

House Tri-Committee Health Reform Discussion Draft
Section-by-Section Analysis
June 30, 2009

DIVISION A - AFFORDABLE HEALTH CARE CHOICES

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

TITLE I - PROTECTIONS AND STANDARDS FOR QUALIFIED HEALTH BENEFITS PLANS

SUBTITLE A - GENERAL STANDARDS

Sec. 101 Requirements reforming health insurance marketplace. Broadly outlines the standards for health insurance reform and sets an effective date for reform as 2013 (or earlier if the President determines that can be achieved).

Sec. 102. Protecting the choice to keep current coverage. Allows the maintenance of current individual health plans as “grandfathered plans” and provides for a five year grace period for current group health plans to meet specified standards (insurance and benefit requirements).

SUBTITLE B - STANDARDS GUARANTEEING ACCESS TO AFFORDABLE COVERAGE

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

Sec. 112. Guaranteed Issue and Renewal for Insured Plans. Requires guaranteed issue (no one can be denied health insurance) and renewal of insurance policies.

Sec. 113. Insurance Rating Rules. Limits age rating to a ratio of 2 to 1; allows variation based on geographic area and family size as permitted by state insurance commissioners and the Health Choices Commissioner.

Sec. 114. Nondiscrimination in benefits. Provides authority to the Health Choices Commissioner to set non-discrimination rules.

Sec. 115. Ensuring Adequacy of provider networks. Provides authority to the Health

Choices Commissioner to set network adequacy standards that qualified plans must meet.

Sec. 116. Minimum Medical Loss Ratio. Requires qualified plans have a medical loss ratio (as defined by the Health Choices Commissioner) of at least 85%. If plans exceed that limit, rebates to enrollees are required.

SUBTITLE C - STANDARDS GUARANTEEING ACCESS TO ESSENTIAL BENEFITS

Sec. 121. Coverage of essential benefits package. Requires qualified plans to meet the benefit standards recommended by the Benefits Advisory Committee and adopted by the Secretary of HHS. Plans outside the Exchange must offer at least the essential benefits and others as they choose. Plans within the Exchange must meet the specified benefit packages which includes a tier with offerings of additional benefits. Allows for the continued offering of separate excepted benefits packages as in current law outside of the Exchange.

Sec 122. Essential Benefits Package Defined. Outlines the broad categories of benefits required to be included in the essential benefit package, prohibits any cost-sharing for preventive benefits (including well child and well baby care), and limits annual out-of-pocket spending in the essential benefits package to \$5,000 for an individual and \$10,000 (indexed to CPI) for a family. Defines the initial essential benefit package as being actuarially equivalent to 70% of the package if there were no cost-sharing imposed.

Sec. 123. Health Benefits Advisory Committee. Establishes a Health Benefits Advisory Committee, chaired by the Surgeon General, with private members appointed by the President, the Comptroller General, and representatives of relevant federal agencies. The Advisory Committee will make recommendations to the Secretary of HHS regarding the details of covered health benefits as outlined in Sec. 122, including the establishment of the three tiers of coverage: basic, enhanced and premium.

Sec. 124. Process for adoption of recommendations; adoption of benefit standards. Establishes the timeline for the initial adoption of benefits by the Secretary of HHS and the period updating of standards in the future.

SUBTITLE D - ADDITIONAL CONSUMER PROTECTIONS

Sec. 131. Requiring fair marketing practices by health insurers. Provides the Health Choices Commissioner with the authority to define marketing standards that qualified plans are required to meet.

Sec. 132. Requiring fair grievance and appeals mechanisms. Requires each qualified plan to meet standards defined by the Health Choices Commissioner for timely internal grievance and appeals mechanisms and to establish an external review process that allows for state processes to remain in place.

Sec. 133. Requiring information transparency and plan disclosure. Requires qualified plans to meet standards established by the Health Choices Commissioner relating to transparency and timely disclosure of plan documents and information, including providing health care providers with information regarding their payments. It also requires the use of plain language in the disclosures and advance notice of changes to the plans.

Sec. 134. Application to qualified health benefits plans not offered through the Health Insurance Exchange. Provides flexibility to the Health Choices Commissioner to decide what protections of Sections 131-133 should apply to qualified plans outside of the Health Insurance Exchange.

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

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

SUBTITLE E - GOVERNANCE

Sec. 141. Health Choices Administration; Health Choices Commissioner. Establishes The Health Choices Administration, an independent executive branch agency. The Health Choices Commissioner is appointed by the President.

Sec. 142. Duties and authority of Commissioner. The Health Choices Commissioner carries out functions including: establishment of qualified plan standards, the establishment and operation of the Health Insurance Exchange, the administration of affordability credits, and additional functions as laid out within the bill. The Commissioner can collect data necessary to carry out his or her duties and to promote quality and value and address disparities in health care. Such information can also be shared with HHS. The Commissioner also has oversight and enforcement authority including the authority to impose sanctions and suspend enrollment of a plan. This authority requires the Commissioner to coordinate with the Department of Health and Human Services, the Department of Labor and state insurance regulators.

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

Sec. 144. Health Insurance Ombudsman. Establishes a Qualified Health Benefits Plan Ombudsman to assist individuals in navigating the new health reform system and report to Congress on recommendations for improvements in administration of the program.

SUBTITLE F - RELATION TO OTHER REQUIREMENTS; MISCELLANEOUS

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

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

TITLE II – HEALTH INSURANCE EXCHANGE AND RELATED PROVISIONS

SUBTITLE A - HEALTH INSURANCE EXCHANGE

Sec. 201. Establishment of Health Insurance Exchange; outline of duties; definitions. Establishes a Health Insurance Exchange under the purview of the Health Choices Administration that will facilitate the offering of health insurance choices. The Health Choices Commissioner establishes a process through which to obtain bids, negotiate and enter into contracts with qualified plans, and ensure that the different levels of benefits are offered with appropriate oversight and enforcement. The Commissioner also facilitates outreach and enrollment, creates and operates a risk pooling mechanism, and ensures consumer protections.

Sec. 202. Exchange-eligible individuals and employers. Defines who is eligible for participation in the Health Insurance Exchange including employers and individuals. In year one, individuals not enrolled in other acceptable coverage are allowed into the Exchange and small employers with 10 or fewer employees. In year two, the employers with 20 and fewer employees are allowed into the Exchange. In subsequent years, the Health Choices Commissioner is granted authority to expand employer participation as appropriate, with the goal of allowing all employers access to the Exchange.

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

During the first four years of the Exchange, Medicaid-eligible individuals would generally be enrolled in Medicaid, not the Exchange. An exception is made for childless adults with incomes under 133% of poverty (\$14,400 per year for an individual) who had other qualifying coverage within the previous six months. They have the choice to obtain coverage through Medicaid or the Exchange.

