Social Security Act, As Amended

Titles II, IV, V, XI, XVIII, XIX, XX, and XXI of the Social Security Act, as added or amended by the Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152)
The following pages display Titles II, IV, V, XI, XVIII, XIX, XX, and XXI of the Social Security Act, as added or amended by the Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). Any changed or added material from P.L. 111-148 is set out in *italics*. Any changed or added material from P.L. 111-148 is set out in **bold italics**. Amendment notes follow each amended section of the Social Security Act.
Social Security Act, As Amended

[¶ 15,000]

INTRODUCTION

The Social Security Act (SSA) provisions amended by the Patient Protection and Affordable Care Act (P.L. 111-148), and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) are shown in the following paragraphs. Deleted SSA material or the text of the SSA section prior to amendment appears in the amendment notes following each amended SSA provision.

Any material revised or added by the Patient Protection and Affordable Care Act is set out in italics. Any material revised or added by the Health Care Reconciliation Act is set out in bold italics. References to Explanations at the end of each Social Security Act section relate to content in volume 1 of CCH's Law, Explanation and Analysis of the Patient Protection and Affordable Care Act.

[¶ 15,001] Sec. 205. Use of Death Certificates to Correct Program Information

[42 U.S.C. § 405]

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

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

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

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

[Explanation at ¶ 1811.]

2010 Amendments:

Sec. 6402(b)(3) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148) amended sec. 205(r), by adding at the end new paragraph (9).

[¶ 15,002] Sec. 402. Eligible States; State Plan

[42 U.S.C. § 602(a)]

(a)

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(1)

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(B)

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(v) The document shall indicate whether the State intends to assist individuals to train for, seek, and maintain employment—

(I) providing direct care in a long-term care facility (as such terms are defined under section 2011); or

§402(a)(1)(B)(v)(I) ¶15,002
(II) in other occupations related to elder care determined appropriate by the State for which the State identifies an unmet need for service personnel, and, if so, shall include an overview of such assistance.

[Explanation at ¶ 1910.]

2010 Amendments:
Sec. 6701(a)(2)(A) of the Patient Protection and Affordable Care Act (P.L. 111-149) amending sec. 402(a)(1)(B) by adding new subparagraph (v).

1999 Amendments:
Section 401(a) of the "Foster Care Independence Act of 1999," effective Aug. 22, 1996, amended clause (a)(1)(B)(iv) by removing "Act" after "enactment of this" and before "," unless the chief" and inserting "section".

1997 Amendments:
Section 5501(a) of the "Balanced Budget Act of 1997," effective July 1, 1997, amended subsection (a) by deleting "2-year period immediately preceding" following "during the" and before "the fiscal year" and inserting "27-month period ending with the close of the 1st quarter of ".

Section 5501(b) of the "Balanced Budget Act of 1997," effective July 1, 1997, amended clause (a)(1)(A)(ii) by adding "consistent with section 407(e)(2)" before the period.

[Explanation at ¶ 625.]

2010 Amendments:
Sec. 2955(c) of the "Patient Protection and Affordable Care Act" (PubLNo 111-148) amended sec. 422(b)(15), in clause (v) by striking "and "; and by adding new clause (vii) at the end.

[¶ 15,003] Sec. 422. STATE PLANS FOR CHILD WELFARE SERVICES

42 U.S.C. § 622

(b) Each plan for child welfare services under this subpart shall—

(15)(A)(vii) steps to ensure that the components of the transition plan development process required under section 475(5)(H) that relate to the health care needs of children aging out of foster care, including the requirements to include options for health insurance, information about a health care power of attorney, health care proxy, or other similar document recognized under State law, and to provide the child with the option to execute such a document, are met; and

[Explanation at ¶ 625.]

2010 Amendments:
Sec. 2955(c) of the "Patient Protection and Affordable Care Act" (PubLNo 111-148) amended sec. 422(b)(15), in clause (v) by striking "and "; and by adding new clause (vii) at the end.

[¶ 15,005] Sec. 475. DEFINITIONS

42 U.S.C. § 675

As used in this part or part B of this title:

(5) The term "case review system" means a procedure for assuring that—

¶ 15,003  § 402(a)(1)(B)(v)(II)
(H) during the 90-day period immediately prior to the date on which the child will attain 18 years of age, or such greater age as the State may elect under paragraph (8)(B)(iii), whether during that period foster care maintenance payments are being made on the child’s behalf or the child is receiving benefits or services under section 477, a caseworker on the staff of the State agency, and, as appropriate, other representatives of the child provide the child with assistance and support in developing a transition plan that is personalized at the direction of the child, includes specific options on housing, health insurance, education, local opportunities for mentors and continuing support services, and work force supports and employment services, includes information about the importance of designating another individual to make health care treatment decisions on behalf of the child if the child becomes unable to participate in such decisions and the child does not have, or does not want, a relative who would otherwise be authorized under State law to make such decisions, and provides the child with the option to execute a health care power of attorney, health care proxy, or other similar document recognized under State law, and is as detailed as the child may elect.

[Explanation at ¶ 625.]

2010 Amendments:
Sec. 2955(a) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148) amended sec. 475(3)(B) by inserting “includes information about the importance of designating another individual to make health care treatment decisions on behalf of the child if the child becomes unable to participate in such decisions and the child does not have, or does not want, a relative who would otherwise be authorized under State law to make such decisions, and provides the child with the option to execute a health care power of attorney, health care proxy, or other similar document recognized under State law,” after “employment services.”

¶ 15,007  Sec. 477. JOHN H. CHAFEE FOSTER CARE INDEPENDENCE PROGRAM

[42 U.S.C. § 677]

(b) Applications.—

(3) Certifications.—The certifications required by this paragraph with respect to a plan are the following:

(K) A certification by the chief executive officer of the State that the State will ensure that an adolescent participating in the program under this section are provided with education about the importance of designating another individual to make health care treatment decisions on behalf of the adolescent if the adolescent becomes unable to participate in such decisions and the adolescent does not have, or does not want, a relative who would otherwise be authorized under State law to make such decisions, whether a health care power of attorney, health care proxy, or other similar document recognized under State law, and how to execute such a document if the adolescent wants to do so.

[Explanation at ¶ 625.]

2010 Amendments:
Sec. 2955(b) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148) amended sec. 477(b)(3) by adding subsection (K) at the end.

¶ 15,009  Sec. 510. SEPARATE PROGRAM FOR ABSTINENCE EDUCATION

[42 U.S.C. 710]

(a) For the purpose described in subsection (b), the Secretary shall, for each of fiscal years 2010 through 2014, allot to each State which has transmitted an application for the fiscal year under section 505(a) an amount equal to the product of—

(1) the amount appropriated in subsection (d) for the fiscal year; and

(2) the percentage determined for the State under section 502(c)(1)(B)(ii).

§510(a)(2)  ¶15,009
(d) For the purpose of allotments under subsection (a), there is appropriated, out of any money in the Treasury not otherwise appropriated, an additional $50,000,000 for each of the fiscal years 2010 through 2014. The appropriation under the preceding sentence for a fiscal year is made on October 1 of the fiscal year, (except that such appropriation shall be made on the date of enactment of the Patient Protection and Affordable Care Act in the case of fiscal year 2010).

[Explanation at ¶ 620.]

2010 Amendments:
Sec. 2954 of the “Patient Protection and Affordable Care Act” (Pub.L.No. 111-148) amended sec. 510(a) by striking “fiscal year 1998 and each subsequent fiscal year” and inserting “each of fiscal years 2010 through 2014”; and (2) in subsection (d), in the first sentence, by striking “1998 through 2003” and inserting “2010 through 2014”; and in the second sentence, by inserting “(except that such appropriation shall be made on the date of enactment of the Patient Protection and Affordable Care Act in the case of fiscal year 2010)” before the period.

[¶15,011] Sec. 511. MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAMS
[42 U.S.C. §711]

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

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

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

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

(b) REQUIREMENT FOR ALL STATES TO ASSESS STATEWIDE NEEDS AND IDENTIFY AT RISK COMMUNITIES.——

(1) IN GENERAL.—Not later than 6 months after the date of enactment of this section, each State shall, as a condition of receiving payments from an allotment for the State under section 502 for fiscal year 2011, conduct a statewide needs assessment (which shall be separate from the statewide needs assessment required under section 505(a)) that identifies—

(A) communities with concentrations of—

(i) premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn, or child health;

(ii) poverty;

(iii) crime;

(iv) domestic violence;

(v) high rates of high-school drop-outs;

(vi) substance abuse;

(vii) unemployment; or

(viii) child maltreatment;

(B) the quality and capacity of existing programs or initiatives for early childhood home visitation in the State including—

(i) the number and types of individuals and families who are receiving services under such programs or initiatives;

(ii) the gaps in early childhood home visitation in the State; and

(iii) the extent to which such programs or initiatives are meeting the needs of eligible families described in subsection (k)(2); and

(C) the State’s capacity for providing substance abuse treatment and counseling services to individuals and families in need of such treatment or services.

(2) COORDINATION WITH OTHER ASSESSMENTS.—In conducting the statewide needs assessment required under paragraphs (1), the State shall coordinate with, and take into account, other appropriate needs assessments conducted by the State, as determined by the Secretary, including the needs assessment required under section 505(a) (both the most recently completed assessment and any such assessment in progress), the communitywide strategic planning and needs assessments conducted in accordance with
section 640(g)(1)(C) of the Head Start Act, and the inventory of current unmet needs and current community-based and prevention-focused programs and activities to prevent child abuse and neglect, and other family resource services operating in the State required under section 205(3) of the Child Abuse Prevention and Treatment Act.

(3) SUBMISSION TO THE SECRETARY.—Each State shall submit to the Secretary, in such form and manner as the Secretary shall require—

(A) the results of the statewide needs assessment required under paragraph (1); and

(B) a description of how the State intends to address needs identified by the assessment, particularly with respect to communities identified under paragraph (1)(A), which may include applying for a grant to conduct an early childhood home visitation program in accordance with the requirements of this section.

(c) GRANTS FOR EARLY CHILDHOOD HOME VISITATION PROGRAMS.—(1) AUTHORITY TO MAKE GRANTS.—In addition to any other payments made under this title to a State, the Secretary shall make grants to eligible entities to enable the entities to deliver services under early childhood home visitation programs that satisfy the requirements of subsection (d) to eligible families in order to promote improvements in maternal and prenatal health, infant health, child health and development, parenting related to child development outcomes, school readiness, and the socioeconomic status of such families, and reductions in child abuse, neglect, and injuries.

(2) AUTHORITY TO USE INITIAL GRANT FUNDS FOR PLANNING OR IMPLEMENTATION.—An eligible entity that receives a grant under paragraph (1) may use a portion of the funds made available to the entity during the first 6 months of the period for which the grant is made for planning or implementation activities to assist with the establishment of early childhood home visitation programs that satisfy the requirements of subsection (d).

(3) GRANT DURATION.—The Secretary shall determine the period of years for which a grant is made to an eligible entity under paragraph (1).

(4) TECHNICAL ASSISTANCE.—The Secretary shall provide an eligible entity that receives a grant under paragraph (1) with technical assistance in administering programs or activities conducted in whole or in part with grant funds.

(d) REQUIREMENTS.—The requirements of this subsection for an early childhood home visitation program conducted with a grant made under this section are as follows:

(1) QUANTIFIABLE, MEASURABLE IMPROVEMENT IN BENCHMARK AREAS.—

(A) IN GENERAL.—The eligible entity establishes, subject to the approval of the Secretary, quantifiable, measurable 3- and 5-year benchmarks for demonstrating that the program results in improvements for the eligible families participating in the program in each of the following areas:

(i) Improved maternal and newborn health.

(ii) Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits.

(iii) Improvement in school readiness and achievement.

(iv) Reduction in crime or domestic violence.

(v) Improvements in family economic self-sufficiency.

(vi) Improvements in the coordination and referrals for other community resources and supports.

(B) DEMONSTRATION OF IMPROVEMENTS AFTER 3 YEARS.—

(i) REPORT TO THE SECRETARY.—Not later than 30 days after the end of the 3rd year in which the eligible entity conducts the program, the entity submits to the Secretary a report demonstrating improvement in at least 4 of the areas specified in subparagraph (A).

(ii) CORRECTIVE ACTION PLAN.—If the report submitted by the eligible entity under clause (i) fails to demonstrate improvement in at least 4 of the areas specified in subparagraph (A), the entity shall develop and implement a plan to improve outcomes in each of the areas specified in subparagraph (A), subject to approval by the Secretary. The plan shall include provisions for the Secretary to monitor implementation of the plan and conduct continued oversight of the program, including through submission by the entity of regular reports to the Secretary.

(iii) TECHNICAL ASSISTANCE.—
IN GENERAL.—The Secretary shall provide an eligible entity required to develop and implement an improvement plan under clause (ii) with technical assistance to develop and implement the plan. The Secretary may provide the technical assistance directly or through grants, contracts, or cooperative agreements.

ADVISORY PANEL.—The Secretary shall establish an advisory panel for purposes of obtaining recommendations regarding the technical assistance provided to entities in accordance with subclause (i).

No improvement or failure to submit report.—If the Secretary determines after a period of time specified by the Secretary that an eligible entity implementing an improvement plan under clause (ii) has failed to demonstrate any improvement in the areas specified in subparagraph (A), or if the Secretary determines that an eligible entity has failed to submit the report required under clause (i), the Secretary shall terminate the entity's grant and may include any unexpended grant funds in grants made to nonprofit organizations under subsection (h)(2)(B).

FINAL REPORT.—Not later than December 31, 2015, the eligible entity shall submit a report to the Secretary demonstrating improvements (if any) in each of the areas specified in subparagraph (A).

2 IMPROVEMENTS IN OUTCOMES FOR INDIVIDUAL FAMILIES.—

(A) IN GENERAL.—The program is designed, with respect to an eligible family participating in the program, to result in the participant outcomes described in subparagraph (B) that the eligible entity identifies on the basis of an individualized assessment of the family, are relevant for that family.

