act'; and

"(D) the matter after the resolving clause of which is as follows: 'That Congress approves the discontinuation of the process for consideration and automatic implementation of the annual proposal of the Independent Medicare Advisory Board under section 1899A of the Social Security Act.'.

"(2) PROCEDURE.—

"(A) REFERRAL.—A joint resolution described in paragraph (1) shall be referred to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

"(B) DISCHARGE.—In the Senate, if the committee to which is referred a joint resolution described in paragraph (1) has not reported such joint resolution (or an identical joint resolution) at the end of 20 days after the joint resolution described in paragraph (1) is introduced, such committee may be discharged from further consideration of such joint resolution upon a petition supported in writing by 30 Members of the Senate, and such joint resolution shall be placed on the calendar.

"(C) CONSIDERATION.—

"(i) IN GENERAL.—In the Senate, when the committee to which a joint resolution is referred has reported, or when a committee is discharged (under subparagraph (C)) from further consideration of a joint resolution described in paragraph (1), it is at any time thereafter in order (even though a previous motion to the same effect has been disagreed to) for a motion to proceed to the consideration of the joint resolution to be made, and all points of order against the joint resolution (and against consideration of the joint resolution) are waived, except for points of order under the Congressional Budget act of 1974 or under budget resolutions pursuant to that Act. The motion is not debatable. A motion to reconsider the vote by which the motion is agreed to or disagreed to shall not be in order. If a motion to proceed to the consideration of the joint resolution is agreed to, the joint resolution shall remain the unfinished business of the Senate until disposed of.

"(ii) DEBATE LIMITATION.—In the Senate, consideration of the joint resolution, and on all debatable motions and appeals in connection therewith, shall be limited to not more than 10 hours, which shall be divided equally between the majority leader and the minority leader, or their designees. A motion further to limit debate is in order and not debatable. An amendment to, or a motion to postpone, or a motion to proceed to the consideration of other business, or a motion to recommit the joint resolution is not in order.

"(iii) PASSAGE.—In the Senate, immediately following the conclusion of the debate on a joint resolution described in paragraph (1), and a single quorum call at the conclusion of the debate if requested in accordance with the rules of the Senate, the vote on passage of the joint resolution shall occur.

"(iv) APPEALS.—Appeals from the decisions of the Chair relating to the application of the rules of the Senate to the procedure relating to a joint resolution described

in paragraph (1) shall be decided without debate.

"(D) OTHER HOUSE ACTS FIRST.—If, before the passage by 1 House of a joint resolution of that House described in paragraph (1), that House receives from the other House a joint resolution described in paragraph (1), then the following procedures shall apply:

"(i) The joint resolution of the other House shall not be referred to a committee.

"(ii) With respect to a joint resolution described in paragraph (1) of the House receiving the joint resolution—

"(I) the procedure in that House shall be the same as if no joint resolution had been received from the other House; but

"(II) the vote on final passage shall be on the joint resolution of the other House.

"(E) EXCLUDED DAYS.—For purposes of determining the period specified in subparagraph (B), there shall be excluded any days either House of Congress is adjourned for more than 3 days during a session of Congress.

"(F) MAJORITY REQUIRED FOR ADOPTION.—A joint resolution considered under this subsection shall require an affirmative vote of three-fifths of the Members, duly chosen and sworn, for adoption.

"(3) TERMINATION.—If a joint resolution described in paragraph (1) is enacted not later than August 15, 2017—

"(A) the Chief Actuary of the Medicare & Medicaid Services shall not—

"(i) make any determinations under subsection (c)(6) after May 1, 2017; or

"(ii) provide any opinion pursuant to subsection (c)(3)(B)(iii) after January 16, 2018;

"(B) the Board shall not submit any proposals or advisory reports to Congress under this section after January 16, 2018; and

"(C) the Board and the consumer advisory council under subsection (k) shall terminate on August 16, 2018.

"(g) BOARD MEMBERSHIP; TERMS OF OFFICE; CHAIRPERSON; REMOVAL.—

"(1) MEMBERSHIP.—

"(A) IN GENERAL.—The Board shall be composed of—

"(i) 15 members appointed by the President, by and with the advice and consent of the Senate; and

"(ii) the Secretary, the Administrator of the Center for Medicare & Medicaid Services, and the Administrator of the Health Resources and Services Administration, all of whom shall serve ex officio as nonvoting members of the Board.

"(B) QUALIFICATIONS.—

"(i) IN GENERAL.—The appointed membership of the Board shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic physicians, and other providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

"(ii) INCLUSION.—The appointed membership of the Board shall include (but not be limited to) physicians and other health professionals, experts in the area of pharmaco-economics or prescription drug benefit programs, employers, third-party payers, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research and expertise in outcomes and effectiveness research and technology assessment. Such membership shall also include representatives of consumers and the elderly.

"(iii) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision or management of the delivery of items and services covered under this title shall not constitute a majority of the appointed membership of the Board.

"(C) ETHICAL DISCLOSURE.—The President shall establish a system for public disclosure by appointed members of the Board of financial and other potential conflicts of interest relating to such members. Appointed members of the Board shall be treated as officers in the executive

branch for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).

"(D) CONFLICTS OF INTEREST.—No individual may serve as an appointed member if that individual engages in any other business, vocation, or employment.

"(E) CONSULTATION WITH CONGRESS.—In selecting individuals for nominations for appointments to the Board, the President shall consult with—

"(i) the majority leader of the Senate concerning the appointment of 3 members;

"(ii) the Speaker of the House of Representatives concerning the appointment of 3 members;

"(iii) the minority leader of the Senate concerning the appointment of 3 members; and

"(iv) the minority leader of the House of Representatives concerning the appointment of 3 members.

"(2) TERM OF OFFICE.—Each appointed member shall hold office for a term of 6 years except that—

"(A) a member may not serve more than 2 full consecutive terms (but may be reappointed to 2 full consecutive terms after being appointed to fill a vacancy on the Board);

"(B) a member appointed to fill a vacancy occurring prior to the expiration of the term for which that member's predecessor was appointed shall be appointed for the remainder of such term;

"(C) a member may continue to serve after the expiration of the member's term until a successor has taken office; and

"(D) of the members first appointed under this section, 5 shall be appointed for a term of 1 year, 5 shall be appointed for a term of 3 years, and 5 shall be appointed for a term of 6 years, the term of each to be designated by the President at the time of nomination.

"(3) CHAIRPERSON.—

"(A) IN GENERAL.—The Chairperson shall be appointed by the President, by and with the advice and consent of the Senate, from among the members of the Board.

"(B) DUTIES.—The Chairperson shall be the principal executive officer of the Board, and

shall exercise all of the executive and administrative functions of the Board, including functions of the Board with respect to—

"(i) the appointment and supervision of personnel employed by the Board;

"(ii) the distribution of business among personnel appointed and supervised by the Chairperson and among administrative units of the Board; and

"(iii) the use and expenditure of funds.

"(C) GOVERNANCE.—In carrying out any of the functions under subparagraph (B), the Chairperson shall be governed by the general policies established by the Board and by the decisions, findings, and determinations the Board shall by law be authorized to make.

"(D) REQUESTS FOR APPROPRIATIONS.—Requests or estimates for regular, supplemental, or deficiency appropriations on behalf of the Board may not be submitted by the Chairperson without the prior approval of a majority vote of the Board.

"(4) REMOVAL.—Any appointed member may be removed by the President for neglect of duty or malfeasance in office, but for no other cause.

"(h) VACANCIES; QUORUM; SEAL; VICE CHAIRPERSON; VOTING ON REPORTS.—

"(1) VACANCIES.—No vacancy on the Board shall impair the right of the remaining members to exercise all the powers of the Board.

"(2) QUORUM.—A majority of the appointed members of the Board shall constitute a quorum for the transaction of business, but a lesser number of members may hold hearings.

"(3) SEAL.—The Board shall have an official seal, of which judicial notice shall be taken.

"(4) VICE CHAIRPERSON.—The Board shall annually elect a Vice Chairperson to act in the absence or disability of the Chairperson or in case of a vacancy in the office of the Chairperson.

"(5) VOTING ON PROPOSALS.—Any proposal of the Board must be approved by the majority of appointed members present.

"(i) POWERS OF THE BOARD.—

"(1) HEARINGS.—The Board may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Board considers advisable to carry out this section.

"(2) AUTHORITY TO INFORM RESEARCH PRIORITIES FOR DATA COLLECTION.—The Board may ad-

vise the Secretary on priorities for health services research, particularly as such priorities pertain to necessary changes and issues regarding payment reforms under Medicare.

"(3) OBTAINING OFFICIAL DATA.—The Board may secure directly from any department or agency of the United States information necessary to enable it to carry out this section. Upon request of the Chairperson, the head of that department or agency shall furnish that information to the Board on an agreed upon schedule.

"(4) POSTAL SERVICES.—The Board may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

"(5) GIFTS.—The Board may accept, use, and dispose of gifts or donations of services or property.

"(6) OFFICES.—The Board shall maintain a principal office and such field offices as it determines necessary, and may meet and exercise any of its powers at any other place.

"(j) PERSONNEL MATTERS.—

"(1) COMPENSATION OF MEMBERS AND CHAIRPERSON.—Each appointed member, other than the Chairperson, shall be compensated at a rate equal to

the annual rate of basic pay prescribed for level III of the Executive Schedule under section 5315 of title 5, United States Code. The Chairperson shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level II of the Executive Schedule under section 5315 of title 5, United States Code.

"(2) TRAVEL EXPENSES.—The appointed members shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Board.

"(3) STAFF.—

"(A) IN GENERAL.—The Chairperson may, without regard to the civil service laws and regulations, appoint and terminate an executive director and such other additional personnel as may be necessary to enable the Board to perform its duties. The employment of an executive director shall be subject to confirmation by the Board.

"(B) COMPENSATION.—The Chairperson may fix the compensation of the executive director and other personnel without regard to chap-

ter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates, except that the rate of pay for the executive director and other personnel may not exceed the rate payable for level V of the Executive Schedule under section 5316 of such title.

"(4) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Board without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

"(5) PROCUREMENT OF TEMPORARY AND INTERMITTENT SERVICES.—The Chairperson may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

"(k) CONSUMER ADVISORY COUNCIL.—

"(1) IN GENERAL.—There is established a consumer advisory council to advise the Board on the impact of payment policies under this title on consumers.

"(2) MEMBERSHIP.—

"(A) NUMBER AND APPOINTMENT.—The consumer advisory council shall be composed of 10 consumer representatives appointed by the Comptroller General of the United States, 1 from among each of the 10 regions established by the Secretary as of the date of enactment of this section.