Beginning with year five of the Exchange, any Medicaid eligible individual will be able to choose between coverage in Medicaid or through the Exchange with their state Medicaid program providing wrap-around benefits. In order for a Medicaid-eligible individual to choose to enroll through the Exchange, the State must demonstrate that it can provide appropriate wrap-around benefits that meet their Medicaid obligations to protect the health of these individuals, the individual must agree, and the Commissioner must determine that the Exchange can handle enrollment by Medicaid beneficiaries.

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

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

Sec. 203. Benefits package levels. The Health Choices Commissioner specifies the benefits that must be made available in each year – including a requirement that each participating plan provide one basic plan in each service area in which they operate. It is then optional for the plan to offer one enhanced and one premium plan. The differences between the three main plans (e.g. basic, enhanced and premium) are the levels of cost-sharing required, not the benefits covered. The Commissioner shall establish a permissible range of cost-sharing variation that is not to exceed plus or minus 10 percent with regard to each benefit category.

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

States can require the application of state benefit mandates to all Exchange participating plans, but only if there is an agreement with the Commissioner that the state will

reimburse the Commissioner for any additional costs of affordability credits in that state due to the State benefit requirements.

Sec. 204. Contracts for the offering of Exchange-participating health benefits plans.

Lays out the responsibilities for the Health Choices Commissioner's contracting authority including the solicitation of bids, negotiation with plans and the entering into contracts with approved plans (that will be for at least one year of duration and can be automatically renewed). Requirements include that plans be licensed in the state in which they plan to do business, abide by data reporting requirements as outlined by the Commissioner, provide for the implementation of affordability credits, and additional requirements.

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

Sec. 205. Outreach and enrollment of Exchange-eligible individuals and employers in Exchange-participating health benefits plan.

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

With regard to Medicaid, establishes rules to ensure continuity of coverage for certain newborns and children eligible for CHIP. Requires the Commissioner to enter into memorandums of understanding with state Medicaid agencies to coordinate enrollment in Medicaid and the Exchange and, beginning in Year 5 for Medicaid-eligible individuals to choose between enrolling in the Exchange and enrolling in Medicaid.

Sec. 206. Other functions. The Health Choices Commissioner coordinates affordability credits and risk-pooling. In order to prevent waste, fraud and abuse, institutes a special inspector general to oversee operation of the program.

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

Sec. 208. Optional operation of State-based health insurance exchanges. Permits states to offer their own health exchange or join with a group of states to create their own exchange, in lieu of the federal health insurance exchange provided that the state(s) perform all of the duties of the federal exchange as approved by the Health

Choices Commissioner. The Commissioner would have authority to terminate state exchanges if they are not meeting their obligations.

SUBTITLE B - PUBLIC HEALTH INSURANCE OPTION

Sec. 221. Establishment and administration of a public health insurance option as an Exchange-qualified health benefits plan. Requires the Secretary of Health and Human Services to develop a public health insurance option to be offered starting in 2013 as a plan choice within the Health Insurance Exchange. It participates on a level playing field with private plan choices. Like private plans, it must offer the same benefits, abide by the same insurance market reforms, follow provider network requirements and other consumer protections.

Sec. 222. Premiums and financing. Premiums for the public option are geographically-adjusted and are required to be set so as to fully cover the cost of coverage as well as administrative costs of the plan. This includes a requirement that the public option, like private plans, include a contingency margin in its premium to cover unexpected cost variations. In order to initiate the public option, there is an initial appropriation of funds, but the plan must be self-sustaining after that initial funding.

Sec. 223. Payment rates for items and services. The Secretary of HHS establishes the provider payment rates for the public option. For the first three years, those rates are based on Medicare rates with a 5% add-on for practitioners who also participate in the Medicare program. This increase also applies to practitioners, like pediatricians, who do not typically participate in Medicare. Flexibility is provided to the Secretary to create payment rates for services not covered by Medicare and adjust rates as necessary to assure competitiveness with Exchange participating plans or for excessive or deficient payments. After three years, the link to Medicare payment rates is broken and the Secretary has authority to adjust such rates to ensure adequate beneficiary access and promote affordability and the efficient delivery of medical care. The Secretary also has authority to negotiate prescription drug prices for the public option.

Sec. 224. Modernized payment initiatives and delivery system reform. The Secretary is empowered to move forward with delivery system reforms to change the way the public option pays for medical services to promote better quality and more efficient use of medical care. Such payment changes must seek to reduce cost for enrollees, improve health outcomes, reduce health disparities, address geographic variation in the provision of medical services, prevent or manage chronic illnesses, or promote integrated patient-centered care.

Sec. 225. Provider participation. Provides the Secretary of HHS with the authority to develop conditions of participation for the public health insurance option. Providers must be licensed in the state in which they do business, must agree to limitations in additional patient charges, and must be excluded from participating in the public option if they are excluded from other federal health programs.

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

SUBTITLE C - INDIVIDUAL AFFORDABILITY CREDITS

Sec. 241. Availability through Health Insurance Exchange. Creates sliding scale affordability credits to ensure that people with incomes up to 400% of the federal poverty have affordable health coverage. These credits apply only to Exchange-participating plans. Affordability credits reduce the costs of both premium and annual out-of-pocket spending.

Sec. 242. Affordable credit eligible individual. Individuals must have individual coverage through an Exchange-participating health benefits plan (though not through an employer purchasing coverage through the Exchange). Family and individual incomes must be below 400% of the federal poverty limit to access the sliding scale affordability credits. In general, before year five, employees who are offered employer coverage are ineligible for affordability credits within the Exchange. Beginning in year two, employees who meet an affordability test showing that coverage under their employer-provided plan would cost more than 10% of income, are eligible obtain income-based affordability credits in the Exchange. Starting in year five, employees of any income can choose to decline their employer-sponsored coverage and enter the Exchange and, if eligible, obtain affordability credits.

Sec. 243. Affordable premium credit. The affordable premium amount is calculated on a sliding scale starting at 1% of income for those at or below 133% of poverty and phasing out at 10% of income for those at 400% of poverty. The reference premium is the average premium for the three lowest cost basic plans in the area in which the individual resides.

Sec. 244. Affordability cost-sharing credit. The affordability cost-sharing credit reduces cost-sharing for individuals and families up to 400% of the federal poverty limit on a sliding scale basis.

Sec. 245. Income determinations. To determine income, the Health Choices Commissioner uses income data from the individual's most recent tax return. Processes

are established for individuals with significant changes in income to inform the Commissioner of such change. There are penalties for misrepresentation of income.

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

Title III – SHARED RESPONSIBILITY

Subtitle A – Individual responsibility

Sec. 301. Individual responsibility. Cross-references the shared responsibility provision in the Internal Revenue Code where an individual has the choice of maintaining acceptable coverage or paying a tax.