(B) PARTICIPANT OUTCOMES.—The participant outcomes described in this subparagraph are the following:

(i) Improvements in prenatal, maternal, and newborn health, including improved pregnancy outcomes

(ii) Improvements in child health and development, including the prevention of child injuries and maltreatment and improvements in cognitive, language, social-emotional, and physical developmental indicators.

(iii) Improvements in parenting skills.

(iv) Improvements in school readiness and child academic achievement.

(v) Reductions in crime or domestic violence.

(vi) Improvements in family economic self-sufficiency.

(vii) Improvements in the coordination of referrals for, and the provision of, other community resources and supports for eligible families, consistent with State child welfare agency training.

3 CORE COMPONENTS.—The program includes the following core components:

(A) SERVICE DELIVERY MODEL OR MODELS.—

(i) IN GENERAL.—Subject to clause (ii), the program is conducted using 1 or more of the service delivery models described in item (aa) or (bb) of subclause (I) or in subclause (II) selected by the eligible entity:

(I) The model conforms to a clear consistent home visitation model that has been in existence for at least 3 years and is research-based, grounded in relevant empirically-based knowledge, linked to program determined outcomes, associated with a national organization or institution of higher education that has comprehensive home visitation program standards that ensure high quality service delivery and continuous program quality improvement, and has demonstrated significant, (and in the case of the service delivery model described in item (aa), sustained) positive outcomes, as described in the benchmark areas specified in paragraph (1)(A) and the participant outcomes described in paragraph (2)(B), when evaluated using well-designed and rigorous—

(aa) randomized controlled research designs, and the evaluation results have been published in a peer-reviewed journal; or

(bb) quasi-experimental research designs.
(II) The model conforms to a promising and new approach to achieving the benchmark areas specified in paragraph (1)(A) and the participant outcomes described in paragraph (2)(B), has been developed or identified by a national organization or institution of higher education, and will be evaluated through well-designed and rigorous process.

(ii) MAJORITY OF GRANT FUNDS USED FOR EVIDENCE-BASED MODELS.—An eligible entity shall use not more than 25 percent of the amount of the grant paid to the entity for a fiscal year for purposes of conducting a program using the service delivery model described in clause (i)(II).

(iii) CRITERIA FOR EVIDENCE OF EFFECTIVENESS OF MODELS.—The Secretary shall establish criteria for evidence of effectiveness of the service delivery models and shall ensure that the process for establishing the criteria is transparent and provides the opportunity for public comment.

(B) ADDITIONAL REQUIREMENTS.—

(i) The program adheres to a clear, consistent model that satisfies the requirements of being grounded in empirically-based knowledge related to home visiting and linked to the benchmark areas specified in paragraph (1)(A) and the participant outcomes described in paragraph (2)(B) related to the purposes of the program.

(ii) The program employs well-trained and competent staff, as demonstrated by education or training, such as nurses, social workers, educators, child development specialists, or other well-trained and competent staff, and provides ongoing and specific training on the model being delivered.

(iii) The program maintains high quality supervision to establish home visitor competencies.

(iv) The program demonstrates strong organizational capacity to implement the activities involved.

(v) The program establishes appropriate linkages and referral networks to other community resources and supports for eligible families.

(vi) The program monitors the fidelity of program implementation to ensure that services are delivered pursuant to the specified model.

(4) PRIORITY FOR SERVING HIGH-RISK POPULATIONS.—The eligible entity gives priority to providing services under the program to the following:

(A) Eligible families who reside in communities in need of such services, as identified in the statewide needs assessment required under subsection (b)(1)(A).

(B) Low-income eligible families.

(C) Eligible families who are pregnant women who have not attained age 21.

(D) Eligible families that have a history of child abuse or neglect or have had interactions with child welfare services.

(E) Eligible families that have a history of substance abuse or need substance abuse treatment.

(F) Eligible families that have users of tobacco products in the home.

(G) Eligible families that are or have children with low student achievement.

(H) Eligible families with children with developmental delays or disabilities.

(I) Eligible families who, or that include individuals who, are serving or formerly served in the Armed Forces, including such families that have members of the Armed Forces who have had multiple deployments outside of the United States.

(e) APPLICATION REQUIREMENTS.—An eligible entity desiring a grant under this section shall submit an application to the Secretary for approval, in such manner as the Secretary may require, that includes the following:

(1) A description of the populations to be served by the entity, including specific information regarding how the entity will serve high risk populations described in subsection (d)(4).

(2) An assurance that the entity will give priority to serving low-income eligible families and eligible families who reside in at risk communities identified in the statewide needs assessment required under subsection (b)(1)(A).
The service delivery model or models described in subsection (d)(3)(A) that the entity will use under the program and the basis for the selection of the model or models.

A statement identifying how the selection of the populations to be served and the service delivery model or models that the entity will use under the program for such populations is consistent with the results of the statewide needs assessment conducted under subsection (b).

The quantifiable, measurable benchmarks established by the State to demonstrate that the program contributes to improvements in the areas specified in subsection (d)(1)(A).

An assurance that the entity will obtain and submit documentation or other appropriate evidence from the organization or entity that developed the service delivery model or models used under the program to verify that the program is implemented and services are delivered according to the model specifications.

Assurances that the entity will establish procedures to ensure that—

(A) the participation of each eligible family in the program is voluntary; and

(B) services are provided to an eligible family in accordance with the individual assessment for that family.

Assurances that the entity will—

(A) submit annual reports to the Secretary regarding the program and activities carried out under the program that include such information and data as the Secretary shall require; and

(B) participate in, and cooperate with, data and information collection necessary for the evaluation required under subsection (g)(2) and other research and evaluation activities carried out under subsection (h)(3).

A description of other State programs that include home visitation services, including, if applicable to the State, other programs carried out under this title with funds made available from allotments under section 502(c), programs funded under title IV, title II of the Child Abuse Prevention and Treatment Act (relating to community-based grants for the prevention of child abuse and neglect), and section 645A of the Head Start Act (relating to Early Head Start programs).

Other information as required by the Secretary.

Maintenance of Effort.—Funds provided to an eligible entity receiving a grant under this section shall supplement, and not supplant, funds from other sources for early childhood home visitation programs or initiatives.

Evaluation.—

Independent, expert advisory panel.—The Secretary, in accordance with subsection (h)(1)(A), shall appoint an independent advisory panel consisting of experts in program evaluation and research, education, and early childhood development—

(A) to review, and make recommendations on, the design and plan for the evaluation required under paragraph (2) within 1 year after the date of enactment of this section;

(B) to maintain and advise the Secretary regarding the progress of the evaluation; and

(C) to comment, if the panel so desires, on the report submitted under paragraph (3).

Authority to conduct evaluation.—On the basis of the recommendations of the advisory panel under paragraph (1), the Secretary shall, by grant, contract, or interagency agreement, conduct an evaluation of the statewide needs assessments submitted under subsection (b) and the grants made under subsections (c) and (h)(3)(B). The evaluation shall include—

(A) an analysis, on a State-by-State basis, of the results of such assessments, including indicators of maternal and prenatal health and infant health and mortality, and State actions in response to the assessments; and

(B) an assessment of—

(i) the effect of early childhood home visitation programs on child and parent outcomes, including with respect to each of the benchmark areas specified in subsection (d)(1)(A) and the participant outcomes described in subsection (d)(2)(B);

(ii) the effectiveness of such programs on different populations, including the extent to which the ability of programs to improve participant outcomes varies across programs and populations; and
(iii) the potential for the activities conducted under such programs, if scaled broadly, to improve health care practices, eliminate health disparities, and improve health care system quality, efficiencies, and reduce costs.

(3) REPORT.—Not later than March 31, 2015, the Secretary shall submit a report to Congress on the results of the evaluation conducted under paragraph (2) and shall make the report publicly available.

(b) OTHER PROVISIONS.—(1) INTRA-AGENCY COLLABORATION.—The Secretary shall ensure that the Maternal and Child Health Bureau and the Administration for Children and Families collaborate with respect to carrying out this section, including with respect to—

(A) reviewing and analyzing the statewide needs assessments required under subsection (b), the awarding and oversight of grants awarded under this section, the establishment of the advisory panels required under subsections (d)(1)(B)(ii)(II) and (g)(1), and the evaluation and report required under subsection (g); and

(B) consulting with other Federal agencies with responsibility for administering or evaluating programs that serve eligible families to coordinate and collaborate with respect to research related to such programs and families, including the Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services, the Centers for Disease Control and Prevention, the National Institute of Child Health and Human Development of the National Institutes of Health, the Office of Juvenile Justice and Delinquency Prevention of the Department of Justice, and the Institute of Education Sciences of the Department of Education.

(2) GRANTS TO ELIGIBLE ENTITIES THAT ARE NOT STATES.—

(A) Indian tribes, tribal organizations, or urban Indian organizations.—The Secretary shall specify requirements for eligible entities that are Indian Tribes (or a consortium of Indian Tribes), Tribal Organizations, or Urban Indian Organizations to apply for and conduct an early childhood home visitation program with a grant under this section. Such requirements shall, to the greatest extent practicable, be consistent with the requirements applicable to eligible entities that are States and shall require an Indian Tribe (or consortium), Tribal Organization, or Urban Indian Organization to—

(i) conduct a needs assessment similar to the assessment required for all States under subsection (b); and

(ii) establish quantifiable, measurable 3- and 5-year benchmarks consistent with subsection (d)(1)(A).

(B) NONPROFIT ORGANIZATIONS.—If, as of the beginning of fiscal year 2012, a State has not applied or been approved for a grant under this section, the Secretary may use amounts appropriated under paragraph (1) of subsection (j) that are available for expenditure under paragraph (3) of that subsection to make a grant to an eligible entity that is a nonprofit organization described in subsection (k)(1)(B) to conduct an early childhood home visitation program in the State. The Secretary shall specify the requirements for such an organization to apply for and conduct the program which shall, to the greatest extent practicable, be consistent with the requirements applicable to eligible entities that are States and shall require the organization to—

(i) carry out the program based on the needs assessment conducted by the State under subsection (b); and

(ii) establish quantifiable, measurable 3- and 5-year benchmarks consistent with subsection (d)(1)(A).

(3) RESEARCH AND OTHER EVALUATION ACTIVITIES.—

(A) IN GENERAL.—The Secretary shall carry out a continuous program of research and evaluation activities in order to increase knowledge about the implementation and effectiveness of home visiting programs, using random assignment designs to the maximum extent feasible. The Secretary may carry out such activities directly, or through grants, cooperative agreements, or contracts.

(B) REQUIREMENTS.—The Secretary shall ensure that—

(i) evaluation of a specific program or project is conducted by persons or individuals not directly involved in the operation of such program or project; and

(ii) the conduct of research and evaluation activities includes consultation with independent researchers, State officials, and developers and providers of home visiting programs on topics including research design and administrative data matching.
(4) REPORT AND RECOMMENDATION.—Not later than December 31, 2015, the Secretary shall submit a report to Congress regarding the programs conducted with grants under this section. The report required under this paragraph shall include—

(A) information regarding the extent to which eligible entities receiving grants under this section demonstrated improvements in each of the areas specified in subsection (d)(1)(A);

(B) information regarding any technical assistance provided under subsection (d)(1)(B)(iii)(I), including the type of any such assistance provided; and

(C) recommendations for such legislative or administrative action as the Secretary determines appropriate.

(i) APPLICATION OF OTHER PROVISIONS OF TITLE.—(1) IN GENERAL.—Except as provided in paragraph (2), the other provisions of this title shall not apply to a grant made under this section.

(2) EXCEPTIONS.—The following provisions of this title shall apply to a grant made under this section to the same extent and in the same manner as such provisions apply to allotments made under section 502(c):

(A) Section 504(b)(6) (relating to prohibition on payments to excluded individuals and entities).

(B) Section 504(c) (relating to the use of funds for the purchase of technical assistance).

(C) Section 504(d) (relating to a limitation on administrative expenditures).

(D) Section 506 (relating to reports and audits), but only to the extent determined by the Secretary to be appropriate for grants made under this section.

(E) Section 507 (relating to penalties for false statements).

(F) Section 508 (relating to nondiscrimination).

(G) Section 509(a) (relating to the administration of the grant program).

(j) APPROPRIATIONS.—

(1) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary to carry out this section—

(A) $100,000,000 for fiscal year 2010;

(B) $250,000,000 for fiscal year 2011;

(C) $350,000,000 for fiscal year 2012;

(D) $400,000,000 for fiscal year 2013; and

(E) $400,000,000 for fiscal year 2014.

(2) RESERVATIONS.—Of the amount appropriated under this subsection for a fiscal year, the Secretary shall reserve—

(A) 3 percent of such amount for purposes of making grants to eligible entities that are Indian Tribes (or a consortium of Indian Tribes), Tribal Organizations, or Urban Indian Organizations; and

(B) 3 percent of such amount for purposes of carrying out subsections (d)(1)(B)(iii), (g), and (h)(3).

(3) AVAILABILITY.—Funds made available to an eligible entity under this section for a fiscal year shall remain available for expenditure by the eligible entity through the end of the second succeeding fiscal year after award. Any funds that are not expended by the eligible entity during the period in which the funds are available under the preceding sentence may be used for grants to nonprofit organizations under subsection (h)(2)(B).

(k) DEFINITIONS.—In this section:

(1) ELIGIBLE ENTITY.—

(A) IN GENERAL.—The term "eligible entity" means a State, an Indian Tribe, Tribal Organization, or Urban Indian Organization, Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, and American Samoa.

(B) NONPROFIT ORGANIZATIONS.—Only for purposes of awarding grants under subsection (h)(2)(B), such term shall include a nonprofit organization with an established record of providing early childhood home visitation programs or initiatives in a State or several States.
(2) ELIGIBLE FAMILY.—The term “eligible family” means—
(A) a woman who is pregnant, and the father of the child if the father is available; or
(B) a parent or primary caregiver of a child, including grandparents or other relatives of the child, and foster parents, who are serving as the child’s primary caregiver from birth to kindergarten entry, and including a noncustodial parent who has an ongoing relationship with, and at times provides physical care for, the child.