"(B) QUALIFICATIONS.—The membership of the council shall represent the interests of consumers and particular communities.

"(3) DUTIES.—The consumer advisory council shall, subject to the call of the Board, meet not less frequently than 2 times each year in the District of Columbia.

"(4) OPEN MEETINGS.—Meetings of the consumer advisory council shall be open to the public.

"(5) ELECTION OF OFFICERS.—Members of the consumer advisory council shall elect their own officers.

"(6) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the consumer advisory council except that section 14 of such Act shall not apply.

"(l) DEFINITIONS.—In this section:

"(1) BOARD; CHAIRPERSON; MEMBER.—The terms 'Board', 'Chairperson', and 'Member' mean the Independent Medicare Advisory Board established under subsection (a) and the Chairperson and any Member thereof, respectively.

"(2) MEDICARE.—The term 'Medicare' means the program established under this title, including parts A, B, C, and D.

"(3) MEDICARE BENEFICIARY.—The term 'Medicare beneficiary' means an individual who is entitled to, or enrolled for, benefits under part A or enrolled for benefits under part B.

"(4) MEDICARE PROGRAM SPENDING.—The term 'Medicare program spending' means program spending under parts A, B, and D net of premiums.

"(m) FUNDING.—

"(1) IN GENERAL.—There are appropriated to the Board to carry out its duties and functions—

"(A) for fiscal year 2012, $15,000,000; and

"(B) for each subsequent fiscal year, the amount appropriated under this paragraph for the previous fiscal year increased by the annual percentage increase in the Consumer Price Index for All Urban Consumers (all items; United

States city average) as of June of the previous fiscal year.

"(2) FROM TRUST FUNDS.—Sixty percent of amounts appropriated under paragraph (1) shall be derived by transfer from the Federal Hospital Insurance Trust Fund under section 1817 and 40 percent of amounts appropriated under such paragraph shall be derived by transfer from the Federal Supplementary Medical Insurance Trust Fund under section 1841.".

(2) LOBBYING COOLING-OFF PERIOD FOR MEMBERS OF THE INDEPENDENT MEDICARE ADVISORY BOARD.—Section 207(c) of title 18, United States Code, is amended by inserting at the end the following:

"(3) MEMBERS OF THE INDEPENDENT MEDICARE ADVISORY BOARD.—

"(A) IN GENERAL.—Paragraph (1) shall apply to a member of the Independent Medicare Advisory Board under section 1899A.

"(B) AGENCIES AND CONGRESS.—For purposes of paragraph (1), the agency in which the individual described in subparagraph (A) served shall be considered to be the Independent Medicare Advisory Board, the Department of Health

and Human Services, and the relevant committees of jurisdiction of Congress, including the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.".

(b) GAO STUDY AND REPORT ON DETERMINATION AND IMPLEMENTATION OF PAYMENT AND COVERAGE POLICIES UNDER THE MEDICARE PROGRAM.—

(1) INITIAL STUDY AND REPORT.—

(A) STUDY.—The Comptroller General of the United States (in this section referred to as the "Comptroller General") shall conduct a study on changes to payment policies, methodologies, and rates and coverage policies and methodologies under the Medicare program under title XVIII of the Social Security Act as a result of the recommendations contained in the proposals made by the Independent Medicare Advisory Board under section 1899A of such Act (as added by subsection (a)), including an analysis of the effect of such recommendations on—

(i) Medicare beneficiary access to providers and items and services;

(ii) the affordability of Medicare premiums and cost-sharing (including deductibles, coinsurance, and copayments);

(iii) the potential impact of changes on other government or private-sector purchasers and payers of care; and

(iv) quality of patient care, including patient experience, outcomes, and other measures of care.

(B) REPORT.—Not later than July 1, 2015, the Comptroller General shall submit to Congress a report containing the results of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(2) SUBSEQUENT STUDIES AND REPORTS.—The Comptroller General shall periodically conduct such additional studies and submit reports to Congress on changes to Medicare payments policies, methodologies, and rates and coverage policies and methodologies as the Comptroller General determines appropriate, in consultation with the Committee on Ways and Means and the Committee on Energy and Commerce of the

House of Representatives and the Committee on Finance of the Senate.

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

(1) by redesignating paragraphs (4) through (8) as paragraphs (5) through (9), respectively; and

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

"(4) REVIEW AND COMMENT ON THE INDEPENDENT MEDICARE ADVISORY BOARD OR SECRETARIAL PROPOSAL.—If the Independent Medicare Advisory Board (as established under subsection (a) of section 1899A) or the Secretary submits a proposal to the Commission under such section in a year, the Commission shall review the proposal and, not later than March 1 of that year, submit to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate written comments on such proposal. Such comments may include such recommendations as the Commission deems appropriate.".

Subtitle F—Health Care Quality Improvements

SEC. 3501. HEALTH CARE DELIVERY SYSTEM RESEARCH; QUALITY IMPROVEMENT TECHNICAL ASSISTANCE.

Part D of title IX of the Public Health Service Act, as amended by section 3013, is further amended by adding at the end the following:

"Subpart II—Health Care Quality Improvement Programs

"SEC. 933. HEALTH CARE DELIVERY SYSTEM RESEARCH.

"(a) PURPOSE.—The purposes of this section are to—

"(1) enable the Director to identify, develop, evaluate, disseminate, and provide training in innovative methodologies and strategies for quality improvement practices in the delivery of health care services that represent best practices (referred to as 'best practices') in health care quality, safety, and value; and

"(2) ensure that the Director is accountable for implementing a model to pursue such research in a collaborative manner with other related Federal agencies.

"(b) GENERAL FUNCTIONS OF THE CENTER.—The Center for Quality Improvement and Patient Safety of the

Agency for Healthcare Research and Quality (referred to in this section as the 'Center'), or any other relevant agency or department designated by the Director, shall—

"(1) carry out its functions using research from a variety of disciplines, which may include epidemiology, health services, sociology, psychology, human factors engineering, biostatistics, health economics, clinical research, and health informatics;

"(2) conduct or support activities consistent with the purposes described in subsection (a), and for—

"(A) best practices for quality improvement practices in the delivery of health care services; and

"(B) that include changes in processes of care and the redesign of systems used by providers that will reliably result in intended health outcomes, improve patient safety, and reduce medical errors (such as skill development for health care providers in team-based health care delivery and rapid cycle process improvement) and facilitate adoption of improved workflow;

"(3) identify health care providers, including health care systems, single institutions, and individual providers, that—

"(A) deliver consistently high-quality, efficient health care services (as determined by the Secretary); and

"(B) employ best practices that are adaptable and scalable to diverse health care settings or effective in improving care across diverse settings;

"(4) assess research, evidence, and knowledge about what strategies and methodologies are most effective in improving health care delivery;

"(5) find ways to translate such information rapidly and effectively into practice, and document the sustainability of those improvements;

"(6) create strategies for quality improvement through the development of tools, methodologies, and interventions that can successfully reduce variations in the delivery of health care;

"(7) identify, measure, and improve organizational, human, or other causative factors, including those related to the culture and system design of a health care organization, that contribute to the success and sustainability of specific quality improvement and patient safety strategies;

"(8) provide for the development of best practices in the delivery of health care services that—

"(A) have a high likelihood of success, based on structured review of empirical evidence;

"(B) are specified with sufficient detail of the individual processes, steps, training, skills, and knowledge required for implementation and incorporation into workflow of health care practitioners in a variety of settings;

"(C) are designed to be readily adapted by health care providers in a variety of settings; and

"(D) where applicable, assist health care providers in working with other health care providers across the continuum of care and in engaging patients and their families in improving the care and patient health outcomes;

"(9) provide for the funding of the activities of organizations with recognized expertise and excellence in improving the delivery of health care services, including children's health care, by involving multiple disciplines, managers of health care entities, broad development and training, patients, caregivers and families, and frontline health care workers, including activities for the examination of strategies to share best quality improvement practices and to promote excellence in the delivery of health care services; and

"(10) build capacity at the State and community level to lead quality and safety efforts through education, training, and mentoring programs to carry out the activities under paragraphs (1) through (9).

"(c) RESEARCH FUNCTIONS OF CENTER.—

"(1) IN GENERAL.—The Center shall support, such as through a contract or other mechanism, research on health care delivery system improvement and the development of tools to facilitate adoption of best practices that improve the quality, safety, and efficiency of health care delivery services. Such support may include establishing a Quality Improvement Network Research Program for the purpose of testing, scaling, and disseminating of interventions to improve quality and efficiency in health care. Recipients of funding under the Program may include national, State, multi-State, or multi-site quality improvement networks.

"(2) RESEARCH REQUIREMENTS.—The research conducted pursuant to paragraph (1) shall—

"(A) address the priorities identified by the Secretary in the national strategic plan established under section 399HH;

"(B) identify areas in which evidence is insufficient to identify strategies and methodologies, taking into consideration areas of insufficient evidence identified by the entity with a contract under section 1890(a) of the Social Security Act in the report required under section 399JJ;

"(C) address concerns identified by health care institutions and providers and communicated through the Center pursuant to subsection (d);

"(D) reduce preventable morbidity, mortality, and associated costs of morbidity and mortality by building capacity for patient safety research;

"(E) support the discovery of processes for the reliable, safe, efficient, and responsive delivery of health care, taking into account discoveries from clinical research and comparative effectiveness research;

"(F) allow communication of research findings and translate evidence into practice recommendations that are adaptable to a variety of settings, and which, as soon as practicable after the establishment of the Center, shall include—

"(i) the implementation of a national application of Intensive Care Unit improvement projects relating to the adult (including geriatric), pediatric, and neonatal patient populations;

"(ii) practical methods for addressing health care associated infections, including Methicillin-Resistant Staphylococcus Aureus and Vancomycin-Resistant Entercoccus infections and other emerging infections; and

"(iii) practical methods for reducing preventable hospital admissions and readmissions;

"(G) expand demonstration projects for improving the quality of children's health care and the use of health information technology, such as through Pediatric Quality Improvement Collaboratives and Learning Networks, consistent with provisions of section 1139A of the Social Security Act for assessing and improving quality, where applicable;

"(H) identify and mitigate hazards by—

"(i) analyzing events reported to patient safety reporting systems and patient safety organizations; and

"(ii) using the results of such analyses to develop scientific methods of response to such events;

"(I) include the conduct of systematic reviews of existing practices that improve the quality, safety, and efficiency of health care delivery, as well as new research on improving such practices; and

"(J) include the examination of how to measure and evaluate the progress of quality and patient safety activities.