Subtitle B – Employer Responsibility

Part 1 – Health coverage participation requirements

Sec. 311. Health coverage participation requirements. Provides the rules that apply to an employer that elects to provide health coverage (an “offering employer”) in lieu of the payroll tax that applies to a non-offering employer. An offering employer generally must offer all of its employees the option of selecting individual or family health coverage.

Sec. 312. Employer responsibility to contribute towards employee and dependent coverage. Provides that the minimum employer contribution in the case of an offering employer is 72.5 percent of the premium for individual coverage, and 65 percent of the premium for family coverage or a proportional amount for non-fulltime employees. Family coverage for this purpose includes the employee’s spouse and qualifying children.

Sec. 313. Employer contributions in lieu of coverage. Requires an offering employer to contribute to the Exchange for each employee who declines the employer’s coverage offer and obtains an affordability credit for coverage through the Exchange. The contribution is 8 percent of the employee’s wages.

Sec. 314. Authority related to improper steering. Authorizes the creation of rules that would prohibit employers from engaging in practices that steer employees away from employer offered coverage and into coverage offered under the Exchange.

Part 2 – Satisfaction of Health Coverage Participation Requirements

Sec. 321. Satisfaction of Health Coverage Participation Requirements under the Employee Retirement Income Security Act of 1974. Provides rules under which an employer that is subject to ERISA makes an election to offer health coverage (an “offering employer”) in lieu of the payroll tax that applies to a non-offering employer. The employer can make a separate election for full-time employees, non-fulltime employees, and separate lines of business. The section also provides remedies to the Department of Labor and employees of an offering employer if the employer does not follow the rules that apply to a coverage offer.

Sec. 322. Satisfaction of health coverage participation requirements under the Internal Revenue Code of 1986. Cross-references the rules in the Internal Revenue Code relating to an employer’s election to be an offering employer.

Sec. 323. Satisfaction of Health Coverage Participation Requirements under the Public Health Service Act. Provides rules under which an employer that is subject to the Public Health Service Act makes an election to offer health coverage (an “offering employer”) in lieu of the payroll tax that applies to a non-offering employer. The employer can make a separate election for full-time employees and non-fulltime employees. The section also provides remedies to the Department of Health and Human Services and employees of an offering employer if the employer does not follow the rules that apply to a coverage offer.

Sec. 324. Additional rules relating to health coverage participation requirements. Requires the Exchange and the Departments of Health and Human Services, Labor, and Treasury to develop coordinated interpretative and enforcement measures with respect to offering employers.

Title IV – AMENDMENTS TO INTERNAL REVENUE CODE OF 1986

Subtitle A – Shared responsibility

Part 1 – Individual responsibility

Sec. 401. Tax on individuals without acceptable health care coverage. Provides for a two percent additional tax on the adjusted gross income of an individual who does not obtain acceptable health coverage for the individual or dependents claimed on the individual’s tax return. Authorizes the Department of Treasury and the Exchange to establish a hardship exemption from the additional tax. Acceptable coverage includes grandfathered individual and employer coverage, certain government coverage (e.g., Medicare, Medicaid, coverage provided to veterans, military employees, retirees, and

their families), and coverage obtained pursuant to the Exchange or an employer offer of coverage.

Part 2 – Employer Responsibility

Sec. 411. Election to satisfy health coverage participation requirements. Provides rules under which an employer makes an election to offer health coverage (an “offering employer”) in lieu of the payroll tax that applies to a non-offering employer. This section also provides for an excise tax that applies to an offering employer if the employer fails to follow the rules governing an offer of coverage.

Sec. 412. Responsibilities of nonelecting employers. Establishes a payroll tax of 8 percent of the wages that an employer pays to its employees for employers who choose not to offer coverage (certain small employers are exempt from this).

Subtitle B – Credit for small business employee health coverage expenses

Sec. 421. Credit for small business employee health coverage expenses. Provides for a tax credit equal to 50 percent of the amount paid by a small employer for employee health coverage. The tax credit is phased out in the case of an employer with 10 to 25 employees, and is also phased out in the case of an employer with average wages of \$20,000 to \$40,000 per year.

Subtitle C – Disclosures to carryout health insurance Exchange subsidies

Sec. 431. Disclosures to carryout health insurance Exchange subsidies. Permits the Exchange to receive taxpayer return information from the Internal Revenue Service in order to assist the Exchange in determining subsidy eligibility.

Subtitle D – Other revenue provisions

Sec. 441. To be provided in the introduced legislation.

TITLE V - IMMEDIATE INVESTMENTS

Sec. 501. Immediate Investments. Requires Secretary (or commissioner) to establish rules for administrative simplifications. Requires plans that exceed a minimum loss ratio of at least 85 percent to return the excess to consumers through rebates. It includes placeholder language to direct the Secretary to establish other programs to improve efficiency and value in health care.

DIVISION B – MEDICARE AND MEDICAID IMPROVEMENTS

TITLE I – IMPROVING HEALTH CARE VALUE

SUBTITLE A – PROVISIONS RELATED TO MEDICARE PART A

Part 1 – Market basket updates

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

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

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

Part 2 – Other Medicare Part A provisions

Sec. 1111 - Payments to skilled nursing facilities. Codifies the recalibration factor included in the FY10 Notice of Proposed Rulemaking for the Medicare skilled nursing facility prospective payment system. Provides a budget neutral adjustment within the payment system to improve payment accuracy for nontherapy ancillary services and therapy services, and creates an outlier payment for nontherapy ancillary services.

Sec. 1112 - Medicare DSH report. Directs the Secretary to submit a report to Congress by July 1, 2016 on Medicare disproportionate share hospital payments.

SUBTITLE B – PROVISIONS RELATED TO PART B

Part 1 – Physicians Services

Sec. 1121 - Sustainable growth rate reform. Permanently reforms the formula that annually updates reimbursement rates for physician services in Medicare. The revised

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

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

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

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

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

Part 2 – Market basket updates

Sec. 1131 - Incorporating productivity adjustment into market basket updates that do not already incorporate such adjustment. Incorporates a productivity adjustment into the market basket update for outpatient hospital services beginning in 2010. Sets a floor for the outpatient hospital market basket update so that the combination of the productivity adjustment and any adjustments for quality reporting cannot cause the market basket update to go below zero. Replaces the existing dialysis update of market basket minus 1.0, which begins in 2012, with a market basket update adjusted for productivity.

PART 3 - OTHER PROVISIONS

Sec. 1141 - Rental and purchase of power-driven wheelchairs. Eliminates the option for Medicare to purchase power-driven wheelchairs with a lump-sum payment at the

time the chair is supplied. Medicare would continue to make the same payments for power-driven chairs over a 13-month period.

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

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

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

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

Sec. 1146 - Medicare Improvement Fund. Eliminates all monies currently held in the Medicare Improvement Fund.