(3) INDIAN TRIBE; TRIBAL ORGANIZATION.—The terms “Indian Tribe” and “Tribal Organization”, and “Urban Indian Organization” have the meanings given such terms in section 4 of the Indian Health Care Improvement Act.

[Explanation at ¶ 605.]

2010 Amendments:
Sec. 2951 of the “Patient Protection and Affordable Care Act” (PubLNo 111-148) added new sec. 511.

¶15,013 Sec. 512. SERVICES TO INDIVIDUALS WITH A POSTPARTUM CONDITION AND THEIR FAMILIES

§512(e) ¶15,013

(a) IN GENERAL.—In addition to any other payments made under this title to a State, the Secretary may make grants to eligible entities for projects for the establishment, operation, and coordination of effective and cost-efficient systems for the delivery of essential services to individuals with or at risk for postpartum conditions and their families.

(b) CERTAIN ACTIVITIES.—To the extent practicable and appropriate, the Secretary shall ensure that projects funded under subsection (a) provide education and services with respect to the diagnosis and management of postpartum conditions for individuals with or at risk for postpartum conditions and their families. The Secretary may allow such projects to include the following:

(1) Delivering or enhancing outpatient and home-based health and support services, including case management and comprehensive treatment services.

(2) Delivering or enhancing inpatient care management services that ensure the well-being of the mother and family and the future development of the infant.

(3) Improving the quality, availability, and organization of health care and support services (including transportation services, attendant care, homemaker services, day or respite care, and providing counseling on financial assistance and insurance).

(4) Providing education about postpartum conditions to promote earlier diagnosis and treatment. Such education may include—
(A) providing complete information on postpartum conditions, symptoms, methods of coping with the illness, and treatment resources; and
(B) in the case of a grantee that is a State, hospital, or birthing facility—
(i) providing education to new mothers and fathers, and other family members as appropriate, concerning postpartum conditions before new mothers leave the health facility; and
(ii) ensuring that training programs regarding such education are carried out at the health facility.

(c) INTEGRATION WITH OTHER PROGRAMS.—To the extent practicable and appropriate, the Secretary may integrate the grant program under this section with other grant programs carried out by the Secretary, including the program under section 330 of the Public Health Service Act.

(d) REQUIREMENTS.—The Secretary shall establish requirements for grants made under this section that include a limit on the amount of grants funds that may be used for administration, accounting, reporting, or program oversight functions and a requirement for each eligible entity that receives a grant to submit, for each grant period, a report to the Secretary that describes how grant funds were used during such period.

(e) TECHNICAL ASSISTANCE.—The Secretary may provide technical assistance to entities seeking a grant under this section in order to assist such entities in complying with the requirements of this section.
(f) **Application of Other Provisions of Title.**—

(1) **In General.**—Except as provided in paragraph (2), the other provisions of this title shall not apply to a grant made under this section.

(2) **Exceptions.**—The following provisions of this title shall apply to a grant made under this section to the same extent and in the same manner as such provisions apply to allotments made under section 502(c):

(A) Section 504(b)(6) (relating to prohibition on payments to excluded individuals and entities).

(B) Section 504(c) (relating to the use of funds for the purchase of technical assistance).

(C) Section 504(d) (relating to a limitation on administrative expenditures).

(D) Section 506 (relating to reports and audits), but only to the extent determined by the Secretary to be appropriate for grants made under this section.

(E) Section 507 (relating to penalties for false statements).

(F) Section 508 (relating to nondiscrimination).

(G) Section 509(a) (relating to the administration of the grant program).

(g) **Definitions.**—In this section:

(1) The term “eligible entity”—

(A) means a public or nonprofit private entity; and

(B) includes a State or local government, public-private partnership, recipient of a grant under section 330H of the Public Health Service Act (relating to the Healthy Start Initiative), public or nonprofit private hospital, community-based organization, hospice, ambulatory care facility, community health center, migrant health center, public housing primary care center, or homeless health center.

(2) The term “postpartum condition” means postpartum depression or postpartum psychosis.

[Explanation at ¶ 610.]

2010 Amendments:
Sec. 2952(b) of the “Patient Protection and Affordable Care Act” [Pub.L.No 111-148] added new sec. 512.

¶ 15,015 [42 U.S.C. § 713] Sec. 513. PERSONAL RESPONSIBILITY EDUCATION

(a) **Allotments to States.**—(1) **Amount.**—

(A) In general.—For the purpose described in subsection (b), subject to the succeeding provisions of this section, for each of fiscal years 2010 through 2014, the Secretary shall allot to each State an amount equal to the product of—

(i) the amount appropriated under subsection (f) for the fiscal year and available for allotments to States after the application of subsection (c); and

(ii) the State youth population percentage determined under paragraph (2).

(B) **Minimum Allotment.**—

(i) In general.—Each State allotment under this paragraph for a fiscal year shall be at least $250,000.

(ii) Pro rata adjustments.—The Secretary shall adjust on a pro rata basis the amount of the State allotments determined under this paragraph for a fiscal year to the extent necessary to comply with clause (i).

(C) **Application Required to Access Allotments.**—

(i) In general.—A State shall not be paid from its allotment for a fiscal year unless the State submits an application to the Secretary for the fiscal year and the Secretary approves the application (or requires changes to the application that the State satisfies) and meets such additional requirements as the Secretary may specify.
(ii) REQUIREMENTS.—The State application shall contain an assurance that the State has complied with the requirements of this section in preparing and submitting the application and shall include the following as well as such additional information as the Secretary may require:

(I) Based on data from the Centers for Disease Control and Prevention National Center for Health Statistics, the most recent pregnancy rates for the State for youth ages 10 to 14 and youth ages 15 to 19 for which data are available, the most recent birth rates for such youth populations in the State for which data are available, and trends in those rates for the most recently preceding 5-year period for which such data are available.

(II) State-established goals for reducing the pregnancy rates and birth rates for such youth populations.

(III) A description of the State’s plan for using the State allotments provided under this section to achieve such goals, especially among youth populations that are the most high-risk or vulnerable for pregnancies or otherwise have special circumstances, including youth in foster care, homeless youth, youth with HIV/AIDS, pregnant youth who are under 21 years of age, mothers who are under 21 years of age, and youth residing in areas with high birth rates for youth.

(2) STATE YOUTH POPULATION PERCENTAGE.—

(A) IN GENERAL.—For purposes of paragraph (1)(A)(ii), the State youth population percentage is, with respect to a State, the proportion (expressed as a percentage) of—

(i) the number of individuals who have attained age 10 but not attained age 20 in the State; to

(ii) the number of such individuals in all States.

(B) DETERMINATION OF NUMBER OF YOUTH.—The number of individuals described in clauses (i) and (ii) of subparagraph (A) in a State shall be determined on the basis of the most recent Bureau of the Census data.

(3) AVAILABILITY OF STATE ALLOTMENTS.—Subject to paragraph (4)(A), amounts allotted to a State pursuant to this subsection for a fiscal year shall remain available for expenditure by the State through the end of the second succeeding fiscal year.

(4) AUTHORITY TO AWARD GRANTS FROM STATE ALLOTMENTS TO LOCAL ORGANIZATIONS AND ENTITIES IN NONPARTICIPATING STATES.—

(A) GRANTS FROM UNEXPENDED ALLOTMENTS.—If a State does not submit an application under this section for fiscal year 2010 or 2011, the State shall no longer be eligible to submit an application to receive funds from the amounts allotted for the State for each of fiscal years 2010 through 2014 and such amounts shall be used by the Secretary to award grants under this paragraph for each of fiscal years 2012 through 2014. The Secretary also shall use any amounts from the allotments of States that submit applications under this section for a fiscal year that remain unexpended as of the end of the period in which the allotments are available for expenditure under paragraph (3) for awarding grants under this paragraph.

(B) 3-YEAR GRANTS.—

(i) IN GENERAL.—The Secretary shall solicit applications to award 3-year grants in each of fiscal years 2012, 2013, and 2014 to local organizations and entities to conduct, consistent with subsection (b), programs and activities in States that do not submit an application for an allotment under this section for fiscal year 2010 or 2011.

(ii) FAITH-BASED ORGANIZATIONS OR CONSORTIA.—The Secretary may solicit and award grants under this paragraph to faith-based organizations or consortia.

(C) EVALUATION.—An organization or entity awarded a grant under this paragraph shall agree to participate in a rigorous Federal evaluation.

(5) MAINTENANCE OF EFFORT.—No payment shall be made to a State from the allotment determined for the State under this subsection or to a local organization or entity awarded a grant under paragraph (4), if the expenditure of non-federal funds by the State, organization, or entity for activities, programs, or initiatives for which amounts from allotments and grants under this subsection may be expended is less than the amount expended by the State, organization, or entity for such programs or initiatives for fiscal year 2009.
(6) DATA COLLECTION AND REPORTING.—A State or local organization or entity receiving funds under this section shall cooperate with such requirements relating to the collection of data and information and reporting on outcomes regarding the programs and activities carried out with such funds, as the Secretary shall specify.

(b) PURPOSE.—(1) IN GENERAL.—The purpose of an allotment under subsection (a)(1) to a State is to enable the State (or, in the case of grants made under subsection (a)(4)(B), to enable a local organization or entity) to carry out personal responsibility education programs consistent with this subsection.

(2) PERSONAL RESPONSIBILITY EDUCATION PROGRAMS.—

(A) IN GENERAL.—In this section, the term "personal responsibility education program" means a program that is designed to educate adolescents on—

(i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and

(ii) at least 3 of the adulthood preparation subjects described in subparagraph (C).

(B) REQUIREMENTS.—The requirements of this subparagraph are the following:

(i) The program replicates evidence-based effective programs or substantially incorporates elements of effective programs that have been proven on the basis of rigorous scientific research to change behavior, which means delaying sexual activity, increasing condom or contraceptive use for sexually active youth, or reducing pregnancy among youth.

(ii) The program is medically-accurate and complete.

(iii) The program includes activities to educate youth who are sexually active regarding responsible sexual behavior with respect to both abstinence and the use of contraception.

(iv) The program places substantial emphasis on both abstinence and contraception for the prevention of pregnancy among youth and sexually transmitted infections.

(v) The program provides age-appropriate information and activities.

(vi) The information and activities carried out under the program are provided in the cultural context that is most appropriate for individuals in the particular population group to which they are directed.

(C) Adulthood preparation subjects.—The adulthood preparation subjects described in this subparagraph are the following:

(i) Healthy relationships, such as positive self-esteem and relationship dynamics, friendships, dating, romantic involvement, marriage, and family interactions.

(ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects.

(iii) Financial literacy.

(iv) Parent-child communication.

(v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity.

(vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management.

(c) RESERVATIONS OF FUNDS.—(1) GRANTS TO IMPLEMENT INNOVATIVE STRATEGIES.—From the amount appropriated under subsection (f) for the fiscal year, the Secretary shall reserve $10,000,000 of such amount for purposes of awarding grants to entities to implement innovative youth pregnancy prevention strategies and target services to high-risk, vulnerable, and culturally under-represented youth populations, including youth in foster care, homeless youth, youth with HIV/AIDS, pregnant women who are under 21 years of age and their partners, mothers who are under 21 years of age and their partners, and youth residing in areas with high birth rates for youth. An entity awarded a grant under this paragraph shall agree to participate in a rigorous Federal evaluation of the activities carried out with grant funds.

(2) OTHER RESERVATIONS.—From the amount appropriated under subsection (f) for the fiscal year that remains after the application of paragraph (1), the Secretary shall reserve the following amounts:
(A) **GRANTS FOR INDIAN TRIBES OR TRIBAL ORGANIZATIONS.**—The Secretary shall reserve 5 percent of such remainder for purposes of awarding grants to Indian tribes and tribal organizations in such manner, and subject to such requirements, as the Secretary, in consultation with Indian tribes and tribal organizations, determines appropriate.

(B) **SECRETARIAL RESPONSIBILITIES.**—

(i) **RESERVATION OF FUNDS.**—The Secretary shall reserve 10 percent of such remainder for expenditures by the Secretary for the activities described in clauses (ii) and (iii).

(ii) **PROGRAM SUPPORT.**—The Secretary shall provide, directly or through a competitive grant process, research, training and technical assistance, including dissemination of research and information regarding effective and promising practices, providing consultation and resources on a broad array of teen pregnancy prevention strategies, including abstinence and contraception, and developing resources and materials to support the activities of recipients of grants and other State, tribal, and community organizations working to reduce teen pregnancy. In carrying out such functions, the Secretary shall collaborate with a variety of entities that have expertise in the prevention of teen pregnancy, HIV and sexually transmitted infections, healthy relationships, financial literacy, and other topics addressed through the personal responsibility education programs.

(iii) **EVALUATION.**—The Secretary shall evaluate the programs and activities carried out with funds made available through allotments or grants under this section.

(d) **ADMINISTRATION.**—(1) **IN GENERAL.**—The Secretary shall administer this section through the Assistant Secretary for the Administration for Children and Families within the Department of Health and Human Services.

(2) **APPLICATION OF OTHER PROVISIONS OF TITLE.**—

(A) **IN GENERAL.**—Except as provided in subparagraph (B), the other provisions of this title shall not apply to allotments or grants made under this section.

(B) **EXCEPTIONS.**—The following provisions of this title shall apply to allotments and grants made under this section to the same extent and in the same manner as such provisions apply to allotments made under section 502(c):

(i) Section 504(b)(6) (relating to prohibition on payments to excluded individuals and entities).

(ii) Section 504(c) (relating to the use of funds for the purchase of technical assistance).

(iii) Section 504(d) (relating to a limitation on administrative expenditures).

(iv) Section 506 (relating to reports and audits), but only to the extent determined by the Secretary to be appropriate for grants made under this section.

(v) Section 507 (relating to penalties for false statements).

(vi) Section 508 (relating to nondiscrimination).

(e) **DEFINITIONS.**—In this section:

(1) **AGE-APPROPRIATE.**—The term “age-appropriate”, with respect to the information in pregnancy prevention, means topics, messages, and teaching methods suitable to particular ages or age groups of children and adolescents, based on developing cognitive, emotional, and behavioral capacity typical for the age or age group.