"(d) DISSEMINATION OF RESEARCH FINDINGS.—

"(1) PUBLIC AVAILABILITY.—The Director shall make the research findings of the Center available to the public through multiple media and appropriate formats to reflect the varying needs of health care providers and consumers and diverse levels of health literacy.

"(2) LINKAGE TO HEALTH INFORMATION TECHNOLOGY.—The Secretary shall ensure that research findings and results generated by the Center are shared with the Office of the National Coordinator of Health Information Technology and used to inform the activities of the health information technology extension program under section 3012, as well as any

relevant standards, certification criteria, or implementation specifications.

"(e) PRIORITIZATION.—The Director shall identify and regularly update a list of processes or systems on which to focus research and dissemination activities of the Center, taking into account—

"(1) the cost to Federal health programs;

"(2) consumer assessment of health care experience;

"(3) provider assessment of such processes or systems and opportunities to minimize distress and injury to the health care workforce;

"(4) the potential impact of such processes or systems on health status and function of patients, including vulnerable populations including children;

"(5) the areas of insufficient evidence identified under subsection (c)(2)(B); and

"(6) the evolution of meaningful use of health information technology, as defined in section 3000.

"(f) COORDINATION.—The Center shall coordinate its activities with activities conducted by the Center for Medicare and Medicaid Innovation established under section 1115A of the Social Security Act.

"(g) FUNDING.—There is authorized to be appropriated to carry out this section $20,000,000 for fiscal years 2010 through 2014.

"SEC. 934. QUALITY IMPROVEMENT TECHNICAL ASSISTANCE AND IMPLEMENTATION.

"(a) IN GENERAL.—The Director, through the Center for Quality Improvement and Patient Safety of the Agency for Healthcare Research and Quality (referred to in this section as the 'Center'), shall award—

"(1) technical assistance grants or contracts to eligible entities to provide technical support to institutions that deliver health care and health care providers (including rural and urban providers of services and suppliers with limited infrastructure and financial resources to implement and support quality improvement activities, providers of services and suppliers with poor performance scores, and providers of services and suppliers for which there are disparities in care among subgroups of patients) so that such institutions and providers understand, adapt, and implement the models and practices identified in the research conducted by the Center, including the Quality Improvement Networks Research Program; and

"(2) implementation grants or contracts to eligible entities to implement the models and practices described under paragraph (1).

"(b) ELIGIBLE ENTITIES.—

"(1) TECHNICAL ASSISTANCE AWARD.—To be eligible to receive a technical assistance grant or contract under subsection (a)(1), an entity—

"(A) may be a health care provider, health care provider association, professional society, health care worker organization, Indian health organization, quality improvement organization, patient safety organization, local quality improvement collaborative, the Joint Commission, academic health center, university, physician-based research network, primary care extension program established under section 399W, a Federal Indian Health Service program or a health program operated by an Indian tribe (as defined in section 4 of the Indian Health Care Improvement Act), or any other entity identified by the Secretary; and

"(B) shall have demonstrated expertise in providing information and technical support and assistance to health care providers regarding quality improvement.

"(2) IMPLEMENTATION AWARD.—To be eligible to receive an implementation grant or contract under subsection (a)(2), an entity—

"(A) may be a hospital or other health care provider or consortium or providers, as determined by the Secretary; and

"(B) shall have demonstrated expertise in providing information and technical support and assistance to health care providers regarding quality improvement.

"(c) APPLICATION.—

"(1) TECHNICAL ASSISTANCE AWARD.—To receive a technical assistance grant or contract under subsection (a)(1), an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing—

"(A) a plan for a sustainable business model that may include a system of—

"(i) charging fees to institutions and providers that receive technical support from the entity; and

"(ii) reducing or eliminating such fees for such institutions and providers that serve low-income populations; and

"(B) such other information as the Director may require.

"(2) IMPLEMENTATION AWARD.—To receive a grant or contract under subsection (a)(2), an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing—

"(A) a plan for implementation of a model or practice identified in the research conducted by the Center including—

"(i) financial cost, staffing requirements, and timeline for implementation; and

"(ii) pre- and projected post-implementation quality measure performance data in targeted improvement areas identified by the Secretary; and

"(B) such other information as the Director may require.

"(d) MATCHING FUNDS.—The Director may not award a grant or contract under this section to an entity unless the entity agrees that it will make available (directly or through contributions from other public or private entities) non-Federal contributions toward the activities to be carried out under the grant or contract in an amount equal to $1 for each $5 of Federal funds provided under the grant

or contract. Such non-Federal matching funds may be provided directly or through donations from public or private entities and may be in cash or in-kind, fairly evaluated, including plant, equipment, or services.

"(e) EVALUATION.—

"(1) IN GENERAL.—The Director shall evaluate the performance of each entity that receives a grant or contract under this section. The evaluation of an entity shall include a study of—

"(A) the success of such entity in achieving the implementation, by the health care institutions and providers assisted by such entity, of the models and practices identified in the research conducted by the Center under section 933;

"(B) the perception of the health care institutions and providers assisted by such entity regarding the value of the entity; and

"(C) where practicable, better patient health outcomes and lower cost resulting from the assistance provided by such entity.

"(2) EFFECT OF EVALUATION.—Based on the outcome of the evaluation of the entity under paragraph (1), the Director shall determine whether to

renew a grant or contract with such entity under this section.

"(f) COORDINATION.—The entities that receive a grant or contract under this section shall coordinate with health information technology regional extension centers under section 3012(c) and the primary care extension program established under section 399W regarding the dissemination of quality improvement, system delivery reform, and best practices information.".

SEC. 3502. ESTABLISHING COMMUNITY HEALTH TEAMS TO SUPPORT THE PATIENT-CENTERED MEDICAL HOME.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the "Secretary") shall establish a program to provide grants to or enter into contracts with eligible entities to establish community-based interdisciplinary, interprofessional teams (referred to in this section as "health teams") to support primary care practices, including obstetrics and gynecology practices, within the hospital service areas served by the eligible entities. Grants or contracts shall be used to—

(1) establish health teams to provide support services to primary care providers; and

(2) provide capitated payments to primary care providers as determined by the Secretary.

(b) ELIGIBLE ENTITIES.—To be eligible to receive a grant or contract under subsection (a), an entity shall—

(1)(A) be a State or State-designated entity; or

(B) be an Indian tribe or tribal organization, as defined in section 4 of the Indian Health Care Improvement Act;

(2) submit a plan for achieving long-term financial sustainability within 3 years;

(3) submit a plan for incorporating prevention initiatives and patient education and care management resources into the delivery of health care that is integrated with community-based prevention and treatment resources, where available;

(4) ensure that the health team established by the entity includes an interdisciplinary, interprofessional team of health care providers, as determined by the Secretary; such team may include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral and mental health providers (including substance use disorder prevention and treatment providers), doctors of chiropractic, licensed complementary and alternative medicine practitioners, and physicians' assistants;

(5) agree to provide services to eligible individuals with chronic conditions, as described in section

1945 of the Social Security Act (as added by section 2703), in accordance with the payment methodology established under subsection (c) of such section; and

(6) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(c) REQUIREMENTS FOR HEALTH TEAMS.—A health team established pursuant to a grant or contract under subsection (a) shall—

(1) establish contractual agreements with primary care providers to provide support services;

(2) support patient-centered medical homes, defined as a mode of care that includes—

(A) personal physicians;

(B) whole person orientation;

(C) coordinated and integrated care;

(D) safe and high-quality care through evidence-informed medicine, appropriate use of health information technology, and continuous quality improvements;

(E) expanded access to care; and

(F) payment that recognizes added value from additional components of patient-centered care;

(3) collaborate with local primary care providers and existing State and community based resources to coordinate disease prevention, chronic disease management, transitioning between health care providers and settings and case management for patients, including children, with priority given to those amenable to prevention and with chronic diseases or conditions identified by the Secretary;

(4) in collaboration with local health care providers, develop and implement interdisciplinary, interprofessional care plans that integrate clinical and community preventive and health promotion services for patients, including children, with a priority given to those amenable to prevention and with chronic diseases or conditions identified by the Secretary;

(5) incorporate health care providers, patients, caregivers, and authorized representatives in program design and oversight;

(6) provide support necessary for local primary care providers to—

(A) coordinate and provide access to high-quality health care services;

(B) coordinate and provide access to preventive and health promotion services;

(C) provide access to appropriate specialty care and inpatient services;

(D) provide quality-driven, cost-effective, culturally appropriate, and patient- and family-centered health care;

(E) provide access to pharmacist-delivered medication management services, including medication reconciliation;

(F) provide coordination of the appropriate use of complementary and alternative (CAM) services to those who request such services;

(G) promote effective strategies for treatment planning, monitoring health outcomes and resource use, sharing information, treatment decision support, and organizing care to avoid duplication of service and other medical management approaches intended to improve quality and value of health care services;

(H) provide local access to the continuum of health care services in the most appropriate setting, including access to individuals that implement the care plans of patients and coordinate care, such as integrative health care practitioners;

(I) collect and report data that permits evaluation of the success of the collaborative effort on patient outcomes, including collection of data on patient experience of care, and identification of areas for improvement; and

(J) establish a coordinated system of early identification and referral for children at risk for developmental or behavioral problems such as through the use of infolines, health information technology, or other means as determined by the Secretary;

(7) provide 24-hour care management and support during transitions in care settings including—

(A) a transitional care program that provides onsite visits from the care coordinator, assists with the development of discharge plans and medication reconciliation upon admission to and discharge from the hospitals, nursing home, or other institution setting;

(B) discharge planning and counseling support to providers, patients, caregivers, and authorized representatives;

(C) assuring that post-discharge care plans include medication management, as appropriate;

(D) referrals for mental and behavioral health services, which may include the use of infolines; and

(E) transitional health care needs from adolescence to adulthood;

(8) serve as a liaison to community prevention and treatment programs;

(9) demonstrate a capacity to implement and maintain health information technology that meets the requirements of certified EHR technology (as defined in section 3000 of the Public Health Service Act (42 U.S.C. 300jj)) to facilitate coordination among members of the applicable care team and affiliated primary care practices; and

(10) where applicable, report to the Secretary information on quality measures used under section 399JJ of the Public Health Service Act.

(d) REQUIREMENT FOR PRIMARY CARE PROVIDERS.—A provider who contracts with a care team shall—

(1) provide a care plan to the care team for each patient participant;

(2) provide access to participant health records; and

(3) meet regularly with the care team to ensure integration of care.

(e) REPORTING TO SECRETARY.—An entity that receives a grant or contract under subsection (a) shall submit to the Secretary a report that describes and evaluates, as requested by the Secretary, the activities carried out by the entity under subsection (c).