Sec. 1147 - Payment for imaging services. Increases the practice expense units for imaging services to reflect a presumed utilization rate of 75 percent instead of 50 percent. Also adjusts the technical component discount on single session imaging studies on contiguous body parts from 25 percent to 50 percent.

SUBTITLE C – PROVISIONS RELATED TO MEDICARE PARTS A AND B

Sec. 1151 - Reducing potentially preventable hospital readmissions. Beginning in fiscal year 2011, adjusts payments for 1886(d) hospitals and critical access hospitals based on the dollar value of each hospital's percentage of potentially preventable Medicare readmissions for 3 conditions with risk adjusted readmission measures that are endorsed by the National Quality Forum. Directs the Secretary to expand the policy to additional conditions in future years and authorizes the Secretary to modify the adjustment based on a hospital's performance in readmissions compared to a ranking of hospitals nationally. Provides assistance to certain hospitals for

transitional care activities to address patient noncompliance issues that may result in high readmission rates. Creates an interim readmissions policy for post-acute providers beginning in FY11, and directs the Secretary to develop risk adjusted readmission rates for post-acute providers and a readmissions payment system for those providers similar to the hospital system by FY13. Directs the Secretary to submit a report to Congress no later than one year after date of enactment on how physicians can be incorporated into the readmissions policy. Directs the Secretary to monitor inappropriate changes in admission practices by hospitals and post-acute providers and authorizes the Secretary to penalize providers that are avoiding patients at risk of a readmission.

Sec. 1152 - Post acute care services payment reform plan. Directs the Secretary to submit to Congress no later than 3 years after date of enactment a detailed plan on how to implement post-acute bundled payments and authorizes the Secretary expand the existing Acute Care Episode demonstration project to include post-acute services.

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

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

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

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

SUBTITLE D - MEDICARE ADVANTAGE REFORMS

PART 1 - PAYMENT AND ADMINISTRATION

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

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

Sec. 1163 – Extension of Secretarial coding intensity adjustment authority. Extends CMS authority to adjust risk scores in Medicare Advantage for observed differences in coding patterns relative to fee-for-service.

Sec. 1164 – Adding 2 week processing period between open election periods and effective date of enrollments. Provides extra time for CMS and health plans to process enrollment paperwork during annual enrollment periods.

Sec. 1165 – Extension of reasonable cost contracts. Extends the period of time for which Cost plans may operate in areas that have other health plan options.

Sec. 1166 – Limitation of waiver authority for employer group plans. Restricts the ability of Medicare Advantage plans to offer coverage outside their service area and grandfathers current contracts.

Sec. 1167 – Improving risk adjustment for MA payments. Requires a study on the effectiveness of risk adjustment for low-income populations.

Sec. 1168 – Elimination of MA Regional Plan Stabilization Fund. Eliminates the Medicare Advantage regional plan stabilization fund.

PART 2 – CONSUMER PROTECTIONS AND ANTI-FRAUD

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

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

Sec. 1173 – Information for beneficiaries on MA plan administrative costs. Requires CMS to publish standardized information on medical loss ratios and other plan information to beneficiaries and the public. For plans with medical loss ratios below 85%, allows imposition of increasing penalties over time, including eventual termination of contracts.

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

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

PART 3 – TREATMENT OF SPECIAL NEEDS INDIVIDUALS; MEDICAID INTEGRATION

Sec. 1176 – Limitation on enrollment outside open enrollment period of individuals into chronic care specialized MA plans for special needs individuals. Ensures that chronic condition special needs plans (SNPs) enroll beneficiaries only during their eligibility periods.

Sec. 1177 – Extension of authority of special needs plans to restrict enrollment. Extends the SNP program through 2012, and extends certain fully integrated dual eligible SNPs through 2015.

Sec. 1178 – Fully integrated dual eligible special needs plans. Defines requirements for fully integrated dual eligible SNPs including contracting with a state and creating a coordinated community care network. Such plans are authorized for the period 2011 through 2015.

Sec. 1179 – Improved coordination for dual eligibles. Requires CMS to increase efforts to coordinate Medicare and Medicaid services for dually eligible beneficiaries.

SUBTITLE E: IMPROVEMENTS TO MEDICARE PART D

Section 1181 – Requiring drug manufacturers to provide drug rebates for certain full premium subsidy eligible individuals. Requires drug manufacturers to provide rebates for drugs used by dual eligibles and full subsidy-eligible enrollees. Rebates paid by manufacturers must be at least as large as Medicaid rebates for the same drugs.

Section 1182 – Phased-in elimination of coverage gap. Eliminates Part D donut hole, beginning with a \$500 reduction in 2011, and completing the phase-out by 2023.

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

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

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

SUBTITLE F – MEDICARE RURAL ACCESS PROTECTIONS

Sec. 1191. Telehealth expansion and enhancements. Directs the Secretary to expand and enhance Medicare beneficiary access to telehealth services.

Sec. 1192. Extension of outpatient hold harmless provision. Extends the existing outpatient hold harmless provision through FY11.

Sec. 1193. Extension of section 508 hospital reclassifications. Extends reclassifications under Section 508 of the Medicare Modernization Act through FY11.

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

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

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

TITLE II – MEDICARE BENEFICIARY IMPROVEMENTS

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

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

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

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

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

Sec. 1205 - Intelligent assignment in enrollment. Gives HHS authority to auto-enroll full subsidy beneficiaries into Part D plans using a process that accounts for the quality, cost and/or formulary of plans.

Sec. 1206 - Automatic enrollment process for certain subsidy eligible individuals. Gives HHS authority to auto-enroll partial subsidy beneficiaries into plans using a process that accounts for the quality, cost and/or formulary of plans.

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

SUBTITLE B - REDUCING HEALTH DISPARITIES

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

Sec. 1222. Demonstration to Promote Access for Medicare Beneficiaries with Limited English Proficiency by Providing Reimbursement for Culturally and Linguistically Appropriate Services. Instructs the Secretary to carry out a demonstration program to reimburse Medicare providers, in multiple provider settings, for the provision of language services. Requires the Secretary to evaluate the demonstration program and make recommendations on the expansion of such services to the entire Medicare program.

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

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

SUBTITLE C – MISCELLANEOUS IMPROVEMENTS

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

Sec.1232 – Extended months of coverage of immunosuppressive drugs for kidney transplant patients and other renal dialysis provisions. Lifts the current 36 month limitation on Medicare coverage of immunosuppressive drugs for kidney transplant patients who would otherwise lose this coverage on or after January 1, 2010, and makes technical changes to the bundled payment system for End Stage Renal Disease.