(2) **MEDICALLY ACCURATE AND COMPLETE.**—The term “medically accurate and complete” means verified or supported by the weight of research conducted in compliance with accepted scientific methods and—

(A) published in peer-reviewed journals, where applicable; or

(B) comprising information that leading professional organizations and agencies with relevant expertise in the field recognize as accurate, objective, and complete.

(3) **INDIAN TRIBES; TRIBAL ORGANIZATIONS.**—The terms “Indian tribe” and “Tribal organization” have the meanings given such terms in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

(4) **YOUTH.**—The term “youth” means an individual who has attained age 10 but has not attained age 20.
(f) Appropriation.—For the purpose of carrying out this section, there is appropriated, out of any money in the Treasury not otherwise appropriated, $75,000,000 for each of fiscal years 2010 through 2014. Amounts appropriated under this subsection shall remain available until expended.

[Explanation at ¶615.]

2010 Amendments:
Sec. 2593 of the “Patient Protection and Affordable Care Act” (Pub.L. No. 111-148) added new sec. 513.

¶15,011 Sec. 1108. Limitation on Payments to Puerto Rico, the Virgin Islands, and Guam

[42 U.S.C. §1308]

(g) Medicaid Payments to Territories for Fiscal Year 1998 and Thereafter.

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(2) Fiscal Year 1999 and Thereafter.—Notwithstanding subsection (f) and subject to and section 1323(a)(2) of the Patient Protection and Affordable Care Act paragraphs (3) and (5), with respect to fiscal year 1999 and any fiscal year thereafter, the total amount certified by the Secretary under title XIX for payment to

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(4) Exclusion of Certain Expenditures from Payment Limits.—With respect to

(A) fiscal years beginning with fiscal year 2009, if Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa qualify for a payment under subparagraph (A)(i), (B), or (F) of section 1903(a)(3) for a calendar quarter of such fiscal year, the payment shall not be taken into account in applying subsection (f) (as increased in accordance with paragraphs (1), (2), (3), and (4) of this subsection) to such commonwealth or territory for such fiscal year; and

(B) fiscal years beginning with fiscal year 2014, payments made to Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa with respect to amounts expended for medical assistance for newly eligible (as defined in section 1905(y)(2)) nonpregnant childless adults who are eligible under subclause (VIII) of section 1902(a)(10)(A)(i) and whose income (as determined under section 1902(e)(14)) does not exceed (in the case of each such commonwealth and territory respectively) the highest income eligibility level in effect for parents under the commonwealth’s or territory’s State plan under title XIX or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act, shall not be taken into account in applying subsection (f) (as increased in accordance with paragraphs (1), (2), (3), and (5) of this subsection) to such commonwealth or territory for such fiscal year.

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

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[Explanation at ¶513.]

2010 Amendments:
Sec. 2055(a) of the “Patient Protection and Affordable Care Act” (Pub.L. No. 111-148) amended sec. 1108(g)(2), in the matter preceding subparagraph (A), by striking “paragraph (3)” and inserting “paragraphs (3) and (5)”; in paragraph (4) by striking “and (3)” and inserting “(3), and (4)”; by adding at the end a new subparagraph (5).

Sec. 2005(b) was subsequently repealed by sec. 1204(b)(2) of the “Health Care and Education Reconciliation Act of 2010” (Pub.L. No 111-152). The amendment made by sec. 10201(d) is no longer reflected due to the removal of sec. 1108(g)(4)(B) by sec. 1204(b)(2)(A) of the “Health Care and Education Reconciliation Act of 2010.”

Secs. 2005(b) and 10201(d) of the “Patient Protection and Affordable Care Act” (Pub.L. No 111-148), amended sec. 1108.

\[\text{(d)}\]

An application or renewal of any experimental, pilot, or demonstration project undertaken under subsection (a) to promote the objectives of title XIX or XXI in a State that would result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing with respect to a State program under title XIX or XXI (in this subsection referred to as a “demonstration project”) shall be considered by the Secretary in accordance with the regulations required to be promulgated under paragraph (2).

(2) Not later than 180 days after the date of enactment of this subsection, the Secretary shall promulgate regulations relating to applications for, and renewals of, a demonstration project that provide—

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

(B) requirements relating to—

(i) the goals of the program to be implemented or renewed under the demonstration project;

(ii) the expected State and Federal costs and coverage projections of the demonstration project; and

(iii) the specific plans of the State to ensure that the demonstration project will be in compliance with title XIX or XXI;

(C) a process for providing public notice and comment after the application is received by the Secretary, that is sufficient to ensure a meaningful level of public input;

(D) a process for the submission to the Secretary of periodic reports by the State concerning the implementation of the demonstration project; and

(E) a process for the periodic evaluation by the Secretary of the demonstration project.

(3) The Secretary shall annually report to Congress concerning actions taken by the Secretary with respect to applications for demonstration projects under this section.

(e)

(2) During the 6-month period ending 1 year before the date the waiver under subsection (a) with respect to a waiver project would otherwise expire, the chief executive officer of the State which is operating the project may submit to the Secretary a written request for an extension, of up to 3 years (5 years, in the case of a waiver described in section 1915(h)(2)), of the project.

(6) An approval of an application for an extension of a waiver project under this subsection shall be for a period not to exceed 3 years (5 years, in the case of a waiver described in section 1915(h)(2)).
Sec. 1115A. CENTER FOR MEDICARE AND MEDICAID INNOVATION

(a) CENTER FOR MEDICARE AND MEDICAID INNOVATION ESTABLISHED.—

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

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

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

(4) DEFINITIONS.—In this section:

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

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

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

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

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

(5) TESTING WITHIN CERTAIN GEOGRAPHIC AREAS.—For purposes of testing payment and service delivery models under this section, the Secretary may elect to limit testing of a model to certain geographic areas.

(b) TESTING OF MODELS (PHASE I).—

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

(2) SELECTION OF MODELS TO BE TESTED.—

(A) IN GENERAL.—The Secretary shall select models to be tested from models where the Secretary determines that there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures. The Secretary shall focus on models expected to reduce program costs under the applicable title while preserving or enhancing the quality of care received by individuals receiving benefits under such title. The models selected under this subparagraph may include, but are not limited to, the models described in subparagraph (B).

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

(i) Promoting broad payment and practice reform in primary care, including patient-centered medical home models for high-need applicable individuals, medical homes that address
women’s unique health care needs, and models that transition primary care practices away from fee-for-service based reimbursement and toward comprehensive payment or salary-based payment.

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

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

(I) An inability to perform 2 or more activities of daily living.
(II) Cognitive impairment, including dementia.

(iv) Promote care coordination between providers of services and suppliers that transition health care providers away from fee-for-service based reimbursement and toward salary-based payment.

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

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

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

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

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

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

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

(xii) Aligning nationally recognized, evidence-based guidelines of cancer care with payment incentives under title XVIII in the areas of treatment planning and follow-up care planning for applicable individuals described in clause (i) or (iii) of subsection (a)(4)(A) with cancer, including the identification of gaps in applicable quality measures.

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

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

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

(I) developing, documenting, and disseminating best practices and proven care methods;
(II) implementing such best practices and proven care methods within such institutions to demonstrate further improvements in quality and efficiency; and
(III) providing assistance to other health care institutions on how best to employ such best practices and proven care methods to improve health care quality and lower costs.
(xvi) Facilitate inpatient care, including intensive care, of hospitalized applicable individuals at their local hospital through the use of electronic monitoring by specialists, including intensivists and critical care specialists, based at integrated health systems.

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

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

(xix) Utilizing, in particular in entities located in medically underserved areas and facilities of the Indian Health Service (whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act)), telehealth services—

(I) in treating behavioral health issues (such as post-traumatic stress disorder) and stroke; and

(II) to improve the capacity of non-medical providers and non-specialized medical providers to provide health services for patients with chronic complex conditions.

(xx) Utilizing a diverse network of providers of services and suppliers to improve care coordination for applicable individuals described in subsection (a)(4)(A)(i) with 2 or more chronic conditions and a history of prior-year hospitalization through interventions developed under the Medicare Coordinated Care Demonstration Project under section 4016 of the Balanced Budget Act of 1997 (42 U.S.C. 1395b-1 note).

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

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

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

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

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

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

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

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

(viii) Whether the model demonstrates effective linkage with other public sector or private sector payers.

(3) BUDGET NEUTRALITY.—

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

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

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

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

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

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

(4) EVALUATION.—

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

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

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

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

(C) MEASURE SELECTION.—To the extent feasible, the Secretary shall select measures under this paragraph that reflect national priorities for quality improvement and patient-centered care consistent with the measures described in 1890(b)(7)(B).

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

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

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

(B) improve the quality of patient care without increasing spending;

(2) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce (or would not result in any increase in) net program spending under applicable titles; and

(3) the Secretary determines that such expansion would not deny or limit the coverage or provision of benefits under the applicable title for applicable individuals.

In determining which models or demonstration projects to expand under the preceding sentence, the Secretary shall focus on models and demonstration projects that improve the quality of patient care and reduce spending.

(d) IMPLEMENTATION.—

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

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

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

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

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

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

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

§1115A(d)(2)(E) ¶15,031
(F) determinations about expansion of the duration and scope of a model under subsection (c), including the determination that a model is not expected to meet criteria described in paragraph (1) or (2) of such subsection.

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

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

(f) FUNDING.—

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

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

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

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

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

(2) USE OF CERTAIN FUNDS.—Out of amounts appropriated under subparagraphs (B) and (C) of paragraph (1), not less than $25,000,000 shall be made available each such fiscal year to design, implement, and evaluate models under subsection (b).

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

[Explanation at ¶ 741.]

2010 Amendments:

Sec. 3021(a) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, added sec. 1115A.

Sec. 1008(e) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1115A(a) by inserting new paragraph (5).

Sec. 1008(b) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1115A in subsection (b)(2)(A), in the second sentence, by striking “the preceding sentence may include” and inserting “this subparagraph may include, but are not limited to,” inserting after the first sentence a new sentence: “The Secretary shall focus on models expected to reduce program costs under the applicable title while preserving or enhancing the quality of care received by individuals receiving benefits under such title,” in subparagraph (b)(2)(B), by adding at the end the new clauses (ix) and (x); and in subparagraph (b)(2)(C), by adding at the end the new clause (vii).

Sec. 1008(3) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1115A(b)(4) by adding at the end new subparagraph (C).

Sec. 1008(4) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1115A(c) in subsection (c)(1)(B) by striking “care and reduce spending, and” and inserting “patient care without increasing spending,” in paragraph (c)(5), by striking “reduce program spending under applicable titles,” and inserting “reduce (or would not result in any increase in) net program spending under applicable titles; and,” and adding at the end new subsection (3) followed by the flush sentence “In determining which models or demonstration projects to expand under the preceding sentence, the Secretary shall focus on models and demonstration projects that improve the quality of patient care and reduce spending.”.

¶15,041 Sec. 1124. DISCLOSURE OF OWNERSHIP AND RELATED INFORMATION

[42 U.S.C. §1320a-3]

* * *

¶15,041 §1115A(d)(2)(F)
(c) **REQUIRED DISCLOSURE OF OWNERSHIP AND ADDITIONAL DISCLOSABLE PARTIES INFORMATION.**—

(1) **DISCLOSURE.**—A facility shall have the information described in paragraph (2) available—

(A) during the period beginning on the date of the enactment of this subsection and ending on the date such information is made available to the public under section 6101(b) of the Patient Protection and Affordable Care Act for submission to the Secretary, the Inspector General of the Department of Health and Human Services, the State in which the facility is located, and the State long-term care ombudsman in the case where the Secretary, the Inspector General, the State, or the State long-term care ombudsman requests such information; and

(B) beginning on the effective date of the final regulations promulgated under paragraph (3)(A), for reporting such information in accordance with such final regulations.

Nothing in subparagraph (A) shall be construed as authorizing a facility to dispose of or delete information described in such subparagraph after the effective date of the final regulations promulgated under paragraph (3)(A).

(2) **INFORMATION DESCRIBED.**—

(A) **IN GENERAL.**—The following information is described in this paragraph:

(i) The information described in subsections (a) and (b), subject to subparagraph (C).

(ii) The identity of and information on—

(I) each member of the governing body of the facility, including the name, title, and period of service of each such member;

(II) each person or entity who is an officer, director, member, partner, trustee, or managing employee of the facility, including the name, title, and period of service of each such person or entity; and

(III) each person or entity who is an additional disclosable party of the facility.

(iii) The organizational structure of each additional disclosable party of the facility and a description of the relationship of each such additional disclosable party to the facility and to one another.

(B) **SPECIAL RULE WHERE INFORMATION IS ALREADY REPORTED OR SUBMITTED.**—To the extent that information reported by a facility to the Internal Revenue Service on Form 990, information submitted by a facility to the Securities and Exchange Commission, or information otherwise submitted to the Secretary or any other Federal agency contains the information described in clauses (i), (ii), or (iii) of subparagraph (A), the facility may provide such Form or such information submitted to meet the requirements of paragraph (1).

(C) **SPECIAL RULE.**—In applying subparagraph (A)(i)—

(i) with respect to subsections (a) and (b), ‘ownership or control interest’ shall include direct or indirect interests, including such interests in intermediate entities; and

(ii) subsection (a)(3)(A)(ii) shall include the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured, in whole or in part, by the entity or any of the property or assets thereof, if the interest is equal to or exceeds 5 percent of the total property or assets of the entirety.

(3) **REPORTING.**—

(A) **IN GENERAL.**—Not later than the date that is 2 years after the date of the enactment of this subsection, the Secretary shall promulgate final regulations requiring, effective on the date that is 90 days after the date on which such final regulations are published in the Federal Register, a facility to report the information described in paragraph (2) to the Secretary in a standardized format, and such other regulations as are necessary to carry out this subsection. Such final regulations shall ensure that the facility certifies, as a condition of participation and payment under the program under title XVIII or XIX, that the information reported by the facility in accordance with such final regulations is, to the best of the facility’s knowledge, accurate and current.