(f) DEFINITION OF PRIMARY CARE.—In this section, the term "primary care" means the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

SEC. 3503. MEDICATION MANAGEMENT SERVICES IN TREATMENT OF CHRONIC DISEASE.

Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.), as amended by section 3501, is further amended by inserting after section 934 the following:

"SEC. 935. GRANTS OR CONTRACTS TO IMPLEMENT MEDICATION MANAGEMENT SERVICES IN TREATMENT OF CHRONIC DISEASES.

"(a) IN GENERAL.—The Secretary, acting through the Patient Safety Research Center established in section 933 (referred to in this section as the 'Center'), shall establish a program to provide grants or contracts to eligible entities to implement medication management (referred to in this

section as 'MTM') services provided by licensed pharmacists, as a collaborative, multidisciplinary, inter-professional approach to the treatment of chronic diseases for targeted individuals, to improve the quality of care and reduce overall cost in the treatment of such diseases. The Secretary shall commence the program under this section not later than May 1, 2010.

"(b) ELIGIBLE ENTITIES.—To be eligible to receive a grant or contract under subsection (a), an entity shall—

"(1) provide a setting appropriate for MTM services, as recommended by the experts described in subsection (e);

"(2) submit to the Secretary a plan for achieving long-term financial sustainability;

"(3) where applicable, submit a plan for coordinating MTM services through local community health teams established in section 3502 of the Patient Protection and Affordable Care Act or in collaboration with primary care extension programs established in section 399W;

"(4) submit a plan for meeting the requirements under subsection (c); and

"(5) submit to the Secretary such other information as the Secretary may require.

"(c) MTM SERVICES TO TARGETED INDIVIDUALS.—The MTM services provided with the assistance of a grant or contract awarded under subsection (a) shall, as allowed by State law including applicable collaborative pharmacy practice agreements, include—

"(1) performing or obtaining necessary assessments of the health and functional status of each patient receiving such MTM services;

"(2) formulating a medication treatment plan according to therapeutic goals agreed upon by the prescriber and the patient or caregiver or authorized representative of the patient;

"(3) selecting, initiating, modifying, recommending changes to, or administering medication therapy;

"(4) monitoring, which may include access to, ordering, or performing laboratory assessments, and evaluating the response of the patient to therapy, including safety and effectiveness;

"(5) performing an initial comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events, quarterly targeted medication reviews for ongoing monitoring, and additional followup interventions on

a schedule developed collaboratively with the prescriber;

"(6) documenting the care delivered and communicating essential information about such care, including a summary of the medication review, and the recommendations of the pharmacist to other appropriate health care providers of the patient in a timely fashion;

"(7) providing education and training designed to enhance the understanding and appropriate use of the medications by the patient, caregiver, and other authorized representative;

"(8) providing information, support services, and resources and strategies designed to enhance patient adherence with therapeutic regimens;

"(9) coordinating and integrating MTM services within the broader health care management services provided to the patient; and

"(10) such other patient care services allowed under pharmacist scopes of practice in use in other Federal programs that have implemented MTM services.

"(d) TARGETED INDIVIDUALS.—MTM services provided by licensed pharmacists under a grant or contract

awarded under subsection (a) shall be offered to targeted individuals who—

"(1) take 4 or more prescribed medications (including over-the-counter medications and dietary supplements);

"(2) take any 'high risk' medications;

"(3) have 2 or more chronic diseases, as identified by the Secretary; or

"(4) have undergone a transition of care, or other factors, as determined by the Secretary, that are likely to create a high risk of medication-related problems.

"(e) CONSULTATION WITH EXPERTS.—In designing and implementing MTM services provided under grants or contracts awarded under subsection (a), the Secretary shall consult with Federal, State, private, public-private, and academic entities, pharmacy and pharmacist organizations, health care organizations, consumer advocates, chronic disease groups, and other stakeholders involved with the research, dissemination, and implementation of pharmacist-delivered MTM services, as the Secretary determines appropriate. The Secretary, in collaboration with this group, shall determine whether it is possible to incorporate rapid cycle process improvement concepts in use in other Federal programs that have implemented MTM services.

"(f) REPORTING TO THE SECRETARY.—An entity that receives a grant or contract under subsection (a) shall submit to the Secretary a report that describes and evaluates, as requested by the Secretary, the activities carried out under subsection (c), including quality measures endorsed by the entity with a contract under section 1890 of the Social Security Act, as determined by the Secretary.

"(g) EVALUATION AND REPORT.—The Secretary shall submit to the relevant committees of Congress a report which shall—

"(1) assess the clinical effectiveness of pharmacist-provided services under the MTM services program, as compared to usual care, including an evaluation of whether enrollees maintained better health with fewer hospitalizations and emergency room visits than similar patients not enrolled in the program;

"(2) assess changes in overall health care resource use by targeted individuals;

"(3) assess patient and prescriber satisfaction with MTM services;

"(4) assess the impact of patient-cost sharing requirements on medication adherence and recommendations for modifications;

"(5) identify and evaluate other factors that may impact clinical and economic outcomes, including de-

mographic characteristics, clinical characteristics, and health services use of the patient, as well as characteristics of the regimen, pharmacy benefit, and MTM services provided; and

"(6) evaluate the extent to which participating pharmacists who maintain a dispensing role have a conflict of interest in the provision of MTM services, and if such conflict is found, provide recommendations on how such a conflict might be appropriately addressed.

"(h) GRANTS OR CONTRACTS TO FUND DEVELOPMENT OF PERFORMANCE MEASURES.—The Secretary may, through the quality measure development program under section 931 of the Public Health Service Act, award grants or contracts to eligible entities for the purpose of funding the development of performance measures that assess the use and effectiveness of medication therapy management services.".

SEC. 3504. DESIGN AND IMPLEMENTATION OF REGIONALIZED SYSTEMS FOR EMERGENCY CARE.

(a) IN GENERAL.—Title XII of the Public Health Service Act (42 U.S.C. 300d et seq.) is amended—

(1) in section 1203—

*(A) in the section heading, by inserting "**FOR TRAUMA SYSTEMS**" after "**GRANTS**"; and*

(B) in subsection (a), by striking "Administrator of the Health Resources and Services Administration" and inserting "Assistant Secretary for Preparedness and Response";

(2) by inserting after section 1203 the following:

"SEC. 1204. COMPETITIVE GRANTS FOR REGIONALIZED SYSTEMS FOR EMERGENCY CARE RESPONSE.

"(a) IN GENERAL.—The Secretary, acting through the Assistant Secretary for Preparedness and Response, shall award not fewer than 4 multiyear contracts or competitive grants to eligible entities to support pilot projects that design, implement, and evaluate innovative models of regionalized, comprehensive, and accountable emergency care and trauma systems.

"(b) ELIGIBLE ENTITY; REGION.—In this section:

"(1) ELIGIBLE ENTITY.—The term 'eligible entity' means—

"(A) a State or a partnership of 1 or more States and 1 or more local governments; or

"(B) an Indian tribe (as defined in section 4 of the Indian Health Care Improvement Act) or a partnership of 1 or more Indian tribes.

"(2) REGION.—The term 'region' means an area within a State, an area that lies within multiple States, or a similar area (such as a multicounty area), as determined by the Secretary.

"(3) EMERGENCY SERVICES.—The term 'emergency services' includes acute, prehospital, and trauma care.

"(c) PILOT PROJECTS.—The Secretary shall award a contract or grant under subsection (a) to an eligible entity that proposes a pilot project to design, implement, and evaluate an emergency medical and trauma system that—

"(1) coordinates with public health and safety services, emergency medical services, medical facilities, trauma centers, and other entities in a region to develop an approach to emergency medical and trauma system access throughout the region, including 9–1–1 Public Safety Answering Points and emergency medical dispatch;

"(2) includes a mechanism, such as a regional medical direction or transport communications system, that operates throughout the region to ensure that the patient is taken to the medically appropriate facility (whether an initial facility or a higher-level facility) in a timely fashion;

"(3) allows for the tracking of prehospital and hospital resources, including inpatient bed capacity, emergency department capacity, trauma center capacity, on-call specialist coverage, ambulance diversion status, and the coordination of such tracking with regional communications and hospital destination decisions; and

"(4) includes a consistent region-wide prehospital, hospital, and interfacility data management system that—

"(A) submits data to the National EMS Information System, the National Trauma Data Bank, and others;

"(B) reports data to appropriate Federal and State databanks and registries; and

"(C) contains information sufficient to evaluate key elements of prehospital care, hospital destination decisions, including initial hospital and interfacility decisions, and relevant health outcomes of hospital care.

"(d) APPLICATION.—

"(1) IN GENERAL.—An eligible entity that seeks a contract or grant described in subsection (a) shall submit to the Secretary an application at such time and in such manner as the Secretary may require.

"(2) APPLICATION INFORMATION.—Each application shall include—

"(A) an assurance from the eligible entity that the proposed system—

"(i) has been coordinated with the applicable State Office of Emergency Medical Services (or equivalent State office);

"(ii) includes consistent indirect and direct medical oversight of prehospital, hospital, and interfacility transport throughout the region;

"(iii) coordinates prehospital treatment and triage, hospital destination, and interfacility transport throughout the region;

"(iv) includes a categorization or designation system for special medical facilities throughout the region that is integrated with transport and destination protocols;

"(v) includes a regional medical direction, patient tracking, and resource allocation system that supports day-to-day emergency care and surge capacity and is integrated with other components of the na-

tional and State emergency preparedness system; and

"(vi) addresses pediatric concerns related to integration, planning, preparedness, and coordination of emergency medical services for infants, children and adolescents; and

"(B) such other information as the Secretary may require.

"(e) REQUIREMENT OF MATCHING FUNDS.—

"(1) IN GENERAL.—The Secretary may not make a grant under this section unless the State (or consortia of States) involved agrees, with respect to the costs to be incurred by the State (or consortia) in carrying out the purpose for which such grant was made, to make available non-Federal contributions (in cash or in kind under paragraph (2)) toward such costs in an amount equal to not less than $1 for each $3 of Federal funds provided in the grant. Such contributions may be made directly or through donations from public or private entities.

"(2) NON-FEDERAL CONTRIBUTIONS.—Non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including equipment or services (and excluding indirect or overhead

costs). Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

"(f) PRIORITY.—The Secretary shall give priority for the award of the contracts or grants described in subsection (a) to any eligible entity that serves a population in a medically underserved area (as defined in section 330(b)(3)).