Sec. 1233 – Part B premium. Ensures that the Part B premium increase for beneficiaries who are not otherwise held harmless from premium increases that result in a reduction in the Social Security benefit under Section 1839(f) is limited to the standard increase for 2010. Provides a government contribution to the Supplementary Medical Insurance Trust Fund equal to the amount not paid in beneficiary premiums under this section. Excludes capital gains from the sale of a primary residence from the calculation determination for the Part B income related premium.

Sec. 1234 – Requiring guaranteed issue for certain individuals under Medigap. Extends Medigap access to disabled Medicare beneficiaries and gives beneficiaries who disenroll from Medicare Advantage 24 months to enroll in a Medigap plan.

Sec. 1235. – Consultation and information regarding end-of-life planning. Provides coverage for consultation between enrollee and practitioners to discuss orders for life-sustaining treatment. Instructs CMS to modify Medicare & You handbook to incorporate information on end-of-life planning resources.

Sec. 1236 – Part B Special Enrollment Period and Waiver of Limited Enrollment Penalty for TRICARE Beneficiaries. Provides for a 12-month Medicare Part B special enrollment period for disabled TRICARE beneficiaries and waives increased premium penalties if beneficiaries sign up during such period.

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

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

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

Sec. 1302 – Medical home pilot program. An expansion/reorientation of the medical home demo in Medicare. Establishes a medical home pilot program to assess the feasibility of reimbursing for qualified patient-centered medical homes. There are two models in the program: 1) the *independent patient-centered medical home*, structured around a provider, is targeted at the top half of high need Medicare beneficiaries with multiple chronic diseases, and 2) the *community based medical home*, is targeted at a broader population of Medicare beneficiaries with chronic diseases and allows for State-based or non-profit entities to provide care-management supervised by a beneficiary designated primary care provider. Provides approximately \$1.6 billion from the Trust Fund for the 5 year pilot programs. The Secretary is authorized to expand the program only if quality measures have been met and budget neutrality is demonstrated.

Sec. 1303 – Rate increase for selected primary care services. Increases the Medicare payment rate by 5% for primary care services of physicians specializing in primary care. Physicians specializing in primary care are defined both by specialty (e.g., family

practitioners, internists, and others) and by share of a practice in primary care (at least 50% of allowed charges are for primary care services).

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

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

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

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

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

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

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

Sec. 1311. Elimination of 190-day lifetime limit on psychiatric hospital stays. Eliminates the 190-day lifetime limit on psychiatric hospital stays for psychiatric hospital services furnished on or after January 1, 2010.

TITLE IV – QUALITY

SUBTITLE A – COMPARATIVE EFFECTIVENESS RESEARCH

Sec. 1401. Comparative Effectiveness Research.

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

Establishes a public/private stakeholder commission known as the “Comparative Effectiveness Research Commission” to oversee the Center, determine national priorities for research, identify research methods and standards of evidence, support forums to increase stakeholder feedback, appoint advisory panels on specific national priorities to advise the center on research questions and methods, and make recommendations for the dissemination of findings.

The 15 member Commission will be appointed by the Secretary with input from the Comptroller General and the Institute of Medicine and will include the Director of AHRQ, the Chief Medical Officer of CMS and stakeholders including clinicians, patients, researchers, third-party payers and consumers. Clinical perspective advisory panels will provide advice on specific research questions and methods for priorities identified by the Commission in order to ensure that the research is clinically relevant. The Commission and the advisory panels it appoints will be subject to strict conflict of interest requirements. The Center and the Commission are prohibited from mandating coverage, reimbursement or other policies to any public or private payer. The Center and the research it conducts are funded out of the Comparative Effectiveness Research Trust Fund (CERTF) which will receive contributions from Medicare and private health insurance plans.

SUBTITLE B.—NURSING HOME TRANSPARENCY

PART I - Improving Transparency of information on skilled nursing facilities and nursing facilities

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

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

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

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

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

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

PART II – Targeting Enforcement

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

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

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

PART III – Improving Staff Training

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

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

SUBTITLE C – QUALITY MEASUREMENTS

Sec. 1441. Establishment of national priorities and performance measures for quality improvement. Directs the Secretary to establish national priorities for performance improvement, incorporating recommendations from outside entities. Based on these priorities, the Secretary, through the Agency on Healthcare Research and Quality, will develop, test, and update new patient-centered and population-based quality measures for the delivery of health care services.

SUBTITLE D – PHYSICIAN PAYMENTS SUNSHINE PROVISIONS

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

TITLE V – MEDICARE GRADUATE MEDICAL EDUCATION

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

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

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

Sec. 1504 - Preservation of resident cap positions from closed hospitals. Directs the Secretary to redistribute medical residency slots from a hospital that closes on or after the date that is 2 years before the enactment of this clause to other hospitals in the same State as recommended to the Secretary of Health and Human Services by the Secretary of Health of the state in which the hospital is located. Such recommendations shall be submitted not later than 180 days after the date of the hospital closure involved.

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

TITLE VI – PROGRAM INTEGRITY

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

Sec. 1601 - Increased funding for HCFAC Fund. Increases funding for the Health Care Fraud and Abuse Control Fund.

SUBTITLE B – ENHANCED PENALTIES FOR FRAUD AND ABUSE

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

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

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

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

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

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

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

Sec. 1618 - Enhanced penalties for obstruction of program audits. Allows for permissive exclusion of individuals or entities that are convicted of obstructing an investigation into or audit of fraud.

SUBTITLE C – ENHANCED PROGRAM AND PROVIDER PROTECTIONS

Sec. 1631 - Enhanced CMS program protection authority. Allows the Secretary to designate program areas of “significant risk” in which enhanced oversight can be applied to prohibit waste, fraud, and abuse. Calls for the Secretary to establish screening procedures for new providers, which may include: licensing board checks, screening lists of those excluded from other federal or state health programs, background checks, unannounced pre-enrollment or other site visits. Allows for enhanced oversight periods (to include site visits, prepayment review, enhanced claims review) for new providers or suppliers in these areas of high risk for up to one year, and allows for a moratorium on enrollment of new suppliers or service providers in areas of high risk if the Secretary determines that there would be no adverse impact on beneficiaries.

Sec. 1632 - Enhanced Medicare, Medicaid, and CHIP program disclosure requirements relating to previous affiliations. Requires new suppliers or providers of services to disclose affiliations within the past 7 years with any provider or supplier that has uncollected debt or has been suspended from Medicare, Medicaid, or CHIP.

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

Sec. 1634 - Evaluations and reports required under Medicare Integrity Program. Requires MIP contractors to conduct periodic evaluations of the effectiveness of their activities.

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

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

Sec. 1637 - Physicians who order durable medical equipment or home health services required to be Medicare participating physicians. Requires that physicians ordering DME or home health services billable to Medicare must be Medicare-participating

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

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

Sec. 1639 - Face to face encounter with patient required before physicians may certify eligibility for home health services under Medicare. Requires a face-to-face (or telemedicine) encounter before a physician may certify home health services.