(B) **GUIDANCE.**—The Secretary shall provide guidance and technical assistance to States on how to adopt the standardized format under subparagraph (A).
(4) **NO EFFECT ON EXISTING REPORTING REQUIREMENTS.**—Nothing in this subsection shall reduce, diminish, or alter any reporting requirement for a facility that is in effect as of the date of the enactment of this subsection.

(5) **DEFINITIONS.**—In this subsection:

(A) **ADDITIONAL DISCLOSABLE PARTY.**—The term ‘additional disclosable party’ means, with respect to a facility, any person or entity who—

(i) exercises operational, financial, or managerial control over the facility or a part thereof, or provides policies or procedures for any of the operations of the facility, or provides financial or cash management services to the facility;

(ii) leases or subleases real property to the facility, or owns a whole or part interest equal to or exceeding 5 percent of the total value of such real property; or

(iii) provides management or administrative services, management or clinical consulting services, or accounting or financial services to the facility.

(B) **FACILITY.**—The term ‘facility’ means a disclosing entity which is—

(i) a skilled nursing facility (as defined in section 1819(a)); or

(ii) a nursing facility (as defined in section 1919(a)).

(C) **MANAGING EMPLOYEE.**—The term ‘managing employee’ means, with respect to a facility, an individual (including a general manager, business manager, administrator, director, or consultant) who directly or indirectly manages, advises, or supervises any element of the practices, finances, or operations of the facility.

(D) **ORGANIZATIONAL STRUCTURE.**—The term ‘organizational structure’ means, in the case of—

(i) a corporation, the officers, directors, and shareholders of the corporation who have an ownership interest in the corporation which is equal to or exceeds 5 percent;

(ii) a limited liability company, the members and managers of the limited liability company (including, as applicable, what percentage each member and manager has of the ownership interest in the limited liability company);

(iii) a general partnership, the partners of the general partnership;

(iv) a limited partnership, the general partners and any limited partners of the limited partnership who have an ownership interest in the limited partnership which is equal to or exceeds 10 percent;

(v) a trust, the trustees of the trust;

(vi) an individual, contact information for the individual; and

(vii) any other person or entity, such information as the Secretary determines appropriate.

[Explanation at ¶ 1630.]

2010 Amendments:
Sec. 6101(a) of the “Patient Protection and Affordable Care Act” (Pub.L. No. 111-148), effective March 23, 2010, amended sec. 1124 by adding at the end new subsection (c).

¶15,051 Sec. 1128. Exclusion of Certain Individuals and Entities From Participation in Medicare and State Health Care Programs

[42 U.S.C. §1320a-7]

***(b)(2) CONVICTION RELATING TO OBSTRUCTION OF AN INVESTIGATION OR AUDIT.**—Any individual or entity that has been convicted, under Federal or State law, in connection with the interference with or obstruction of any investigation or audit related to—

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

¶15,051 §1124(c)(4)
(ii) the use of funds received, directly or indirectly, from any Federal health care program (as defined in section 1128B(f)).

***

(11) FAILURE TO SUPPLY PAYMENT INFORMATION.—Any individual or entity furnishing, ordering, referring for furnishing, or certifying the need for items or services for which payment may be made under title XVIII or a State health care program that fails to provide such information as the Secretary or the appropriate State agency finds necessary to determine whether such payments are or were due and the amounts thereof, or has refused to permit such examination of its records by or on behalf of the Secretary or that agency as may be necessary to verify such information.

***

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

(c) ***

(3) ***

(B) Subject to subparagraph (G), in the case of an exclusion under subsection (a), the minimum period of exclusion shall be not less than five years, except that, upon the request of the administrator of a Federal health care program (as defined in section 1128B(f)) who determines that the exclusion would impose a hardship on beneficiaries (as defined in section 1128A(i)(5)) of that program, the Secretary may, after consulting with the Inspector General of the Department of Health and Human Services, waive the exclusion under subsection (a)(1), (a)(3), or (a)(4) with respect to that program in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community. The Secretary’s decision whether to waive the exclusion shall not be reviewable.

***

(f) ***

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

***

[Explanation at ¶ 1813, ¶ 1815, ¶ 1827, ¶ 1837, ¶ 1841.]

2010 Amendments:

Sec. 6406(c) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective for orders, certifications, and referrals made on or after Jan. 1, 2010, amended sec. 1128(b)(11) by inserting “, ordering, referring for furnishing, or certifying the need for” after “furnishing”.

Sec. 6408(c) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective for acts committed on or after Jan. 1, 2010, amended sec. 1128(b)(2) by inserting “OR AUDIT” after “INVESTIGATION” and by striking “investigation or audit related to—”

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

“(ii) the use of funds received, directly or indirectly, from any Federal health care program (as defined in section 1128B(f)).”
Sec. 6402(d)(1) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1128(b) by adding at the end the new paragraph (16).

Sec. 6402(k) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1128(c)(3)(B) by striking “individuals entitled to benefits under part A of title XVIII or enrolled under part B of such title, or both” and inserting “beneficiaries (as defined in section 1128A(i)(5)) of that program”.

Sec. 6402(e) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1128(c)(3)(B) by adding at the end the new subparagraph (4).

[¶ 15,061] Sec. 1128A. CIVIL MONETARY PENALTIES

[42 U.S.C. § 1320a-7a]

(a) ***

(1) ***

(D) is for a medical or other item or service furnished during a period in which the person was excluded from the Federal health care program (as defined in section 1128B(f)) under which the claim was made pursuant to Federal law, or

(6) arranges or contracts (by employment or otherwise) with an individual or entity that the person knows or should know is excluded from participation in a Federal health care program (as defined in section 1128B(f)), for the provision of items or services for which payment may be made under such a program;

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

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

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

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

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

shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $10,000 for each item or service (or, in cases under paragraph (3), $15,000 for each individual with respect to whom false or misleading information was given; in cases under paragraph (4), $10,000 for each day the prohibited relationship occurs; in cases under paragraph (7), $50,000 for each such act, in cases under paragraph (8), $50,000 for each false record or statement, or in cases under paragraph (9), $15,000 for each day of the failure described in such paragraph). In addition, such a person shall be subject to an assessment of not more than three times the amount claimed for each

¶15,061 §1128A(a)
such item or service in lieu of damages sustained by the United States or a State agency because of such claim (in cases under paragraph (7), damages of not more than 3 times the total amount of remuneration offered, paid, solicited, or received, without regard to whether a portion of such remuneration was offered, paid, solicited, or received for a lawful purpose; or in cases under paragraph (9), an assessment of not more than 3 times the total amount claimed for each item or service for which payment was made based upon the application containing the false statement or misrepresentation of a material fact). In addition the Secretary may make a determination in the same proceeding to exclude the person from participation in the Federal health care programs (as defined in section 1128B(f)(1)) and to direct the appropriate State agency to exclude the person from participation in any State health care program.

***

(i) For the purposes of this section:

***

(6)

***

(C) differentials in coinsurance and deductible amounts as part of a benefit plan design as long as the differentials have been disclosed in writing to all beneficiaries, third party payers, and providers, to whom claims are presented and as long as the differentials meet the standards as defined in regulations promulgated by the Secretary not later than 180 days after the date of the enactment of the Health Insurance Portability and Accountability Act of 1996;

(D) incentives given to individuals to promote the delivery of preventive care as determined by the Secretary in regulations so promulgated;

(E) a reduction in the copayment amount for covered OPD services under section 1833(t)(5)(B); or

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

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

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

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

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

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

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

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

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

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

(I) effective on a date specified by the Secretary (but not earlier than January 1, 2011), the waiver by a PDP sponsor of a prescription drug plan under part D of title XVIII or an MA organization offering an MA-PD plan under part C of such title of any copayment for the first fill of a covered part D drug (as defined in section 1860D-2(e)) that is a generic drug for individuals enrolled in the prescription drug plan or MA-PD plan, respectively.
[Explanation at ¶ 1813 and ¶ 1841.]

2010 Amendments:

Sec. 6402(d)(2)(A)(i) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1128A(a) in paragraph (1)(D), by striking “was excluded” and all that follows through the period at the end and inserting “was excluded from the Federal health care program (as defined in section 1128A(b)) under which the claim was made pursuant to Federal law.”

Prior to this change, this section read as follows:

“(D) is for a medical or other item or service furnished during a period in which the person was excluded from the program under which the claim was made pursuant to a determination by the Secretary under this section or under section 1128, 1156, 1160(b) (as in effect on September 2, 1982), 1862(d) (as in effect on the date of the enactment of the Medicare and Medicaid Patient and Program Protection Act of 1987), or 1866(b) or as a result of the application of the provisions of section 1842(j)(2), or”

“(E) is for a pattern of medical or other items or services that a person knows or should know are not medically necessary.”

Sec. 6402(d)(2)(A)(ii) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1128A(a), in paragraph (6), by striking “or” at the end.

Sec. 6402(d)(2)(A)(iii) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1128A(a) by inserting after paragraph (7), the new paragraphs (8), (9) and (10).

Sec. 6402(d)(2)(A)(iv) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended the first sentence of subsection 1128A(a) by making following changes:

by striking the “or” after “prohibited relationship occurs,”;

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

in the second sentence, by striking “purpose)” and inserting “purpose; or in cases under paragraph (9), an assessment of not more than 3 times the total amount claimed for each item or service for which payment was made based upon the application containing the false statement or misrepresentation of a material fact).

Sec. 6402(d)(2)(B) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1128A(a) by making the following changes:

in paragraph (6), by striking “or” at the end;

by inserting after paragraph (7), the new paragraphs (8) and (9);

in the first sentence of subsection 1128A(a), making the following changes:

by striking “or in cases under paragraph (7)” and inserting “in cases under paragraph (7)”.

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

Sec. 6402(d)(2)(B) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1128A(i)(6) by making the following changes:

in subparagraph (C), by striking “or” at the end;

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

by redesigning subparagraph (D), as added by section 4323(c) of such Act, as subparagraph (E) and striking the period at the end and inserting “; or”;

by adding at the end the new subparagraphs (F), (G), (H) and (I).

¶15,071 Sec. 1128B. Criminal Penalties for Acts Involving Federal Health Care Programs

[42 U.S.C. § 1320a-7b]

¶ 15,071

(b) ***

(3) ***

(G) the waiver or reduction by pharmacies (including pharmacies of the Indian Health Service, Indian tribes, tribal organizations, and urban Indian organizations) of any cost-sharing imposed under part D of title XVIII, if the conditions described in clauses (i) through (iii) of section 1128A(i)(6)(A) are met with respect to the waiver or reduction (except that, in the case of such a waiver or reduction on behalf of a subsidy eligible individual (as defined in section 1860D-14(a)(3)), section 1128A(i)(6)(A) shall be applied without regard to clauses (ii) and (iii) of that section);

(H) any remuneration between a federally qualified health center (or an entity controlled by such a health center) and an MA organization pursuant to a written agreement described in section 1853(a)(4);

(I) any remuneration between a health center entity described under clause (i) or (ii) of section 1905(l)(2)(B) and any individual or entity providing goods, items, services, dona-
tions, loans, or a combination thereof, to such health center entity pursuant to a contract, lease, grant, loan, or other agreement, if such agreement contributes to the ability of the health center entity to maintain or increase the availability, or enhance the quality, of services provided to a medically underserved population served by the health center entity; and

\( (f) \) a discount in the price of an applicable drug (as defined in paragraph (2) of section 1860D-14A(g)) of a manufacturer that is furnished to an applicable beneficiary (as defined in paragraph (1) of such section) under the Medicare coverage gap discount program under section 1860D-14A.

\[ \text{Sec. 6402(f)(1) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1128B by adding at the end subsection (g).} \]

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

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

[Explanation at ¶ 1205 and ¶ 1815.]

2010 Amendments:

Sec. 3301(d)(1) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective for drugs dispensed on or after January 1, 2010, amended sec. 1128B(h)(3) by striking “and” at the end of subparagraph (G); in subparagraph (H) by moving such subparagraph 2 ems to the left; by striking the period at the end and inserting a semicolon; by redesignating such subparagraph as subparagraph (I); by striking the period at the end and inserting “; and”; by adding at the end the new subparagraph (J).

\[ \text{Sec. 6402(f)(1) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1128B by adding at the end subsection (g).} \]

\[ \text{Sec. 6402(f)(2) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1128B by adding at the end subsection (h).} \]

[¶ 15,081] Sec. 1128C. FRAUD AND ABUSE CONTROL PROGRAM

[42 U.S.C. § 1320a-7c]

(a)***

(1) IN GENERAL.—

***

(C) to facilitate the enforcement of the provisions of sections 1128, 1128A, and 1128B and other statutes applicable to health care fraud and abuse, and

(D) to provide for the modification and establishment of safe harbors and to issue advisory opinions and special fraud alerts pursuant to section 1128D.

***

[Explanation at ¶ 1831.]

2010 Amendments:

Sec. 6403(c) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective on the first day after the final day of the transition period noted in Act Sec. 6403(d), amended sec. 1128C(a)(1) by making the following changes: in subparagraph (C), by adding “and” after the comma at the end; in subparagraph (D), by striking “, and” and inserting a period; by striking subparagraph (E).

[¶ 15,091] Sec. 1128E. HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM

[42 U.S.C. § 1320a-7e]

(a) IN GENERAL.—The Secretary shall maintain a national health care fraud and abuse data collection program under this section for the reporting of certain final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practitioners as required by subsection (b), with access as set forth in subsection (d), and shall furnish the information collected under this

§1128E(a) ¶15,091
section to the National Practitioner Data Bank established pursuant to the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11101 et seq.).

***

(d) ACCESS TO REPORTED INFORMATION.——

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

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

***

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

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

(III) any other loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewability, or otherwise, or

(IV) any other negative action or finding by such Federal agency that is publicly available information.

(iv) Exclusion from participation in a Federal health care program (as defined in section 1128B(f)).