"(g) REPORT.—Not later than 90 days after the completion of a pilot project under subsection (a), the recipient of such contract or grant described in shall submit to the Secretary a report containing the results of an evaluation of the program, including an identification of—

"(1) the impact of the regional, accountable emergency care and trauma system on patient health outcomes for various critical care categories, such as trauma, stroke, cardiac emergencies, neurological emergencies, and pediatric emergencies;

"(2) the system characteristics that contribute to the effectiveness and efficiency of the program (or lack thereof);

"(3) methods of assuring the long-term financial sustainability of the emergency care and trauma system;

"(4) the State and local legislation necessary to implement and to maintain the system;

"(5) the barriers to developing regionalized, accountable emergency care and trauma systems, as well as the methods to overcome such barriers; and

"(6) recommendations on the utilization of available funding for future regionalization efforts.

"(h) DISSEMINATION OF FINDINGS.—The Secretary shall, as appropriate, disseminate to the public and to the appropriate Committees of the Congress, the information contained in a report made under subsection (g).''; and

(3) in section 1232—

(A) in subsection (a), by striking "appropriated" and all that follows through the period at the end and inserting "appropriated $24,000,000 for each of fiscal years 2010 through 2014."; and

(B) by inserting after subsection (c) the following:

"(d) AUTHORITY.—For the purpose of carrying out parts A through C, beginning on the date of enactment of the Patient Protection and Affordable Care Act, the Sec-

retary shall transfer authority in administering grants and related authorities under such parts from the Administrator of the Health Resources and Services Administration to the Assistant Secretary for Preparedness and Response.".

(b) SUPPORT FOR EMERGENCY MEDICINE RESEARCH.—Part H of title IV of the Public Health Service Act (42 U.S.C. 289 et seq.) is amended by inserting after the section 498C the following:

"SEC. 498D. SUPPORT FOR EMERGENCY MEDICINE RESEARCH.

"(a) EMERGENCY MEDICAL RESEARCH.—The Secretary shall support Federal programs administered by the National Institutes of Health, the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, the Centers for Disease Control and Prevention, and other agencies involved in improving the emergency care system to expand and accelerate research in emergency medical care systems and emergency medicine, including—

"(1) the basic science of emergency medicine;

"(2) the model of service delivery and the components of such models that contribute to enhanced patient health outcomes;

"(3) the translation of basic scientific research into improved practice; and

"(4) the development of timely and efficient delivery of health services.

"(b) PEDIATRIC EMERGENCY MEDICAL RESEARCH.—The Secretary shall support Federal programs administered by the National Institutes of Health, the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, the Centers for Disease Control and Prevention, and other agencies to coordinate and expand research in pediatric emergency medical care systems and pediatric emergency medicine, including—

"(1) an examination of the gaps and opportunities in pediatric emergency care research and a strategy for the optimal organization and funding of such research;

"(2) the role of pediatric emergency services as an integrated component of the overall health system;

"(3) system-wide pediatric emergency care planning, preparedness, coordination, and funding;

"(4) pediatric training in professional education; and

"(5) research in pediatric emergency care, specifically on the efficacy, safety, and health outcomes of medications used for infants, children, and adolescents in emergency care settings in order to improve patient safety.

"(c) IMPACT RESEARCH.—The Secretary shall support research to determine the estimated economic impact of, and savings that result from, the implementation of coordinated emergency care systems.

"(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2010 through 2014.".

SEC. 3505. TRAUMA CARE CENTERS AND SERVICE AVAILABILITY.

(a) TRAUMA CARE CENTERS.—

(1) GRANTS FOR TRAUMA CARE CENTERS.—Section 1241 of the Public Health Service Act (42 U.S.C. 300d–41) is amended by striking subsections (a) and (b) and inserting the following:

"(a) IN GENERAL.—The Secretary shall establish 3 programs to award grants to qualified public, nonprofit Indian Health Service, Indian tribal, and urban Indian trauma centers—

"(1) to assist in defraying substantial uncompensated care costs;

"(2) to further the core missions of such trauma centers, including by addressing costs associated with patient stabilization and transfer, trauma education and outreach, coordination with local and regional

trauma systems, essential personnel and other fixed costs, and expenses associated with employee and non-employee physician services; and

"(3) to provide emergency relief to ensure the continued and future availability of trauma services.

"(b) MINIMUM QUALIFICATIONS OF TRAUMA CENTERS.—

"(1) PARTICIPATION IN TRAUMA CARE SYSTEM OPERATING UNDER CERTAIN PROFESSIONAL GUIDELINES.—Except as provided in paragraph (2), the Secretary may not award a grant to a trauma center under subsection (a) unless the trauma center is a participant in a trauma system that substantially complies with section 1213.

"(2) EXEMPTION.—Paragraph (1) shall not apply to trauma centers that are located in States with no existing trauma care system.

"(3) QUALIFICATION FOR SUBSTANTIAL UNCOMPENSATED CARE COSTS.—The Secretary shall award substantial uncompensated care grants under subsection (a)(1) only to trauma centers meeting at least 1 of the criteria in 1 of the following 3 categories:

"(A) CATEGORY A.—The criteria for category A are as follows:

"(i) At least 40 percent of the visits in the emergency department of the hospital in which the trauma center is located were charity or self-pay patients.

"(ii) At least 50 percent of the visits in such emergency department were Medicaid (under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.)) and charity and self-pay patients combined.

"(B) CATEGORY B.—The criteria for category B are as follows:

"(i) At least 35 percent of the visits in the emergency department were charity or self-pay patients.

"(ii) At least 50 percent of the visits in the emergency department were Medicaid and charity and self-pay patients combined.

"(C) CATEGORY C.—The criteria for category C are as follows:

"(i) At least 20 percent of the visits in the emergency department were charity or self-pay patients.

"(ii) At least 30 percent of the visits in the emergency department were Medicaid and charity and self-pay patients combined.

"(4) TRAUMA CENTERS IN 1115 WAIVER STATES.—Notwithstanding paragraph (3), the Secretary may award a substantial uncompensated care grant to a trauma center under subsection (a)(1) if the trauma center qualifies for funds under a Low Income Pool or Safety Net Care Pool established through a waiver approved under section 1115 of the Social Security Act (42 U.S.C. 1315).

"(5) DESIGNATION.—The Secretary may not award a grant to a trauma center unless such trauma center is verified by the American College of Surgeons or designated by an equivalent State or local agency.

"(c) ADDITIONAL REQUIREMENTS.—The Secretary may not award a grant to a trauma center under subsection (a)(1) unless such trauma center—

"(1) submits to the Secretary a plan satisfactory to the Secretary that demonstrates a continued commitment to serving trauma patients regardless of their ability to pay; and

"(2) has policies in place to assist patients who cannot pay for part or all of the care they receive, including a sliding fee scale, and to ensure fair billing and collection practices.".

(2) CONSIDERATIONS IN MAKING GRANTS.—Section 1242 of the Public Health Service Act (42 U.S.C.

300d–42) is amended by striking subsections (a) and (b) and inserting the following:

"(a) SUBSTANTIAL UNCOMPENSATED CARE AWARDS.—

"(1) IN GENERAL.—The Secretary shall establish an award basis for each eligible trauma center for grants under section 1241(a)(1) according to the percentage described in paragraph (2), subject to the requirements of section 1241(b)(3).

"(2) PERCENTAGES.—The applicable percentages are as follows:

"(A) With respect to a category A trauma center, 100 percent of the uncompensated care costs.

"(B) With respect to a category B trauma center, not more than 75 percent of the uncompensated care costs.

"(C) With respect to a category C trauma center, not more than 50 percent of the uncompensated care costs.

"(b) CORE MISSION AWARDS.—

"(1) IN GENERAL.—In awarding grants under section 1241(a)(2), the Secretary shall—

"(A) reserve 25 percent of the amount allocated for core mission awards for Level III and Level IV trauma centers; and

"(B) reserve 25 percent of the amount allocated for core mission awards for large urban Level I and II trauma centers—

"(i) that have at least 1 graduate medical education fellowship in trauma or trauma related specialties for which demand is exceeding supply;

"(ii) for which—

"(I) annual uncompensated care costs exceed $10,000,000; or

"(II) at least 20 percent of emergency department visits are charity or self-pay or Medicaid patients; and

"(iii) that are not eligible for substantial uncompensated care awards under section 1241(a)(1).

"(c) EMERGENCY AWARDS.—In awarding grants under section 1241(a)(3), the Secretary shall—

"(1) give preference to any application submitted by a trauma center that provides trauma care in a geographic area in which the availability of trauma care has significantly decreased or will significantly

decrease if the center is forced to close or downgrade service or growth in demand for trauma services exceeds capacity; and

"(2) reallocate any emergency awards funds not obligated due to insufficient, or a lack of qualified, applications to the significant uncompensated care award program.".

(3) CERTAIN AGREEMENTS.—Section 1243 of the Public Health Service Act (42 U.S.C. 300d–43) is amended by striking subsections (a), (b), and (c) and inserting the following:

"(a) MAINTENANCE OF FINANCIAL SUPPORT.—The Secretary may require a trauma center receiving a grant under section 1241(a) to maintain access to trauma services at comparable levels to the prior year during the grant period.

"(b) TRAUMA CARE REGISTRY.—The Secretary may require the trauma center receiving a grant under section 1241(a) to provide data to a national and centralized registry of trauma cases, in accordance with guidelines developed by the American College of Surgeons, and as the Secretary may otherwise require.".

(4) GENERAL PROVISIONS.—Section 1244 of the Public Health Service Act (42 U.S.C. 300d–44) is

amended by striking subsections (a), (b), and (c) and inserting the following:

"(a) APPLICATION.—The Secretary may not award a grant to a trauma center under section 1241(a) unless such center submits an application for the grant to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this part.

"(b) LIMITATION ON DURATION OF SUPPORT.—The period during which a trauma center receives payments under a grant under section 1241(a)(3) shall be for 3 fiscal years, except that the Secretary may waive such requirement for a center and authorize such center to receive such payments for 1 additional fiscal year.

"(c) LIMITATION ON AMOUNT OF GRANT.—Notwithstanding section 1242(a), a grant under section 1241 may not be made in an amount exceeding $2,000,000 for each fiscal year.

"(d) ELIGIBILITY.—Except as provided in section 1242(b)(1)(B)(iii), acquisition of, or eligibility for, a grant under section 1241(a) shall not preclude a trauma center from being eligible for other grants described in such section.

"(e) FUNDING DISTRIBUTION.—Of the total amount appropriated for a fiscal year under section 1245, 70 percent shall be used for substantial uncompensated care awards under section 1241(a)(1), 20 percent shall be used for core mission awards under section 1241(a)(2), and 10 percent shall be used for emergency awards under section 1241(a)(3).