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

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

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

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

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

Sec. 1651 - Access to Information Necessary to Identify Waste and Abuse. Clarifies that the Department of Justice, working with OIG in consultation with CMS, has access to Medicare and Medicaid claims and payment databases, in a manner that complies with privacy and security laws, including HIPAA. Clarifies that the DOJ and GAO have access to Part C and Part D contract information in order to carry out audit, evaluation, and enforcement activities.

Sec. 1652 - Elimination of duplication between the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank. Directs the Secretary

to reduce duplication between the two databases. Allows access to the National Practitioner Databank by the VA.

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

TITLE VII – MISCELLANEOUS PROVISIONS

Sec. 1701 - Repeal of trigger provision. Repeals Subtitle A of Title VIII of the Medicare Prescription Drug, Improvement and Modernization act, commonly referred to as the “45 percent trigger”.

Sec. 1702 - Repeal of comparative cost adjustment (CCA) program. Repeals section 1860-1 of the Social Security Act, as added by section 241(a) of the Medicare, Prescription Drug, Improvement and Modernization Act of 2003, commonly referred to as the “premium support demonstration project.”

Sec. 1703 - Extension of Gainsharing Demonstration. Extends Gainsharing Demonstration of the Deficit Reduction Act of 2005 from December 31, 2009 to September 30, 2011.

Sec. 1704 - Grants to States for quality home visitation programs for families with young children and families expecting children. Provides grants to States to support voluntary, evidence-based home visitation programs for pregnant women and for families with pre-school age children in order to improve the well-being, health and development of children.

TITLE VIII – MEDICAID AND CHIP

Part 1 – Medicaid and Health Reform

Sec.1801. Eligibility for Individuals with Income Below 133-1/3 Percent of the Federal Poverty Level. (a) Requires State Medicaid programs to cover non-disabled, childless adults under age 65 with income at or below 133% of FPL (\$14,400 per year for an individual). The federal government would pay 100% of the costs of Medicaid coverage for this population. Effective in 2013.

(b) Requires State Medicaid programs to cover parents and individuals with disabilities under age 65 with income at or below 133% of FPL (\$29,300 per year for a family of 4). The federal government would pay 100% of the costs of Medicaid coverage for

individuals in these categories with incomes between the levels in effect in the state as of June 16, 2009 and 133% of FPL. Effective in 2013.

(c) Requires State Medicaid programs to cover newborns during the first year of life who do not otherwise have acceptable coverage upon birth. The federal government would pay 100% of the costs of Medicaid coverage for these newborns. Effective in 2013.

Sec.1802. Requirements and Special Rules for Certain Medicaid Enrollees and for Medicaid Eligible Individuals Enrolled in a Non-Medicaid Exchange-Participating Health Benefits Plan

(a) Requires State Medicaid programs to enter into a memorandum of understanding with the Health Choices Commissioner to coordinate enrollment of low-income individuals into the Exchange or Medicaid as appropriate.

(b) Requires States that opt to allow Medicaid eligible individuals to enroll in a health plan in the Exchange beginning in 2017 and, in the case of beneficiaries other than non-disabled childless adults, to pay a portion of the cost of the affordability credits and of the wrap-around services.

Sec.1803. CHIP Maintenance of Effort. (a) Prohibits States from adopting eligibility standards, methodologies, or procedures in their CHIP programs that are more restrictive than those in effect as of June 16, 2009. Maintenance of effort ends with expiration of CHIP in 2013.

(b) Prohibits States from adopting eligibility standards, methodologies, or procedures in their Medicaid programs more restrictive than those in effect as of June 16, 2009.

Sec.1804. Medicaid DSH Report. Requires the Secretary of HHS to report to the Congress by July 1, 2016, on the continued role of Medicaid Disproportionate Share Hospital payments after implementation of health reform.

Part 2 – Prevention

Sec.1811. Required Coverage of Preventive Services. Requires State Medicaid programs to cover preventive services not otherwise covered that the Secretary determines are recommended by the U.S. Preventive Services Task Force and appropriate for Medicaid beneficiaries. Prohibits imposition of cost-sharing on such services. Provides an enhanced federal matching rate for the cost of such services. Effective July 1, 2010.

Sec.1812. Tobacco Cessation. Prohibits State Medicaid programs from excluding tobacco cessation products from coverage. Includes tobacco cessation counseling in the definition of pregnancy-related services that States are required to provide to eligible pregnant women. Effective July 1, 2010.

Sec.1813. Optional Coverage of Nurse Home Visitation Services. Allows State Medicaid programs to cover home visits by trained nurses to families with a first-time pregnant woman or child under 2 eligible for Medicaid. Provides an enhanced federal matching rate for the cost of such services. Effective January 1, 2010.

Sec.1814. State Eligibility Option for Family Planning Services. Allows State Medicaid programs to cover low-income women who are not pregnant for family planning services and supplies without obtaining a waiver. Allows State Medicaid programs to cover such services for such women during a presumptive eligibility period. Effective on enactment.

Sec.1815. Payment for Items and Services Furnished by Certain School-Based Health Clinics. Requires State Medicaid programs to pay for services furnished to eligible children in school-based health clinics if the programs would pay for such services in physician's office or other outpatient clinic. Effective July 1, 2010.

Part 3 – Access

Sec.1821. Payments to Primary Care Practitioners. Requires that State Medicaid programs reimburse for primary care services furnished by physicians and other practitioners at no less than 80% of Medicare rates in 2010, 90% in 2011, and 100 percent in 2012 and after. The federal government would pay 100% of the costs attributable to this requirement.

Sec.1822. Medical Home Pilot Program. Establishes a 5-year pilot program to test the medical home concept with high-need Medicaid beneficiaries. The federal government would match costs of community care workers at 90% for the first two years and 75% for the next 3 years, up to a total of \$1.235 billion.

Sec.1823. Translation Services. Provides a 75 percent federal matching rate for the costs of translation or interpretation services for Medicaid-eligible adults for whom English is not the primary language. Effective January 1, 2010.

Sec.1824. Optional Coverage for Freestanding Birth Center Services. Allows State Medicaid programs to cover services provided by birth centers that are not hospitals. Effective on enactment.

Sec.1825. Inclusion of Public Health Clinics under the Vaccines for Children Program. Allows children who do not have insurance coverage for immunizations to receive vaccines through the VFC program at a public health clinic. Effective upon enactment.

Part 4 – Coverage

Sec.1831. Optional Medicaid Coverage of Low-Income HIV-Infected Individuals.

Allows State Medicaid programs to cover individuals with HIV with incomes and resources below state eligibility levels for individuals with disabilities. The costs of coverage of such individuals would be matched at an enhanced rate. Effective on enactment.