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(3)

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(D) Federal agencies responsible for the licensing and certification of health care providers and licensed health care practitioners.}
“(d) ACCESS TO REPORTED INFORMATION. (1) AVAILABILITY. The information in the database main-
tained under this section shall be available to Federal and State government agencies and health plans pursuant to procedures that the Secretary shall provide by regulation. (2) FEES FOR DISCLOSURE. The Secretary may establish or approve reasonable fees for the disclosure of information in such database (other than with respect to requests by Fed-
eral agencies). The amount of such a fee shall be sufficient to recover the full costs of operating the database. Such fees shall be available to the Secretary or, in the Secretary’s discretion to the agency designated under this section to cover such costs.”

Sec. 6403(a)(3) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective on the first day after the final day of the transition period noted in Act Sec. 6403(d), amended sec. 1128E(f) by redesignating subclauses (II) and (III) as subclauses (III) and (IV), respectively; and

by inserting after subclause (I) the new subclause (II).

Sec. 6403(a)(4)(A)(i)(I) of the “Patient Protection and Af-
fordable Care Act” (PubLNo 111-148), effective on the first
day after the final day of the transition period noted in Act Sec. 6403(d), amended sec. 1128E(g)(1)(A) by striking clause (iv) and inserting new clause (iv).

Prior to being replaced, sec. 1128E(g)(1)(A)(iv) read as follows:

“(iv) Exclusion from participation in Federal or State health care programs (as defined in sections 1128(b) and 1128(h), respectively).”

Sec. 6403(a)(4)(B) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective on the first day after the final day of the transition period noted in Act Sec. 6403(d), amended sec. 1128E(g)(1)(A)(iv) by redesignating subparagraphs (D) and (E) by redesignating subparagraph (F) as subparagraph (D); and, in subparagraph (D) (as so redesignated), by striking “or State.”

Prior to being struck, subparagraphs (D) and (E) read as follows:

“(D) State law enforcement agencies. (E) State medicaid fraud control units.”

[¶15,101] Sec. 1128G. TRANSPARENCY REPORTS AND REPORTING OF PHYSICIAN OWNERSHIP OR INVESTMENT INTERESTS.

(a) TRANSPARENCY REPORTS.—

(1) PAYMENTS OR OTHER TRANSFERS OF VALUE.—

(A) IN GENERAL.—On March 31, 2013, and on the 90th day of each calendar year beginning thereafter, any applicable manufacturer that provides a payment or other transfer of value to a covered recipient (or to an entity or individual at the request of or designated on behalf of a covered recipient), shall submit to the Secretary, in such electronic form as the Secretary shall require, the following information with respect to the preceding calendar year:

(i) The name of the covered recipient.

(ii) The business address of the covered recipient and, in the case of a covered recipient who is a physician, the specialty and National Provider Identifier of the covered recipient.

(iii) The amount of the payment or other transfer of value.

(iv) The dates on which the payment or other transfer of value was provided to the covered recipient.

(v) A description of the form of the payment or other transfer of value, indicated (as appropriate for all that apply) as—

(I) cash or a cash equivalent;

(II) in-kind items or services;

(III) stock, a stock option, or any other ownership interest, dividend, profit, or other return on investment; or

(IV) any other form of payment or other transfer of value (as defined by the Secretary).
(vi) A description of the nature of the payment or other transfer of value, indicated (as appropriate for all that apply) as—

(I) consulting fees;
(II) compensation for services other than consulting;
(III) honoraria;
(IV) gift;
(V) entertainment;
(VI) food;
(VII) travel (including the specified destinations);
(VIII) education;
(IX) research;
(X) charitable contribution;
(XI) royalty or license;
(XII) current or prospective ownership or investment interest;
(XIII) direct compensation for serving as faculty or as a speaker for a medical education program;
(XIV) grant; or
(XV) any other nature of the payment or other transfer of value (as defined by the Secretary).

(vii) If the payment or other transfer of value is related to marketing, education, or research specific to a covered drug, device, biological, or medical supply, the name of that covered drug, device, biological, or medical supply.

(viii) Any other categories of information regarding the payment or other transfer of value the Secretary determines appropriate.

(B) SPECIAL RULE FOR CERTAIN PAYMENTS OR OTHER TRANSFERS OF VALUE.—In the case where an applicable manufacturer provides a payment or other transfer of value to an entity or individual at the request of or designated on behalf of a covered recipient, the applicable manufacturer shall disclose that payment or other transfer of value under the name of the covered recipient.

(2) PHYSICIAN OWNERSHIP.—In addition to the requirement under paragraph (1)(A), on March 31, 2013, and on the 90th day of each calendar year beginning thereafter, any applicable manufacturer or applicable group purchasing organization shall submit to the Secretary, in such electronic form as the Secretary shall require, the following information regarding any ownership or investment interest (other than an ownership or investment interest in a publicly traded security and mutual fund, as described in section 1877(c)) held by a physician (or an immediate family member of such physician (as defined for purposes of section 1877(a))) in the applicable manufacturer or applicable group purchasing organization during the preceding year:

(A) The dollar amount invested by each physician holding such an ownership or investment interest.

(B) The value and terms of each such ownership or investment interest.

(C) Any payment or other transfer of value provided to a physician holding such an ownership or investment interest (or to an entity or individual at the request of or designated on behalf of a physician holding such an ownership or investment interest), including the information described in clauses (i) through (viii) of paragraph (1)(A), except that in applying such clauses, ‘physician’ shall be substituted for ‘covered recipient’ each place it appears.

(D) Any other information regarding the ownership or investment interest the Secretary determines appropriate.
(b) **Penalties for Noncompliance.**

1. **Failure to Report.**

   (A) In general.—Subject to subparagraph (B) except as provided in paragraph (2), any applicable manufacturer or applicable group purchasing organization that fails to submit information required under subsection (a) in a timely manner in accordance with rules or regulations promulgated to carry out such subsection, shall be subject to a civil money penalty of not less than $1,000, but not more than $10,000, for each payment or other transfer of value or ownership or investment interest not reported as required under such subsection. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

   (B) Limitation.—The total amount of civil money penalties imposed under subparagraph (A) with respect to each annual submission of information under subsection (a) by an applicable manufacturer or applicable group purchasing organization shall not exceed $150,000.

2. **Knowing Failure to Report.**

   (A) In general.—Subject to subparagraph (B), any applicable manufacturer or applicable group purchasing organization that knowingly fails to submit information required under subsection (a) in a timely manner in accordance with rules or regulations promulgated to carry out such subsection, shall be subject to a civil money penalty of not less than $10,000, but not more than $100,000, for each payment or other transfer of value or ownership or investment interest not reported as required under such subsection. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

   (B) Limitation.—The total amount of civil money penalties imposed under subparagraph (A) with respect to each annual submission of information under subsection (a) by an applicable manufacturer or applicable group purchasing organization shall not exceed $1,000,000.

3. **Use of Funds.**—Funds collected by the Secretary as a result of the imposition of a civil money penalty under this subsection shall be used to carry out this section.

(c) **Procedures for Submission of Information and Public Availability.**

1. **In general.**

   (A) Establishment.—Not later than October 1, 2011, the Secretary shall establish procedures—

   (i) for applicable manufacturers and applicable group purchasing organizations to submit information to the Secretary under subsection (a); and

   (ii) for the Secretary to make such information submitted available to the public.

   (B) Definition of Terms.—The procedures established under subparagraph (A) shall provide for the definition of terms (other than those terms defined in subsection (e)), as appropriate, for purposes of this section.

   (C) Public Availability.—Except as provided in subparagraph (E), the procedures established under subparagraph (A)(ii) shall ensure that, not later than September 30, 2013, and on June 30 of each calendar year beginning thereafter, the information submitted under subsection (a) with respect to the preceding calendar year is made available through an Internet website that—

   (i) is searchable and is in a format that is clear and understandable;

   (ii) contains information that is presented by the name of the applicable manufacturer or applicable group purchasing organization, the name of the covered recipient, the business address of the covered recipient, the specialty of the covered recipient, the value of the payment or other transfer of value, the date on which the payment or other transfer of value was provided to the covered recipient, the form of the payment or other transfer of value, indicated (as appropriate) under subsection (a)(1)(A)(v), the nature of the payment or other transfer of value, indicated (as appropriate) under subsection (a)(1)(A)(vi), and the name of the covered drug, device, biological, or medical supply, as applicable;

   (iii) contains information that is able to be easily aggregated and downloaded;
(iv) contains a description of any enforcement actions taken to carry out this section, including any penalties imposed under subsection (b), during the preceding year;

(v) contains background information on industry-physician relationships;

(vi) in the case of information submitted with respect to a payment or other transfer of value described in subparagraph (E)(i), lists such information separately from the other information submitted under subsection (a) and designates such separately listed information as funding for clinical research;

(vii) contains any other information the Secretary determines would be helpful to the average consumer;

(viii) does not contain the National Provider Identifier of the covered recipient, and

(ix) subject to subparagraph (D), provides the applicable manufacturer, applicable group purchasing organization, or covered recipient an opportunity to review and submit corrections to the information submitted with respect to the applicable manufacturer, applicable group purchasing organization, or covered recipient, respectively, for a period of not less than 45 days prior to such information being made available to the public.

(D) CLARIFICATION OF TIME PERIOD FOR REVIEW AND CORRECTIONS.—In no case may the 45-day period for review and submission of corrections to information under subparagraph (C)(ix) prevent such information from being made available to the public in accordance with the dates described in the matter preceding clause (i) in subparagraph (C).

(E) DELAYED PUBLICATION FOR PAYMENTS MADE PURSUANT TO PRODUCT RESEARCH OR DEVELOPMENT AGREEMENTS AND CLINICAL INVESTIGATIONS.—

(i) IN GENERAL.—In the case of information submitted under subsection (a) with respect to a payment or other transfer of value made to a covered recipient by an applicable manufacturer pursuant to a product research or development agreement for services furnished in connection with research on a potential new medical technology or a new application of an existing medical technology or the development of a new drug, device, biological, or medical supply, or by an applicable manufacturer in connection with a clinical investigation regarding a new drug, device, biological, or medical supply, the procedures established under subparagraph (A)(ii) shall provide that such information is made available to the public on the first date described in the matter preceding clause (i) in subparagraph (C) after the earlier of the following:

(I) The date of the approval or clearance of the covered drug, device, biological, or medical supply by the Food and Drug Administration.

(II) Four calendar years after the date such payment or other transfer of value was made.

(ii) CONFIDENTIALITY OF INFORMATION PRIOR TO PUBLICATION.—Information described in clause (i) shall be considered confidential and shall not be subject to disclosure under section 552 of title 5, United States Code, or any other similar Federal, State, or local law, until on or after the date on which the information is made available to the public under such clause.

(2) CONSULTATION.—In establishing the procedures under paragraph (1), the Secretary shall consult with the Inspector General of the Department of Health and Human Services, affected industry, consumers, consumer advocates, and other interested parties in order to ensure that the information made available to the public under such paragraph is presented in the appropriate overall context.

(d) ANNUAL REPORTS AND RELATION TO STATE LAWS.—

(1) ANNUAL REPORT TO CONGRESS.—Not later than April 1 of each year beginning with 2013, the Secretary shall submit to Congress a report that includes the following:

(A) The information submitted under subsection (a) during the preceding year, aggregated for each applicable manufacturer and applicable group purchasing organization that submitted such information during such year (except, in the case of information submitted with respect to a payment or other transfer of value described in subsection (c)(1)(E)(i), such information shall be included in the first report submitted to Congress after the date on which such information is made available to the public under such subsection).
(B) A description of any enforcement actions taken to carry out this section, including any penalties imposed under subsection (b), during the preceding year.

(2) ANNUAL REPORTS TO STATES.—Not later than September 30, 2013 and on June 30 of each calendar year thereafter, the Secretary shall submit to States a report that includes a summary of the information submitted under subsection (a) during the preceding year with respect to covered recipients in the State (except, in the case of information submitted with respect to a payment or other transfer of value described in subsection (c)(1)(E)(i), such information shall be included in the first report submitted to States after the date on which such information is made available to the public under such subsection).

(3) RELATION TO STATE LAWS.—

(A) IN GENERAL.—In the case of a payment or other transfer of value provided by an applicable manufacturer that is received by a covered recipient (as defined in subsection (e)) on or after January 1, 2012, subject to subparagraph (B), the provisions of this section shall preempt any statute or regulation of a State or of a political subdivision of a State that requires an applicable manufacturer (as so defined) to disclose or report, in any format, the type of information (as described in subsection (a)) regarding such payment or other transfer of value.

(B) NO PREEMPTION OF ADDITIONAL REQUIREMENTS.—Subparagraph (A) shall not preempt any statute or regulation of a State or of a political subdivision of a State that requires the disclosure or reporting of information—

(i) not of the type required to be disclosed or reported under this section;
(ii) described in subsection (c)(10)(B), except in the case of information described in clause (i) of such subsection;
(iii) by any person or entity other than an applicable manufacturer (as so defined) or a covered recipient (as defined in subsection (e)); or
(iv) to a Federal, State, or local governmental agency for public health surveillance, investigation, or other public health purposes or health oversight purposes.

(C) Nothing in subparagraph (A) shall be construed to limit the discovery or admissibility of information described in such subparagraph in a criminal, civil, or administrative proceeding.

(4) CONSULTATION.—The Secretary shall consult with the Inspector General of the Department of Health and Human Services on the implementation of this section.

(e) DEFINITIONS.—In this section:

(1) APPLICABLE GROUP PURCHASING ORGANIZATION.—The term ‘applicable group purchasing organization’ means a group purchasing organization (as defined by the Secretary) that purchases, arranges for, or negotiates the purchase of a covered drug, device, biological, or medical supply which is operating in the United States, or in a territory, possession, or commonwealth of the United States.

(2) APPLICABLE MANUFACTURER.—The term ‘applicable manufacturer’ means a manufacturer of a covered drug, device, biological, or medical supply which is operating in the United States, or in a territory, possession, or commonwealth of the United States.

(3) CLINICAL INVESTIGATION.—The term ‘clinical investigation’ means any experiment involving 1 or more human subjects, or materials derived from human subjects, in which a drug or device is administered, dispensed, or used.

(4) COVERED DEVICE.—The term ‘covered device’ means any device for which payment is available under title XVIII or a State plan under title XIX or XXI (or a waiver of such a plan).