"(f) MINIMUM ALLOWANCE.—Notwithstanding subsection (e), if the amount appropriated for a fiscal year under section 1245 is less than $25,000,000, all available funding for such fiscal year shall be used for substantial uncompensated care awards under section 1241(a)(1).

"(g) SUBSTANTIAL UNCOMPENSATED CARE AWARD DISTRIBUTION AND PROPORTIONAL SHARE.—Notwithstanding section 1242(a), of the amount appropriated for substantial uncompensated care grants for a fiscal year, the Secretary shall—

"(1) make available—

"(A) 50 percent of such funds for category A trauma center grantees;

"(B) 35 percent of such funds for category B trauma center grantees; and

"(C) 15 percent of such funds for category C trauma center grantees; and

"(2) provide available funds within each category in a manner proportional to the award basis specified in section 1242(a)(2) to each eligible trauma center.

"(h) REPORT.—Beginning 2 years after the date of enactment of the Patient Protection and Affordable Care Act, and every 2 years thereafter, the Secretary shall biennially report to Congress regarding the status of the grants made under section 1241 and on the overall financial stability of trauma centers.".

(5) AUTHORIZATION OF APPROPRIATIONS.—Section 1245 of the Public Health Service Act (42 U.S.C. 300d–45) is amended to read as follows:

"SEC. 1245. AUTHORIZATION OF APPROPRIATIONS.

"For the purpose of carrying out this part, there are authorized to be appropriated $100,000,000 for fiscal year 2009, and such sums as may be necessary for each of fiscal years 2010 through 2015. Such authorization of appropriations is in addition to any other authorization of appropriations or amounts that are available for such purpose.".

(6) DEFINITION.—Part D of title XII of the Public Health Service Act (42 U.S.C. 300d–41 et seq.) is amended by adding at the end the following:

"SEC. 1246. DEFINITION.

"In this part, the term 'uncompensated care costs' means unreimbursed costs from serving self-pay, charity, or Medicaid patients, without regard to payment under section 1923 of the Social Security Act, all of which are attributable to emergency care and trauma care, including costs related to subsequent inpatient admissions to the hospital.".

(b) TRAUMA SERVICE AVAILABILITY.—Title XII of the Public Health Service Act (42 U.S.C. 300d et seq.) is amended by adding at the end the following:

"PART H—TRAUMA SERVICE AVAILABILITY

"SEC. 1281. GRANTS TO STATES.

"(a) ESTABLISHMENT.—To promote universal access to trauma care services provided by trauma centers and trauma-related physician specialties, the Secretary shall provide funding to States to enable such States to award grants to eligible entities for the purposes described in this section.

"(b) AWARDING OF GRANTS BY STATES.—Each State may award grants to eligible entities within the State for the purposes described in subparagraph (d).

"(c) ELIGIBILITY.—

"(1) IN GENERAL.—To be eligible to receive a grant under subsection (b) an entity shall—

"(A) be—

"(i) a public or nonprofit trauma center or consortium thereof that meets that requirements of paragraphs (1), (2), and (5) of section 1241(b);

"(ii) a safety net public or nonprofit trauma center that meets the requirements of paragraphs (1) through (5) of section 1241(b); or

"(iii) a hospital in an underserved area (as defined by the State) that seeks to establish new trauma services; and

"(B) submit to the State an application at such time, in such manner, and containing such information as the State may require.

"(2) LIMITATION.—A State shall use at least 40 percent of the amount available to the State under this part for a fiscal year to award grants to safety net trauma centers described in paragraph (1)(A)(ii).

"(d) USE OF FUNDS.—The recipient of a grant under subsection (b) shall carry out 1 or more of the following activities consistent with subsection (b):

"(1) Providing trauma centers with funding to support physician compensation in trauma-related physician specialties where shortages exist in the re-

gion involved, with priority provided to safety net trauma centers described in subsection (c)(1)(A)(ii).

"(2) Providing for individual safety net trauma center fiscal stability and costs related to having service that is available 24 hours a day, 7 days a week, with priority provided to safety net trauma centers described in subsection (c)(1)(A)(ii) located in urban, border, and rural areas.

"(3) Reducing trauma center overcrowding at specific trauma centers related to throughput of trauma patients.

"(4) Establishing new trauma services in underserved areas as defined by the State.

"(5) Enhancing collaboration between trauma centers and other hospitals and emergency medical services personnel related to trauma service availability.

"(6) Making capital improvements to enhance access and expedite trauma care, including providing helipads and associated safety infrastructure.

"(7) Enhancing trauma surge capacity at specific trauma centers.

"(8) Ensuring expedient receipt of trauma patients transported by ground or air to the appropriate trauma center.

"(9) Enhancing interstate trauma center collaboration.

"(e) LIMITATION.—

"(1) IN GENERAL.—A State may use not more than 20 percent of the amount available to the State under this part for a fiscal year for administrative costs associated with awarding grants and related costs.

"(2) MAINTENANCE OF EFFORT.—The Secretary may not provide funding to a State under this part unless the State agrees that such funds will be used to supplement and not supplant State funding otherwise available for the activities and costs described in this part.

"(f) DISTRIBUTION OF FUNDS.—The following shall apply with respect to grants provided in this part:

"(1) LESS THAN $10,000,000.—If the amount of appropriations for this part in a fiscal year is less than $10,000,000, the Secretary shall divide such funding evenly among only those States that have 1 or more trauma centers eligible for funding under section 1241(b)(3)(A).

"(2) LESS THAN $20,000,000.—If the amount of appropriations in a fiscal year is less than $20,000,000, the Secretary shall divide such funding

evenly among only those States that have 1 or more trauma centers eligible for funding under subparagraphs (A) and (B) of section 1241(b)(3).

"(3) LESS THAN $30,000,000.—If the amount of appropriations for this part in a fiscal year is less than $30,000,000, the Secretary shall divide such funding evenly among only those States that have 1 or more trauma centers eligible for funding under section 1241(b)(3).

"(4) $30,000,000 OR MORE.—If the amount of appropriations for this part in a fiscal year is $30,000,000 or more, the Secretary shall divide such funding evenly among all States.

"SEC. 1282. AUTHORIZATION OF APPROPRIATIONS.

"For the purpose of carrying out this part, there is authorized to be appropriated $100,000,000 for each of fiscal years 2010 through 2015.".

SEC. 3506. PROGRAM TO FACILITATE SHARED DECISION-MAKING.

Part D of title IX of the Public Health Service Act, as amended by section 3503, is further amended by adding at the end the following:

"SEC. 936. PROGRAM TO FACILITATE SHARED DECISION-MAKING.

"(a) PURPOSE.—The purpose of this section is to facilitate collaborative processes between patients, caregivers or authorized representatives, and clinicians that engages the patient, caregiver or authorized representative in decisionmaking, provides patients, caregivers or authorized representatives with information about trade-offs among treatment options, and facilitates the incorporation of patient preferences and values into the medical plan.

"(b) DEFINITIONS.—In this section:

"(1) PATIENT DECISION AID.—The term 'patient decision aid' means an educational tool that helps patients, caregivers or authorized representatives understand and communicate their beliefs and preferences related to their treatment options, and to decide with their health care provider what treatments are best for them based on their treatment options, scientific evidence, circumstances, beliefs, and preferences.

"(2) PREFERENCE SENSITIVE CARE.—The term 'preference sensitive care' means medical care for which the clinical evidence does not clearly support one treatment option such that the appropriate course of treatment depends on the values of the patient or the preferences of the patient, caregivers or authorized representatives regarding the benefits, harms and sci-

entific evidence for each treatment option, the use of such care should depend on the informed patient choice among clinically appropriate treatment options.

"(c) ESTABLISHMENT OF INDEPENDENT STANDARDS FOR PATIENT DECISION AIDS FOR PREFERENCE SENSITIVE CARE.—

"(1) CONTRACT WITH ENTITY TO ESTABLISH STANDARDS AND CERTIFY PATIENT DECISION AIDS.—

"(A) IN GENERAL.—For purposes of supporting consensus-based standards for patient decision aids for preference sensitive care and a certification process for patient decision aids for use in the Federal health programs and by other interested parties, the Secretary shall have in effect a contract with the entity with a contract under section 1890 of the Social Security Act. Such contract shall provide that the entity perform the duties described in paragraph (2).

"(B) TIMING FOR FIRST CONTRACT.—As soon as practicable after the date of the enactment of this section, the Secretary shall enter into the first contract under subparagraph (A).

"(C) PERIOD OF CONTRACT.—A contract under subparagraph (A) shall be for a period of

18 months (except such contract may be renewed after a subsequent bidding process).

"(2) DUTIES.—The following duties are described in this paragraph:

"(A) DEVELOP AND IDENTIFY STANDARDS FOR PATIENT DECISION AIDS.—The entity shall synthesize evidence and convene a broad range of experts and key stakeholders to develop and identify consensus-based standards to evaluate patient decision aids for preference sensitive care.

"(B) ENDORSE PATIENT DECISION AIDS.—The entity shall review patient decision aids and develop a certification process whether patient decision aids meet the standards developed and identified under subparagraph (A). The entity shall give priority to the review and certification of patient decision aids for preference sensitive care.

"(d) PROGRAM TO DEVELOP, UPDATE AND PATIENT DECISION AIDS TO ASSIST HEALTH CARE PROVIDERS AND PATIENTS.—

"(1) IN GENERAL.—The Secretary, acting through the Director, and in coordination with heads of other relevant agencies, such as the Director of the Centers for Disease Control and Prevention and the

Director of the National Institutes of Health, shall establish a program to award grants or contracts—

"(A) to develop, update, and produce patient decision aids for preference sensitive care to assist health care providers in educating patients, caregivers, and authorized representatives concerning the relative safety, relative effectiveness (including possible health outcomes and impact on functional status), and relative cost of treatment or, where appropriate, palliative care options;

"(B) to test such materials to ensure such materials are balanced and evidence based in aiding health care providers and patients, caregivers, and authorized representatives to make informed decisions about patient care and can be easily incorporated into a broad array of practice settings; and

"(C) to educate providers on the use of such materials, including through academic curricula.

"(2) REQUIREMENTS FOR PATIENT DECISION AIDS.—Patient decision aids developed and produced pursuant to a grant or contract under paragraph (1)—

"(A) shall be designed to engage patients, caregivers, and authorized representatives in informed decisionmaking with health care providers;

"(B) shall present up-to-date clinical evidence about the risks and benefits of treatment options in a form and manner that is age-appropriate and can be adapted for patients, caregivers, and authorized representatives from a variety of cultural and educational backgrounds to reflect the varying needs of consumers and diverse levels of health literacy;

"(C) shall, where appropriate, explain why there is a lack of evidence to support one treatment option over another; and

"(D) shall address health care decisions across the age span, including those affecting vulnerable populations including children.