Sec.1832. Extending Transitional Medicaid Assistance (TMA). Extends the 1-year transitional Medicaid coverage for families leaving cash assistance to work from December 31, 2010 through December 31, 2012.

Sec.1833. Upgrading Electronic Eligibility Systems. Provides enhanced federal matching payments (90% for development and installation, 75% for operation) for implementation of electronic eligibility systems that are compatible with eligibility systems used in Medicare and in the new Exchange. Effective from January 1, 2010 through December 31, 2012.

Sec.1834. Expanded Outstationing. Requires State Medicaid programs to allow adults to apply for coverage at DSH hospitals, FQHCs, and other locations than welfare offices (requirement already applies to pregnant women and children). Effective July 1, 2010.

Part 5 – Financing

Sec.1841. Payments to Pharmacists. Limits Medicaid payments to pharmacists for multiple source drugs to 130 percent of the weighted average manufacturer price. Effective October 1, 2009.

Sec.1842. Prescription Drug Rebates. Increases the minimum manufacturer rebate for brand-name drugs purchased by State Medicaid programs from 15.1% of average manufacturer price to 22.1% of average manufacturer price, and applies the additional Medicaid rebate to new formulations of brand-name drugs. Effective January 1, 2010.

Sec.1843. Extension of Prescription Drug Discounts to Enrollees of Medicaid Managed Care Organizations. Requires manufacturers to pay rebates to State Medicaid programs for drugs dispensed to program beneficiaries enrolled in Medicaid managed care organizations. Effective upon enactment.

Sec.1844 Payments for Graduate Medical Education. Clarifies that State Medicaid programs may receive federal matching payments for the costs of graduate medical education. Directs the Secretary to specify program goals for the use of such funds based on workforce needs. Effective upon enactment.

Part 6 – Waste, Fraud, and Abuse

Sec.1851. Health-Care Acquired Conditions. Prohibits federal matching payments for the cost of health care acquired conditions that are determined to be non-covered services for Medicare purposes. Effective on enactment.

Sec.1852. Evaluations and Reports Required Under Medicaid Integrity Program. Requires Medicaid Integrity Program contractors to submit to the Secretary an annual report on integrity activities. Effective on enactment.

Sec.1853. Require Providers and Suppliers to Adopt Programs to Reduce Waste, Fraud, and Abuse. Requires providers and suppliers participating in Medicaid to establish compliance programs. Effective on enactment.

Sec.1854. Overpayments. Allows State Medicaid programs up to 1 year to return the federal share of overpayments to providers due to fraud. Effective on enactment.

Sec.1855. Minimum Medical Loss Ratio for Medicaid Managed Care Organizations. Limits Medicaid MCO spending on administration, marketing, and distributions to shareholders to no more than 15% of Medicaid premium revenues. Effective July 1, 2010.

Part 7 – Puerto Rico and the Territories

Sec.1861. Puerto Rico and Territories. Provides additional federal Medicaid matching payments to Puerto Rico and the territories totaling \$10.350 billion over the period 2011 through 2019.

Part 8 – Miscellaneous

Sec.1871. Technical Corrections. Makes technical corrections relating to the administration of the low-income subsidy program under Medicaid Part D.

Sec.1872. Making QI Program Permanent. Provides 100% federal Medicaid matching payments for the costs of Part B premiums for Medicare beneficiaries with incomes between 120% and 135% of the federal poverty level. Effective January 1, 2011.

DIVISION C - PUBLIC HEALTH AND WORKFORCE DEVELOPMENT

Sec. 2001 - Table of Contents; References.

Sec. 2002 - Public Health Investment Fund. Establishes the Public Health Investment Fund and deposits a total of \$33.7 billion into it. These funds are authorized to be

appropriated by the Committee on Appropriations for activities in this Division (described below) and are over and above the level of appropriations provided for these activities for FY 2008.

TITLE I - COMMUNITY HEALTH CENTERS

Sec. 2101 - Increased Funding. Authorizes an additional \$12 billion in FY 2010 through FY 2014 for community health centers to be appropriated from the Public Health Investment Fund (under Sec. 2002). (Such funds are over and above the level of appropriations provided for FY 2008.)

TITLE II - WORKFORCE

SUBTITLE A - PRIMARY CARE WORKFORCE

CHAPTER 1 - NATIONAL HEALTH SERVICE CORPS

Sec. 2201 - National Health Service Corps. Increases loan repayment benefits for each Corps member to a maximum of \$50,000 per year and allows fulfillment of Corps service obligation through part-time service.

Sec. 2202 - Authorization of Appropriations. Authorizes an additional \$375 million in FY 2010 through FY 2014 for the National Health Service Corps to be appropriated from the Public Health Investment Fund (under Sec. 2002). (Such sums are over and above the level of appropriations provided for FY 2008.)

CHAPTER 2 - PROMOTION OF PRIMARY CARE AND DENTISTRY

Sec. 2211 - Frontline Health Providers. Establishes a loan repayment and scholarship program at HRSA to address health care needs in geographic areas ("health professional needs areas") not currently recognized as health professional shortage areas. Physicians and other health professionals that do not qualify to participate in the National Health Service Corps are eligible for this program.

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

Sec. 2213 - Training in Family Medicine, General Internal Medicine, General Pediatrics, Geriatrics, and Physician Assistantship. Provides funding to support primary care training programs and build academic capacity in primary care.

Sec. 2214 - Training for General, Pediatric, and Public Health Dentists and Dental Hygienists. Provides funding to support training programs for general, pediatric, and public health dentists and dental hygienists, including faculty loan repayment benefits.

Sec. 2215 - Authorization of Appropriations. Authorizes an additional \$200 million in FY 2010 through FY 2014 for various primary care programs to be appropriated from the Public Health Investment Fund (under Sec. 2002) (Such funds are over and above the level of appropriations provided for FY 2008.)

SUBTITLE B - NURSING WORKFORCE

Sec. 2221 - Amendments to Public Health Service Act.

Makes a number of changes in nursing programs including increasing loan repayment benefits for nursing students and faculty; removing the cap on awards for nursing students pursuing a doctoral degree; and clarifying that nurse-managed health centers are eligible for grant awards. Authorizes an additional \$220 million in FY 2010 through 2014 for various nursing programs to be appropriated from the Public Health Investment Fund (under Sec. 2002). (Such funds are over and above the level of appropriations provided for FY 2008.)

SUBTITLE C - PUBLIC HEALTH WORKFORCE

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

Sec. 2232 - Enhancing the Public Health Workforce. Provides funding to support public health training programs.

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

Sec. 2234 – Preventive Medicine and Public Health Training Grant Program. Provides funding to support training grant programs for preventive medicine physicians.

Sec. 2235 – Authorization of Appropriations. Authorizes an additional \$50 million in FY 2010 through FY 2014 for various public health workforce programs to be appropriated from the Public Health Investment Fund (under Sec. 2002). (Such funds are over and above the level of appropriations provided for 2008.)