(5) COVERED DRUG, DEVICE, BIOLOGICAL, OR MEDICAL SUPPLY.—The term ‘covered drug, device, biological, or medical supply’ means any drug, biological product, device, or medical supply for which payment is available under title XVIII or a State plan under title XIX or XXI (or a waiver of such a plan).

(6) COVERED RECIPIENT.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the term ‘covered recipient’ means the following:

(i) A physician.
(ii) A teaching hospital.

(B) EXCLUSION.—Such term does not include a physician who is an employee of the applicable manufacturer that is required to submit information under subsection (a).

(7) EMPLOYEE.—The term ‘employee’ has the meaning given such term in section 1877(h)(2).

(8) KNOWINGLY.—The term ‘knowingly’ has the meaning given such term in section 3729(b) of title 31, United States Code.

(9) MANUFACTURER OF A COVERED DRUG, DEVICE, BIOLOGICAL, OR MEDICAL SUPPLY.—The term ‘manufacturer of a covered drug, device, biological, or medical supply’ means any entity which is engaged in the production, preparation, propagation, compounding, or conversion of a covered drug, device, biological, or medical supply (or any entity under common ownership with such entity which provides assistance or support to such entity with respect to the production, preparation, propagation, compounding, conversion, marketing, promotion, sale, or distribution of a covered drug, device, biological, or medical supply).

(10) PAYMENT OR OTHER TRANSFER OF VALUE.—

(A) IN GENERAL.—The term ‘payment or other transfer of value’ means a transfer of anything of value. Such term does not include a transfer of anything of value that is made indirectly to a covered recipient through a third party in connection with an activity or service in the case where the applicable manufacturer is unaware of the identity of the covered recipient.

(B) EXCLUSIONS.—An applicable manufacturer shall not be required to submit information under subsection (a) with respect to the following:

(i) A transfer of anything the value of which is less than $10, unless the aggregate amount transferred to, requested by, or designated on behalf of the covered recipient by the applicable manufacturer during the calendar year exceeds $100. For calendar years after 2012, the dollar amounts specified in the preceding sentence shall be increased by the same percentage as the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) for the 12-month period ending with June of the previous year.

(ii) Product samples that are not intended to be sold and are intended for patient use.

(iii) Educational materials that directly benefit patients or are intended for patient use.

(iv) The loan of a covered device for a short-term trial period, not to exceed 90 days, to permit evaluation of the covered device by the covered recipient.

(v) Items or services provided under a contractual warranty, including the replacement of a covered device, where the terms of the warranty are set forth in the purchase or lease agreement for the covered device.

(vi) A transfer of anything of value to a covered recipient when the covered recipient is a patient and not acting in the professional capacity of a covered recipient.

(vii) Discounts (including rebates).

(viii) In-kind items used for the provision of charity care.

(ix) A dividend or other profit distribution from, or ownership or investment interest in, a publicly traded security and mutual fund (as described in section 1877(c)).

(x) In the case of an applicable manufacturer who offers a self-insured plan, payments for the provision of health care to employees under the plan.

(xi) In the case of a covered recipient who is a licensed non-medical professional, a transfer of anything of value to the covered recipient if the transfer is payment solely for the non-medical professional services of such licensed non-medical professional.

(xii) In the case of a covered recipient who is a physician, a transfer of anything of value to the covered recipient if the transfer is payment solely for the services of the covered recipient with respect to a civil or criminal action or an administrative proceeding.

(11) PHYSICIAN.—The term ‘physician’ has the meaning given that term in section 1861(r).
Sec. 1128H. REPORTING OF INFORMATION RELATING TO DRUG SAMPLES

(a) IN GENERAL.—Not later than April 1 of each year (beginning with 2012), each manufacturer and authorized distributor of record of an applicable drug shall submit to the Secretary (in a form and manner specified by the Secretary) the following information with respect to the preceding year:

(1) In the case of a manufacturer or authorized distributor of record which makes distributions by mail or common carrier under subsection (d)(2) of section 503 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 353), the identity and quantity of drug samples requested and the identity and quantity of drug samples distributed under such subsection during that year, aggregated by—

(A) the name, address, professional designation, and signature of the practitioner making the request under subparagraph (A)(i) of such subsection, or of any individual who makes or signs for the request on behalf of the practitioner; and

(B) any other category of information determined appropriate by the Secretary.

(2) In the case of a manufacturer or authorized distributor of record which makes distributions by means other than mail or common carrier under subsection (d)(3) of such section 503, the identity and quantity of drug samples requested and the identity and quantity of drug samples distributed under such subsection during that year, aggregated by—

(A) the name, address, professional designation, and signature of the practitioner making the request under subparagraph (A)(i) of such subsection, or of any individual who makes or signs for the request on behalf of the practitioner; and

(B) any other category of information determined appropriate by the Secretary.

(b) DEFINITIONS.—In this section:

(1) APPLICABLE DRUG.—The term ‘applicable drug’ means a drug—

(A) which is subject to subsection (b) of such section 503; and

(B) for which payment is available under title XVIII or a State plan under title XIX or XXI (or a waiver of such a plan).

(2) AUTHORIZED DISTRIBUTOR OF RECORD.—The term ‘authorized distributor of record’ has the meaning given that term in subsection (e)(3)(A) of such section.

(3) MANUFACTURER.—The term ‘manufacturer’ has the meaning given that term for purposes of subsection (d) of such section.

Sec. 1128I. ACCOUNTABILITY REQUIREMENTS FOR FACILITIES

(a) DEFINITION OF FACILITY.—In this section, the term ‘facility’ means—

(1) a skilled nursing facility (as defined in section 1819(a)); or

(2) a nursing facility (as defined in section 1919(a)).

(b) EFFECTIVE COMPLIANCE AND ETHICS PROGRAMS.—

(1) REQUIREMENT.—On or after the date that is 36 months after the date of the enactment of this section, a facility shall, with respect to the entity that operates the facility (in this subparagraph referred to as the ‘operating organization’ or ‘organization’), have in operation a compliance and ethics program that...
is effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care consistent with regulations developed under paragraph (2).

(2) **Development of Regulations.—**

(A) **In General.**—Not later than the date that is 2 years after such date of the enactment, the Secretary, working jointly with the Inspector General of the Department of Health and Human Services, shall promulgate regulations for an effective compliance and ethics program for operating organizations, which may include a model compliance program.

(B) **Design of Regulations.**—Such regulations with respect to specific elements or formality of a program shall, in the case of an organization that operates 5 or more facilities, vary with the size of the organization, such that larger organizations should have a more formal program and include established written policies defining the standards and procedures to be followed by its employees. Such requirements may specifically apply to the corporate level management of multi unit nursing home chains.

(C) **Evaluation.**—Not later than 3 years after the date of the promulgation of regulations under this paragraph, the Secretary shall complete an evaluation of the compliance and ethics programs required to be established under this subsection. Such evaluation shall determine if such programs led to changes in deficiency citations, changes in quality performance, or changes in other metrics of patient quality of care. The Secretary shall submit to Congress a report on such evaluation and shall include in such report such recommendations regarding changes in the requirements for such programs as the Secretary determines appropriate.

(3) **Requirements for Compliance and Ethics Programs.**—In this subsection, the term ‘compliance and ethics program’ means, with respect to a facility, a program of the operating organization that—

(A) has been reasonably designed, implemented, and enforced so that it generally will be effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care; and

(B) includes at least the required components specified in paragraph (4).

(4) **Required Components of Program.**—The required components of a compliance and ethics program of an operating organization are the following:

(A) The organization must have established compliance standards and procedures to be followed by its employees and other agents that are reasonably capable of reducing the prospect of criminal, civil, and administrative violations under this Act.

(B) Specific individuals within high-level personnel of the organization must have been assigned overall responsibility to oversee compliance with such standards and procedures and have sufficient resources and authority to assure such compliance.

(C) The organization must have used due care not to delegate substantial discretionary authority to individuals whom the organization knew, or should have known through the exercise of due diligence, had a propensity to engage in criminal, civil, and administrative violations under this Act.

(D) The organization must have taken steps to communicate effectively its standards and procedures to all employees and other agents, such as by requiring participation in training programs or by disseminating publications that explain in a practical manner what is required.

(E) The organization must have taken reasonable steps to achieve compliance with its standards, such as by utilizing monitoring and auditing systems reasonably designed to detect criminal, civil, and administrative violations under this Act by its employees and other agents, and by having in place and publicizing a reporting system whereby employees and other agents could report violations by others within the organization without fear of retribution.

(F) The standards must have been consistently enforced through appropriate disciplinary mechanisms, including, as appropriate, discipline of individuals responsible for the failure to detect an offense.

(G) After an offense has been detected, the organization must have taken all reasonable steps to respond appropriately to the offense and to prevent further similar offenses, including any necessary modification to its program to prevent and detect criminal, civil, and administrative violations under this Act.
(H) The organization must periodically undertake reassessment of its compliance program to identify changes necessary to reflect changes within the organization and its facilities.

(c) QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM.—

(1) In general.—Not later than December 31, 2011, the Secretary shall establish and implement a quality assurance and performance improvement program (in this subparagraph referred to as the 'QAPI program') for facilities, including multi unit chains of facilities. Under the QAPI program, the Secretary shall establish standards relating to quality assurance and performance improvement with respect to facilities and provide technical assistance to facilities on the development of best practices in order to meet such standards. Not later than 1 year after the date on which the regulations are promulgated under paragraph (2), a facility must submit to the Secretary a plan for the facility to meet such standards and implement such best practices, including how to coordinate the implementation of such plan with quality assessment and assurance activities conducted under sections 1819(b)(1)(B) and 1919(b)(1)(B), as applicable.

(2) Regulations.—The Secretary shall promulgate regulations to carry out this subsection.

Caution: [CCH note: The Patient Protection and Affordable Care Act (PubLNo 111-148), which added sec. 1128I, did not include subsections (d) and (e).]

(f) STANDARDIZED COMPLAINT FORM.—

(1) Development by the Secretary.—The Secretary shall develop a standardized complaint form for use by a resident (or a person acting on the resident’s behalf) in filing a complaint with a State survey and certification agency and a State long-term care ombudsman program with respect to a facility.

(2) Complaint forms and resolution processes.—

(A) Complaint forms.—The State must make the standardized complaint form developed under paragraph (1) available upon request to—

(i) a resident of a facility; and

(ii) any person acting on the resident’s behalf.

(B) Complaint resolution process.—The State must establish a complaint resolution process in order to ensure that the legal representative of a resident of a facility or other responsible party is not denied access to such resident or otherwise retaliated against if they have complained about the quality of care provided by the facility or other issues relating to the facility. Such complaint resolution process shall include—

(i) procedures to assure accurate tracking of complaints received, including notification to the complainant that a complaint has been received;

(ii) procedures to determine the likely severity of a complaint and for the investigation of the complaint; and

(iii) deadlines for responding to a complaint and for notifying the complainant of the outcome of the investigation.

(3) Rule of construction.—Nothing in this subsection shall be construed as preventing a resident of a facility (or a person acting on the resident’s behalf) from submitting a complaint in a manner or format other than by using the standardized complaint form developed under paragraph (1) (including submitting a complaint orally).

(g) Submission of Staffing Information Based on Payroll Data in a Uniform Format.—Beginning not later than 2 years after the date of the enactment of this subsection, and after consulting with State long-term care ombudsman programs, consumer advocacy groups, provider stakeholder groups, employees and their representatives, and other parties the Secretary deems appropriate, the Secretary shall require a facility to electronically submit to the Secretary direct care staffing information (including information with respect to agency and contract staff) based on payroll and other verifiable and auditable data in a uniform format (according to specifications established by the Secretary in consultation with such programs, groups, and parties). Such specifications shall require that the information submitted under the preceding sentence—

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(1) specify the category of work a certified employee performs (such as whether the employee is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other medical personnel);

(2) include resident census data and information on resident case mix;

(3) include a regular reporting schedule; and

(4) include information on employee turnover and tenure and on the hours of care provided by each category of certified employees referenced in paragraph (1) per resident per day.

Nothing in this subsection shall be construed as preventing the Secretary from requiring submission of such information with respect to specific categories, such as nursing staff, before other categories of certified employees. Information under this subsection with respect to agency and contract staff shall be kept separate from information on employee staffing.

(h) Notification of Facility Closure.—

(1) In General.—Any individual who is the administrator of a facility must—

(A) submit to the Secretary, the State long-term care ombudsman, residents of the facility, and the legal representatives of such residents or other responsible parties, written notification of an impending closure—

(i) subject to clause (ii), not later than the date that is 60 days prior to the date of such closure; and

(ii) in the case of a facility where the Secretary terminates the facility’s participation under this title, not later than the date that the Secretary determines appropriate;

(B) ensure that the facility does not admit any new residents on or after the date on which such written notification is submitted; and

(C) include in the notice a plan for the transfer and adequate relocation of the residents of the facility by a specified date prior to closure that has been approved by the State, including assurances that the residents will be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs, choice, and best interests of each resident.

(2) Relocation.—

(A) In General.—The State shall ensure that, before a facility closes, all residents of the facility have been successfully relocated to another facility or an alternative home and community-based setting.

(B) Continuation of Payments Until Residents Relocated.—The Secretary may, as the Secretary determines appropriate, continue to make payments under this title with respect to residents of a facility that has submitted a notification under paragraph (1) during the period beginning on the date such notification is submitted and ending on the date on which the resident is successfully relocated.

(3) Sanctions.—Any individual who is the administrator of a facility that fails to comply with the requirements of paragraph (1)—

(A) shall be subject to a civil monetary penalty of up to $100,000;

(B) may be subject to exclusion from participation in any Federal health care program (as defined in section 1128B(f)); and

(C) shall be subject to any other penalties that may be prescribed by law.

(4) Procedure.—The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to a civil money penalty or exclusion under paragraph (3) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

[Explanation at ¶ 1635, ¶ 1640, ¶ 1650, ¶ 1655, and ¶ 1680.]

2010 Amendments:

Sec. 6102 of the “Patient Protection and Affordable Care Act” (Pub.L. No. 111-148), effective March 23, 2010, added new sec. 1128I.