"(3) DISTRIBUTION.—The Director shall ensure that patient decision aids produced with grants or contracts under this section are available to the public.

"(4) NONDUPLICATION OF EFFORTS.—The Director shall ensure that the activities under this section of the Agency and other agencies, including the Cen-

ters for Disease Control and Prevention and the National Institutes of Health, are free of unnecessary duplication of effort.

"(e) GRANTS TO SUPPORT SHARED DECISIONMAKING IMPLEMENTATION.—

"(1) IN GENERAL.—The Secretary shall establish a program to provide for the phased-in development, implementation, and evaluation of shared decisionmaking using patient decision aids to meet the objective of improving the understanding of patients of their medical treatment options.

"(2) SHARED DECISIONMAKING RESOURCE CENTERS.—

"(A) IN GENERAL.—The Secretary shall provide grants for the establishment and support of Shared Decisionmaking Resource Centers (referred to in this subsection as 'Centers') to provide technical assistance to providers and to develop and disseminate best practices and other information to support and accelerate adoption, implementation, and effective use of patient decision aids and shared decisionmaking by providers.

"(B) OBJECTIVES.—The objective of a Center is to enhance and promote the adoption of

patient decision aids and shared decisionmaking through—

"(i) providing assistance to eligible providers with the implementation and effective use of, and training on, patient decision aids; and

"(ii) the dissemination of best practices and research on the implementation and effective use of patient decision aids.

"(3) SHARED DECISIONMAKING PARTICIPATION GRANTS.—

"(A) IN GENERAL.—The Secretary shall provide grants to health care providers for the development and implementation of shared decisionmaking techniques and to assess the use of such techniques.

"(B) PREFERENCE.—In order to facilitate the use of best practices, the Secretary shall provide a preference in making grants under this subsection to health care providers who participate in training by Shared Decisionmaking Resource Centers or comparable training.

"(C) LIMITATION.—Funds under this paragraph shall not be used to purchase or implement use of patient decision aids other than

those certified under the process identified in subsection (c).

"(4) GUIDANCE.—The Secretary may issue guidance to eligible grantees under this subsection on the use of patient decision aids.

"(f) FUNDING.—For purposes of carrying out this section there are authorized to be appropriated such sums as may be necessary for fiscal year 2010 and each subsequent fiscal year.".

SEC. 3507. PRESENTATION OF PRESCRIPTION DRUG BENEFIT AND RISK INFORMATION.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the "Secretary"), acting through the Commissioner of Food and Drugs, shall determine whether the addition of quantitative summaries of the benefits and risks of prescription drugs in a standardized format (such as a table or drug facts box) to the promotional labeling or print advertising of such drugs would improve health care decisionmaking by clinicians and patients and consumers.

(b) REVIEW AND CONSULTATION.—In making the determination under subsection (a), the Secretary shall review all available scientific evidence and research on decisionmaking and social and cognitive psychology and consult with drug manufacturers, clinicians, patients and con-

sumers, experts in health literacy, representatives of racial and ethnic minorities, and experts in women's and pediatric health.

(c) REPORT.—Not later than 1 year after the date of enactment of this Act, the Secretary shall submit to Congress a report that provides—

(1) the determination by the Secretary under subsection (a); and

(2) the reasoning and analysis underlying that determination.

(d) AUTHORITY.—If the Secretary determines under subsection (a) that the addition of quantitative summaries of the benefits and risks of prescription drugs in a standardized format (such as a table or drug facts box) to the promotional labeling or print advertising of such drugs would improve health care decisionmaking by clinicians and patients and consumers, then the Secretary, not later than 3 years after the date of submission of the report under subsection (c), shall promulgate proposed regulations as necessary to implement such format.

(e) CLARIFICATION.—Nothing in this section shall be construed to restrict the existing authorities of the Secretary with respect to benefit and risk information.

SEC. 3508. DEMONSTRATION PROGRAM TO INTEGRATE QUALITY IMPROVEMENT AND PATIENT SAFETY TRAINING INTO CLINICAL EDUCATION OF HEALTH PROFESSIONALS.

(a) IN GENERAL.—The Secretary may award grants to eligible entities or consortia under this section to carry out demonstration projects to develop and implement academic curricula that integrates quality improvement and patient safety in the clinical education of health professionals. Such awards shall be made on a competitive basis and pursuant to peer review.

(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity or consortium shall—

(1) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require;

(2) be or include—

(A) a health professions school;

(B) a school of public health;

(C) a school of social work;

(D) a school of nursing;

(E) a school of pharmacy;

(F) an institution with a graduate medical education program; or

(G) a school of health care administration;

(3) collaborate in the development of curricula described in subsection (a) with an organization that accredits such school or institution;

(4) provide for the collection of data regarding the effectiveness of the demonstration project; and

(5) provide matching funds in accordance with subsection (c).

(c) MATCHING FUNDS.—

(1) IN GENERAL.—The Secretary may award a grant to an entity or consortium under this section only if the entity or consortium agrees to make available non-Federal contributions toward the costs of the program to be funded under the grant in an amount that is not less than $1 for each $5 of Federal funds provided under the grant.

(2) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions under paragraph (1) may be in cash or in-kind, fairly evaluated, including equipment or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such contributions.

(d) EVALUATION.—The Secretary shall take such action as may be necessary to evaluate the projects funded

under this section and publish, make publicly available, and disseminate the results of such evaluations on as wide a basis as is practicable.

(e) REPORTS.—Not later than 2 years after the date of enactment of this section, and annually thereafter, the Secretary shall submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives a report that—

(1) describes the specific projects supported under this section; and

(2) contains recommendations for Congress based on the evaluation conducted under subsection (d).

SEC. 3509. IMPROVING WOMEN'S HEALTH.

(a) HEALTH AND HUMAN SERVICES OFFICE ON WOMEN'S HEALTH.—

(1) ESTABLISHMENT.—Part A of title II of the Public Health Service Act (42 U.S.C. 202 et seq.) is amended by adding at the end the following:

"SEC. 229. HEALTH AND HUMAN SERVICES OFFICE ON WOMEN'S HEALTH.

"(a) ESTABLISHMENT OF OFFICE.—There is established within the Office of the Secretary, an Office on Women's Health (referred to in this section as the 'Office'). The

Office shall be headed by a Deputy Assistant Secretary for Women's Health who may report to the Secretary.

"(b) DUTIES.—The Secretary, acting through the Office, with respect to the health concerns of women, shall—

"(1) establish short-range and long-range goals and objectives within the Department of Health and Human Services and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Department that relate to disease prevention, health promotion, service delivery, research, and public and health care professional education, for issues of particular concern to women throughout their lifespan;

"(2) provide expert advice and consultation to the Secretary concerning scientific, legal, ethical, and policy issues relating to women's health;

"(3) monitor the Department of Health and Human Services' offices, agencies, and regional activities regarding women's health and identify needs regarding the coordination of activities, including intramural and extramural multidisciplinary activities;

"(4) establish a Department of Health and Human Services Coordinating Committee on Women's Health, which shall be chaired by the Deputy As-

sistant Secretary for Women's Health and composed of senior level representatives from each of the agencies and offices of the Department of Health and Human Services;

"(5) establish a National Women's Health Information Center to—

"(A) facilitate the exchange of information regarding matters relating to health information, health promotion, preventive health services, research advances, and education in the appropriate use of health care;

"(B) facilitate access to such information;

"(C) assist in the analysis of issues and problems relating to the matters described in this paragraph; and

"(D) provide technical assistance with respect to the exchange of information (including facilitating the development of materials for such technical assistance);

"(6) coordinate efforts to promote women's health programs and policies with the private sector; and

"(7) through publications and any other means appropriate, provide for the exchange of information between the Office and recipients of grants, contracts,

and agreements under subsection (c), and between the Office and health professionals and the general public.

"(c) GRANTS AND CONTRACTS REGARDING DUTIES.—

"(1) AUTHORITY.—In carrying out subsection (b), the Secretary may make grants to, and enter into cooperative agreements, contracts, and interagency agreements with, public and private entities, agencies, and organizations.

"(2) EVALUATION AND DISSEMINATION.—The Secretary shall directly or through contracts with public and private entities, agencies, and organizations, provide for evaluations of projects carried out with financial assistance provided under paragraph (1) and for the dissemination of information developed as a result of such projects.

"(d) REPORTS.—Not later than 1 year after the date of enactment of this section, and every second year thereafter, the Secretary shall prepare and submit to the appropriate committees of Congress a report describing the activities carried out under this section during the period for which the report is being prepared.

"(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.".

(2) TRANSFER OF FUNCTIONS.—There are transferred to the Office on Women's Health (established under section 229 of the Public Health Service Act, as added by this section), all functions exercised by the Office on Women's Health of the Public Health Service prior to the date of enactment of this section, including all personnel and compensation authority, all delegation and assignment authority, and all remaining appropriations. All orders, determinations, rules, regulations, permits, agreements, grants, contracts, certificates, licenses, registrations, privileges, and other administrative actions that—

(A) have been issued, made, granted, or allowed to become effective by the President, any Federal agency or official thereof, or by a court of competent jurisdiction, in the performance of functions transferred under this paragraph; and

(B) are in effect at the time this section takes effect, or were final before the date of enactment of this section and are to become effective on or after such date,

shall continue in effect according to their terms until modified, terminated, superseded, set aside, or revoked in accordance with law by the President, the Sec-

retary, or other authorized official, a court of competent jurisdiction, or by operation of law.

(b) CENTERS FOR DISEASE CONTROL AND PREVENTION OFFICE OF WOMEN'S HEALTH.—Part A of title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by adding at the end the following:

"SEC. 310A. CENTERS FOR DISEASE CONTROL AND PREVENTION OFFICE OF WOMEN'S HEALTH.

"(a) ESTABLISHMENT.—There is established within the Office of the Director of the Centers for Disease Control and Prevention, an office to be known as the Office of Women's Health (referred to in this section as the 'Office'). The Office shall be headed by a director who shall be appointed by the Director of such Centers.