SUBTITLE D – ADAPTING WORKFORCE TO EVOLVING HEALTH SYSTEM NEEDS

CHAPTER 1 – HEALTH PROFESSIONS TRAINING FOR DIVERSITY

Sec. 2241 – Centers of Excellence. Provides funding to health professions schools with a demonstrated commitment to educating underrepresented minorities to recruit and train these individuals.

Sec. 2242 – Scholarships for Disadvantaged Students, Loan Repayments and Fellowships Regarding Faculty Positions, and Educational Assistance in the Health Professions Regarding Individuals from Disadvantaged Backgrounds. Provides scholarship and loan repayment support for individuals from disadvantaged backgrounds serving in the health professions. Provides funding for the Health Careers Opportunities Program that supports health professions schools that recruit and train individuals from disadvantaged backgrounds.

Sec. 2243 – Nursing Workforce Diversity Grants. Clarifies requirements for the Secretary to consult with various nursing associations.

Sec. 2244 – Coordination of Diversity and Cultural Competency Programs. Requires the Secretary to coordinate workforce diversity and cultural and linguistic competency activities to enhance effectiveness and avoid duplication of effort.

CHAPTER 2 – INTERDISCIPLINARY TRAINING PROGRAMS

Sec. 2251 – Cultural and Linguistic Competence Training for Health Care Professionals. Establishes a grant program at HRSA to promote cultural and linguistic competence of health care professionals.

Sec. 2252 – Innovations in Interdisciplinary Care Training. Establishes a grant program at HRSA to support the development and operation of interdisciplinary care training programs to improve coordination within and across health care settings, including training in medical home models and models that coordinate both physical and mental health services.

CHAPTER 3 – ADVISORY COMMITTEE ON HEALTH WORKFORCE EVALUATION AND ASSESSMENT

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

CHAPTER 4 – NATIONAL CENTER FOR HEALTH WORKFORCE ANALYSIS

Sec. 2271 – Health Care Workforce Program Assessment. Establishes a National Center for Health Workforce Analysis to gather data to evaluate the effectiveness of federal workforce programs.

Sec. 2272 – Reports. Requires an annual report from the Secretary on the activities carried under Title IV.

CHAPTER 5 – AUTHORIZATION OF APPROPRIATIONS

Sec. 2281 – Authorization of Appropriations. Authorizes an additional \$90 million in FY 2010 through 2014 for various workforce programs to be appropriated from the Public Health Investment Fund (under Sec. 2002). (Such funds are over and above the level of appropriations provided in FY 2008.)

TITLE III – PREVENTION AND WELLNESS

Sec. 2301 – Prevention and Wellness. Amends the Public Health Service Act by establishing a new Title XXIII and creating 10 new sections – Sec. 3111, 3121, 3131, 3132, 3141, 3142, 3151, 3161, 3162, and 3171 (described below).

SUBTITLE A – PREVENTION AND WELLNESS TRUST

Sec. 3111 – Prevention and Wellness Trust. Establishes a Prevention and Wellness Trust that authorizes appropriations from the Public Health Investment Fund (under Sec. 2002) of \$15.2 billion from FY 2010 through FY 2014 to fund activities under Subtitle

C (Prevention Task Forces), Subtitle D (Prevention and Wellness Research), Subtitle E (Delivery of Community-Based Prevention and Wellness Services) and Subtitle F (Core Public Health Infrastructure and Activities).

SUBTITLE B - NATIONAL PREVENTION AND WELLNESS STRATEGY

Sec. 3121 - National Prevention and Wellness Strategy. Requires the Secretary to submit a national strategy designed to improve the nation's health through evidence-based clinical and community-based prevention and wellness activities within one year of enactment and at least every two years thereafter. The strategy must identify specific national goals and standards and establish national priorities for prevention and wellness activities.

SUBTITLE C - PREVENTION TASK FORCES

Sec. 3131 - Task Force on Clinical Preventive Services. Converts the existing U.S. Preventive Services Task Force into the Task Force on Clinical Preventive Services. Staffed by AHRQ, this task force of non-governmental experts conducts evidence-based systemic reviews of data and literature to determine what clinical preventive services (e.g., preventive services delivered by traditional health care providers in clinical settings) are scientifically proven to be effective.

Sec. 3132 - Task Force on Community Preventive Services. Codifies the existing Task Force on Community Preventive Services. Staffed by CDC, this task force of non-governmental experts conducts evidence-based systematic reviews of data and literature to determine what community preventive services (e.g., preventive services that are not "clinical preventive services" but are delivered by nontraditional providers in nontraditional settings) are scientifically proven to be effective.

SUBTITLE D - PREVENTION AND WELLNESS RESEARCH

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

Sec. 3142 - Community-Based Prevention and Wellness Research Grants. Provides funding to CDC to support research on community preventive services.

SUBTITLE E - DELIVERY OF COMMUNITY-BASED PREVENTION AND WELLNESS SERVICES

Sec. 3151 - Community-Based Prevention and Wellness Services Grants. Establishes a grant program at CDC to fund the delivery of evidence-based, community-based prevention and wellness services across the country. Eligible entities include state and local governments, nonprofits, and community partnerships representing Health Empowerment Zones. At least 50% of these funds must be spent on implementing services whose primary purpose is to reduce health disparities.

SUBTITLE F - CORE PUBLIC HEALTH INFRASTRUCTURE ACTIVITIES

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

Sec. 3162 - Core Public Health Infrastructure and Activities for CDC. Authorizes additional funds for CDC to address unmet and emerging public health needs.

SUBTITLE G - GENERAL PROVISIONS

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

TITLE IV - QUALITY AND SURVEILLANCE

Sec. 2401 - Implementation of Best Practices in the Delivery of Health Care. Creates a Center for Quality Improvement at AHQR to prioritize quality improvement activities, assist with implementation, and measure outcomes.

Sec. 2402 - Assistant Secretary for Health Information. Creates a Bureau of Health Information, headed by a new Assistant Secretary for Health Information (established

under this section), to provide full and complete statistics on key health indicators and to facilitate better data sharing.

Sec. 2403 -- Authorization of Appropriations. Authorizes an additional \$300 million for quality improvement and data-related activities to be appropriated from the Public Health Investment Fund (under Sec. 2002). (Such funds are over and above the level of appropriations provided for FY 2008.)

TITLE V - OTHER PROVISIONS

Sec. 2501 - Expanded Participation in 340B Program. Expands the types of entities that qualify for discounts on covered outpatient drugs under sec. 340B of the Public Health Service Act.

Sec. 2502 - Establishment of Grant Program. Establishes a grant program at the Department of Labor to address projected nurse shortages, increase the capacity for educating nurses, and provide training programs. Authorizes “such sums as may be necessary” to carry out the program.