"(b) PURPOSE.—The Director of the Office shall—

"(1) report to the Director of the Centers for Disease Control and Prevention on the current level of the Centers' activity regarding women's health conditions across, where appropriate, age, biological, and sociocultural contexts, in all aspects of the Centers' work, including prevention programs, public and professional education, services, and treatment;

"(2) establish short-range and long-range goals and objectives within the Centers for women's health and, as relevant and appropriate, coordinate with

other appropriate offices on activities within the Centers that relate to prevention, research, education and training, service delivery, and policy development, for issues of particular concern to women;

"(3) identify projects in women's health that should be conducted or supported by the Centers;

"(4) consult with health professionals, nongovernmental organizations, consumer organizations, women's health professionals, and other individuals and groups, as appropriate, on the policy of the Centers with regard to women; and

"(5) serve as a member of the Department of Health and Human Services Coordinating Committee on Women's Health (established under section 229(b)(4)).

"(c) DEFINITION.—As used in this section, the term 'women's health conditions', with respect to women of all age, ethnic, and racial groups, means diseases, disorders, and conditions—

"(1) unique to, significantly more serious for, or significantly more prevalent in women; and

"(2) for which the factors of medical risk or type of medical intervention are different for women, or for which there is reasonable evidence that indicates that such factors or types may be different for women.

"(d) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.".

(c) OFFICE OF WOMEN'S HEALTH RESEARCH.—Section 486(a) of the Public Health Service Act (42 U.S.C. 287d(a)) is amended by inserting "and who shall report directly to the Director" before the period at the end thereof.

(d) SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION.—Section 501(f) of the Public Health Service Act (42 U.S.C. 290aa(f)) is amended—

(1) in paragraph (1), by inserting "who shall report directly to the Administrator" before the period;

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

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

"(4) OFFICE.—Nothing in this subsection shall be construed to preclude the Secretary from establishing within the Substance Abuse and Mental Health Administration an Office of Women's Health.".

(e) AGENCY FOR HEALTHCARE RESEARCH AND QUALITY ACTIVITIES REGARDING WOMEN'S HEALTH.—Part C

of title IX of the Public Health Service Act (42 U.S.C. 299c et seq.) is amended—

(1) by redesignating sections 925 and 926 as sections 926 and 927, respectively; and

(2) by inserting after section 924 the following:

"SEC. 925. ACTIVITIES REGARDING WOMEN'S HEALTH.

"(a) ESTABLISHMENT.—There is established within the Office of the Director, an Office of Women's Health and Gender-Based Research (referred to in this section as the 'Office'). The Office shall be headed by a director who shall be appointed by the Director of Healthcare and Research Quality.

"(b) PURPOSE.—The official designated under subsection (a) shall—

"(1) report to the Director on the current Agency level of activity regarding women's health, across, where appropriate, age, biological, and sociocultural contexts, in all aspects of Agency work, including the development of evidence reports and clinical practice protocols and the conduct of research into patient outcomes, delivery of health care services, quality of care, and access to health care;

"(2) establish short-range and long-range goals and objectives within the Agency for research important to women's health and, as relevant and appro-

priate, coordinate with other appropriate offices on activities within the Agency that relate to health services and medical effectiveness research, for issues of particular concern to women;

"(3) identify projects in women's health that should be conducted or supported by the Agency;

"(4) consult with health professionals, nongovernmental organizations, consumer organizations, women's health professionals, and other individuals and groups, as appropriate, on Agency policy with regard to women; and

"(5) serve as a member of the Department of Health and Human Services Coordinating Committee on Women's Health (established under section 229(b)(4)).".

"(c) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.".

(f) HEALTH RESOURCES AND SERVICES ADMINISTRATION OFFICE OF WOMEN'S HEALTH.—Title VII of the Social Security Act (42 U.S.C. 901 et seq.) is amended by adding at the end the following:

"SEC. 713. OFFICE OF WOMEN'S HEALTH.

"(a) ESTABLISHMENT.—The Secretary shall establish within the Office of the Administrator of the Health Resources and Services Administration, an office to be known as the Office of Women's Health. The Office shall be headed by a director who shall be appointed by the Administrator.

"(b) PURPOSE.—The Director of the Office shall—

"(1) report to the Administrator on the current Administration level of activity regarding women's health across, where appropriate, age, biological, and sociocultural contexts;

"(2) establish short-range and long-range goals and objectives within the Health Resources and Services Administration for women's health and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Administration that relate to health care provider training, health service delivery, research, and demonstration projects, for issues of particular concern to women;

"(3) identify projects in women's health that should be conducted or supported by the bureaus of the Administration;

"(4) consult with health professionals, nongovernmental organizations, consumer organizations, women's health professionals, and other individuals

and groups, as appropriate, on Administration policy with regard to women; and

"(5) serve as a member of the Department of Health and Human Services Coordinating Committee on Women's Health (established under section 229(b)(4) of the Public Health Service Act).

"(c) CONTINUED ADMINISTRATION OF EXISTING PROGRAMS.—The Director of the Office shall assume the authority for the development, implementation, administration, and evaluation of any projects carried out through the Health Resources and Services Administration relating to women's health on the date of enactment of this section.

"(d) DEFINITIONS.—For purposes of this section:

"(1) ADMINISTRATION.—The term 'Administration' means the Health Resources and Services Administration.

"(2) ADMINISTRATOR.—The term 'Administrator' means the Administrator of the Health Resources and Services Administration.

"(3) OFFICE.—The term 'Office' means the Office of Women's Health established under this section in the Administration.

"(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized

to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.".

(g) FOOD AND DRUG ADMINISTRATION OFFICE OF WOMEN'S HEALTH.—Chapter X of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 391 et seq.) is amended by adding at the end the following:

"SEC. 1011. OFFICE OF WOMEN'S HEALTH.

"(a) ESTABLISHMENT.—There is established within the Office of the Commissioner, an office to be known as the Office of Women's Health (referred to in this section as the 'Office'). The Office shall be headed by a director who shall be appointed by the Commissioner of Food and Drugs.

"(b) PURPOSE.—The Director of the Office shall—

"(1) report to the Commissioner of Food and Drugs on current Food and Drug Administration (referred to in this section as the 'Administration') levels of activity regarding women's participation in clinical trials and the analysis of data by sex in the testing of drugs, medical devices, and biological products across, where appropriate, age, biological, and sociocultural contexts;

"(2) establish short-range and long-range goals and objectives within the Administration for issues of particular concern to women's health within the jurisdiction of the Administration, including, where rel-

evant and appropriate, adequate inclusion of women and analysis of data by sex in Administration protocols and policies;

"(3) provide information to women and health care providers on those areas in which differences between men and women exist;

"(4) consult with pharmaceutical, biologics, and device manufacturers, health professionals with expertise in women's issues, consumer organizations, and women's health professionals on Administration policy with regard to women;

"(5) make annual estimates of funds needed to monitor clinical trials and analysis of data by sex in accordance with needs that are identified; and

"(6) serve as a member of the Department of Health and Human Services Coordinating Committee on Women's Health (established under section 229(b)(4) of the Public Health Service Act).

"(c) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.".

(h) NO NEW REGULATORY AUTHORITY.—Nothing in this section and the amendments made by this section may

be construed as establishing regulatory authority or modifying any existing regulatory authority.

(i) LIMITATION ON TERMINATION.—Notwithstanding any other provision of law, a Federal office of women's health (including the Office of Research on Women's Health of the National Institutes of Health) or Federal appointive position with primary responsibility over women's health issues (including the Associate Administrator for Women's Services under the Substance Abuse and Mental Health Services Administration) that is in existence on the date of enactment of this section shall not be terminated, reorganized, or have any of it's powers or duties transferred unless such termination, reorganization, or transfer is approved by Congress through the adoption of a concurrent resolution of approval.

(j) RULE OF CONSTRUCTION.—Nothing in this section (or the amendments made by this section) shall be construed to limit the authority of the Secretary of Health and Human Services with respect to women's health, or with respect to activities carried out through the Department of Health and Human Services on the date of enactment of this section.

SEC. 3510. PATIENT NAVIGATOR PROGRAM.

Section 340A of the Public Health Service Act (42 U.S.C. 256a) is amended—

(1) by striking subsection (d)(3) and inserting the following:

"(3) LIMITATIONS ON GRANT PERIOD.—In carrying out this section, the Secretary shall ensure that the total period of a grant does not exceed 4 years.";

(2) in subsection (e), by adding at the end the following:

"(3) MINIMUM CORE PROFICIENCIES.—The Secretary shall not award a grant to an entity under this section unless such entity provides assurances that patient navigators recruited, assigned, trained, or employed using grant funds meet minimum core proficiencies, as defined by the entity that submits the application, that are tailored for the main focus or intervention of the navigator involved."; and

(3) in subsection (m)—

(A) in paragraph (1), by striking "and $3,500,000 for fiscal year 2010." and inserting "$3,500,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2015."; and

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

SEC. 3511. AUTHORIZATION OF APPROPRIATIONS.

Except where otherwise provided in this subtitle (or an amendment made by this subtitle), there is authorized to be appropriated such sums as may be necessary to carry out this subtitle (and such amendments made by this subtitle).

Subtitle G—Protecting and Improving Guaranteed Medicare Benefits

SEC. 3601. PROTECTING AND IMPROVING GUARANTEED MEDICARE BENEFITS.

(a) PROTECTING GUARANTEED MEDICARE BENEFITS.—Nothing in the provisions of, or amendments made by, this Act shall result in a reduction of guaranteed benefits under title XVIII of the Social Security Act.

(b) ENSURING THAT MEDICARE SAVINGS BENEFIT THE MEDICARE PROGRAM AND MEDICARE BENEFICIARIES.—Savings generated for the Medicare program under title XVIII of the Social Security Act under the provisions of, and amendments made by, this Act shall extend the solvency of the Medicare trust funds, reduce Medicare premiums and other cost-sharing for beneficiaries, and improve or expand guaranteed Medicare benefits and protect access to Medicare providers.

SEC. 3602. NO CUTS IN GUARANTEED BENEFITS.

Nothing in this Act shall result in the reduction or elimination of any benefits guaranteed by law to participants in Medicare Advantage plans.

TITLE IV—PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH

Subtitle A—Modernizing Disease Prevention and Public Health Systems

SEC. 4001. NATIONAL PREVENTION, HEALTH PROMOTION AND PUBLIC HEALTH COUNCIL.

(a) ESTABLISHMENT.—The President shall establish, within the Department of Health and Human Services, a council to be known as the "National Prevention, Health Promotion and Public Health Council" (referred to in this section as the "Council").

(b) CHAIRPERSON.—The President shall appoint the Surgeon General to serve as the chairperson of the Council.

(c) COMPOSITION.—The Council shall be composed of—

(1) the Secretary of Health and Human Services;

(2) the Secretary of Agriculture;

(3) the Secretary of Education;