Sec. 6105(a) of the “Patient Protection and Affordable Care Act” (Pub.L. No. 111-148), effective one year after March 23, 2010, the date of enactment, amended sec. 1128I by adding new subsection (f).
Sec. 6106 of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1128 by adding new subsection (g).

Sec. 6113(a) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective one year after March 23, 2010, the date of enactment, amended sec. 1128I by adding new subsection (h).

[§15,121] Sec. 1128J. MEDICARE AND MEDICAID PROGRAM INTEGRITY PROVISIONS

(a) DATA MATCHING.—

(1) INTEGRATED DATA REPOSITORY.—

(A) INCLUSION OF CERTAIN DATA.—

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

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

(II) The program under title XXI.

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

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

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

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

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

(B) DATA SHARING AND MATCHING.—

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

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


(II) The Secretary of Veterans Affairs.

(III) The Secretary of Defense.

(IV) The Director of the Indian Health Service.

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

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

(b) OIG AUTHORITY TO OBTAIN INFORMATION.—

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

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

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

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

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

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

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

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

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

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

(d) REPORTING AND RETURNING OF OVERPAYMENTS.—

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

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

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

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

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

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

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

(4) DEFINITIONS.—In this subsection:

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

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

(i) IN GENERAL.—The term ‘person’ means a provider of services, supplier, medicaid managed care organization (as defined in section 1903(m)(1)(A)), Medicare Advantage organization (as defined in section 1839(a)(1)), or PDP sponsor (as defined in section 1860D-41(a)(13)).

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

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

[Explanation at ¶ 1809.]

2010 Amendments:
Sec. 6402(a) of the “Patient Protection and Affordable Care Act” (Pub.L. No. 111-148), effective March 23, 2010, added new sec. 1128J.

[¶ 15,131] Sec. 1139. IMPROVED ACCESS TO, AND DELIVERY OF, HEALTH CARE FOR INDIANS UNDER TITLES XIX AND XXI

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(c) DEFINITION OF INDIAN; INDIAN TRIBE; INDIAN HEALTH PROGRAM; TRIBAL ORGANIZATION; URBAN INDIAN ORGANIZATION.—For purposes of this section, title XIX, and title XXI, the terms Indian, Indian Tribe, Indian Health Program, Tribal Organization, and Urban Indian Organization have the meanings given those terms in section 4 of the Indian Health Care Improvement Act.

[Explanation at ¶ 573.]

2010 Amendments:
Sec. 2901(d) of the “Patient Protection and Affordable Care Act” (Pub.L. No. 111-148), effective March 23, 2010, amended sec. 1139(c) by striking “In this section” and inserting “For purposes of this section, title XIX, and title XXI”.

[¶ 15,141] Sec. 1139A. CHILD HEALTH QUALITY MEASURES

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(e)

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(8) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this subsection, $25,000,000 for the period of fiscal years 2010 through 2014.

[Explanation at ¶ 1437.]

2010 Amendments:
Sec. 4306 of the “Patient Protection and Affordable Care Act” (Pub.L. No. 111-148), effective March 23, 2010, amended sec. 1139A(e)(8) by striking original paragraph (8) and inserting a new paragraph (8). Prior to amendment, sec. 1139A(e)(8) read as follows: “AUTHORIZATION OF APPROPRIATIONS—There is authorized to be appropriated to carry out this subsection, $25,000,000 for the period of fiscal years 2009 through 2013.”

[¶ 15,151] Sec. 1139B. ADULT HEALTH QUALITY MEASURES

(a) DEVELOPMENT OF CORE SET OF HEALTH CARE QUALITY MEASURES FOR ADULTS ELIGIBLE FOR BENEFITS UNDER MEDICAID.—The Secretary shall identify and publish a recommended core set of adult health quality measures for Medicaid eligible adults in the same manner as the Secretary identifies and publishes a core set of child health quality measures under section 1139A, including with respect to identifying and publishing existing adult health quality measures that are in use under public and privately sponsored health care coverage arrangements, or that are part of reporting systems that measure both the presence and duration of health insurance coverage over time, that may be applicable to Medicaid eligible adults.
(b) **Deadlines.**—

(1) **Recommended Measures.**—Not later than January 1, 2011, the Secretary shall identify and publish for comment a recommended core set of adult health quality measures for Medicaid eligible adults.

(2) **Dissemination.**—Not later than January 1, 2012, the Secretary shall publish an initial core set of adult health quality measures that are applicable to Medicaid eligible adults.

(3) **Standardized Reporting.**—Not later than January 1, 2013, the Secretary, in consultation with States, shall develop a standardized format for reporting information based on the initial core set of adult health quality measures and create procedures to encourage States to use such measures to voluntarily report information regarding the quality of health care for Medicaid eligible adults.

(4) **Reports to Congress.**—Not later than January 1, 2014, and every 3 years thereafter, the Secretary shall include in the report to Congress required under section 1139A(a)(6) information similar to the information required under that section with respect to the measures established under this section.

(5) **Establishment of Medicaid Quality Measurement Program.**—

(A) **In General.**—Not later than 12 months after the release of the recommended core set of adult health quality measures under paragraph (1), the Secretary shall establish a Medicaid Quality Measurement Program in the same manner as the Secretary establishes the pediatric quality measures program under section 1139A(b). The aggregate amount awarded by the Secretary for grants and contracts for the development, testing, and validation of emerging and innovative evidence-based measures under such program shall equal the aggregate amount awarded by the Secretary for grants under section 1139A(b)(4)(A).

(B) **Revising, Strengthening, and Improving Initial Core Measures.**—Beginning not later than 24 months after the establishment of the Medicaid Quality Measurement Program, and annually thereafter, the Secretary shall publish recommended changes to the initial core set of adult health quality measures that shall reflect the results of the testing, validation, and consensus process for the development of adult health quality measures.

(c) **Construction.**—Nothing in this section shall be construed as supporting the restriction of coverage, under title XIX or XXI or otherwise, to only those services that are evidence-based, or in anyway limiting available services.

(d) **Annual State Reports Regarding State-Specific Quality of Care Measures Applied Under Medicaid.**—

(1) **Annual State Reports.**—Each State with a State plan or waiver approved under title XIX shall annually report (separately or as part of the annual report required under section 1139A(c)), to the Secretary on the—

(A) State-specific adult health quality measures applied by the State under the such plan, including measures described in subsection (a)(5); and

(B) State-specific information on the quality of health care furnished to Medicaid eligible adults under such plan, including information collected through external quality reviews of managed care organizations under section 1932 and benchmark plans under section 1937.

(2) **Publication.**—Not later than September 30, 2014, and annually thereafter, the Secretary shall collect, analyze, and make publicly available the information reported by States under paragraph (1).

(e) ** Appropriation.**—Out of any funds in the Treasury not otherwise appropriated, there is appropriated for each of fiscal years 2010 through 2014, $60,000,000 for the purpose of carrying out this section. Funds appropriated under this subsection shall remain available until expended.
Sec. 1150A. PHARMACY BENEFIT MANAGERS TRANSPARENCY REQUIREMENTS

(a) Provision of Information.—A health benefits plan or any entity that provides pharmacy benefits management services on behalf of a health benefits plan (in this section referred to as a ‘PBM’) that manages prescription drug coverage under a contract with—

(1) a PDP sponsor of a prescription drug plan or an MA organization offering an MA-PD plan under part D of title XVIII; or

(2) a qualified health benefits plan offered through an exchange established by a State under section 1311 of the Patient Protection and Affordable Care Act,

shall provide the information described in subsection (b) to the Secretary and, in the case of a PBM, to the plan with which the PBM is under contract with, at such times, and in such form and manner, as the Secretary shall specify.

(b) Information Described.—The information described in this subsection is the following with respect to services provided by a health benefits plan or PBM for a contract year:

(1) The percentage of all prescriptions that were provided through retail pharmacies compared to mail order pharmacies, and the percentage of prescriptions for which a generic drug was available and dispensed (generic dispensing rate), by pharmacy type (which includes an independent pharmacy, chain pharmacy, supermarket pharmacy, or mass merchandiser pharmacy that is licensed as a pharmacy by the State and that dispenses medication to the general public), that is paid by the health benefits plan or PBM under the contract.

(2) The aggregate amount, and the type of rebates, discounts, or price concessions (excluding bona fide service fees, which include but are not limited to distribution service fees, inventory management fees, product stocking allowances, and fees associated with administrative services agreements and patient care programs (such as medication compliance programs and patient education programs)) that the PBM negotiates that are attributable to patient utilization under the plan, and the aggregate amount of the rebates, discounts, or price concessions that are passed through to the plan sponsor, and the total number of prescriptions that were dispensed.

(3) The aggregate amount of the difference between the amount the health benefits plan pays the PBM and the amount that the PBM pays retail pharmacies, and mail order pharmacies, and the total number of prescriptions that were dispensed.

(c) Confidentiality.—Information disclosed by a health benefits plan or PBM under this section is confidential and shall not be disclosed by the Secretary or by a plan receiving the information, except that the Secretary may disclose the information in a form which does not disclose the identity of a specific PBM, plan, or prices charged for drugs, for the following purposes:

(1) As the Secretary determines to be necessary to carry out this section or part D of title XVIII.

(2) To permit the Comptroller General to review the information provided.

(3) To permit the Director of the Congressional Budget Office to review the information provided.

(4) To States to carry out section 1311 of the Patient Protection and Affordable Care Act.

(d) Penalties.—The provisions of subsection (b)(3)(C) of section 1927 shall apply to a health benefits plan or PBM that fails to provide information required under subsection (a) on a timely basis or that knowingly provides false information in the same manner as such provisions apply to a manufacturer with an agreement under that section.
Sec. 1150B. REPORTING TO LAW ENFORCEMENT OF CRIMES OCCURRING IN FEDERALLY FUNDED LONG-TERM CARE FACILITIES

(a) Determination and Notification.—

(1) Determination.—The owner or operator of each long-term care facility that receives Federal funds under this Act shall annually determine whether the facility received at least $10,000 in such Federal funds during the preceding year.

(2) Notification.—If the owner or operator determines under paragraph (1) that the facility received at least $10,000 in such Federal funds during the preceding year, such owner or operator shall annually notify each covered individual (as defined in paragraph (3)) of that individual's obligation to comply with the reporting requirements described in subsection (b).

(3) Covered Individual Defined.—In this section, the term 'covered individual' means each individual who is an owner, operator, employee, manager, agent, or contractor of a long-term care facility that is the subject of a determination described in paragraph (1).

(b) Reporting Requirements.—

(1) In General.—Each covered individual shall report to the Secretary and 1 or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime (as defined by the law of the applicable political subdivision) against any individual who is a resident of, or is receiving care from, the facility.

(2) Timing.—If the events that cause the suspicion—

(A) result in serious bodily injury, the individual shall report the suspicion immediately, but not later than 2 hours after forming the suspicion; and

(B) do not result in serious bodily injury, the individual shall report the suspicion not later than 24 hours after forming the suspicion.

(c) Penalties.—

(1) In General.—If a covered individual violates subsection (b)—

(A) the covered individual shall be subject to a civil money penalty of not more than $200,000; and

B) the Secretary may make a determination in the same proceeding to exclude the covered individual from participation in any Federal health care program (as defined in section 1128B(f)).

(2) Increased Harm.—If a covered individual violates subsection (b) and the violation exacerbates the harm to the victim of the crime or results in harm to another individual—

(A) the covered individual shall be subject to a civil money penalty of not more than $300,000; and

(B) the Secretary may make a determination in the same proceeding to exclude the covered individual from participation in any Federal health care program (as defined in section 1128B(f)).

(3) Excluded Individual.—During any period for which a covered individual is classified as an excluded individual under paragraph (1)(B) or (2)(B), a long-term care facility that employs such individual shall be ineligible to receive Federal funds under this Act.

(4) Extenuating Circumstances.—

(A) In General.—The Secretary may take into account the financial burden on providers with underserved populations in determining any penalty to be imposed under this subsection.

(B) Underserved Population Defined.—In this paragraph, the term 'underserved population' means the population of an area designated by the Secretary as an area with a shortage of elder justice programs or a population group designated by the Secretary as having a shortage of such programs. Such areas or groups designated by the Secretary may include—

(i) areas or groups that are geographically isolated (such as isolated in a rural area); and

(ii) racial and ethnic minority populations; and
(iii) populations underserved because of special needs (such as language barriers, disabilities, alien status, or age).

(d) ADDITIONAL PENALTIES FOR RETALIATION.—

(1) IN GENERAL.—A long-term care facility may not—

(A) discharge, demote, suspend, threaten, harass, or deny a promotion or other employment-related benefit to an employee, or in any other manner discriminate against an employee in the terms and conditions of employment because of lawful acts done by the employee; or

(B) file a complaint or a report against a nurse or other employee with the appropriate State professional disciplinary agency because of lawful acts done by the nurse or employee, for making a report, causing a report to be made, or for taking steps in furtherance of making a report pursuant to subsection (b)(1).

(2) PENALTIES FOR RETALIATION.—If a long-term care facility violates subparagraph (A) or (B) of paragraph (1) the facility shall be subject to a civil money penalty of not more than $200,000 or the Secretary may classify the entity as an excluded entity for a period of 2 years pursuant to section 1128(b), or both.

(3) REQUIREMENT TO POST NOTICE.—Each long-term care facility shall post conspicuously in an appropriate location a sign (in a form specified by the Secretary) specifying the rights of employees under this section. Such sign shall include a statement that an employee may file a complaint with the Secretary against a long-term care facility that violates the provisions of this subsection and information with respect to the manner of filing such a complaint.

(e) PROCEDURE.—The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to a civil money penalty or exclusion under this section in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(f) DEFINITIONS.—In this section, the terms ‘elder justice’, ‘long-term care facility’, and ‘law enforcement’ have the meanings given those terms in section 1101.

[Explanation at ¶ 1925.]

2010 Amendments:
Sec. 6703(b)(3) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, added new sec. 1150B.

[¶ 15,181] Sec. 1171. DEFINITIONS

[42 U.S.C. 1320d]

* * *

(9) OPERATING RULES.—The term ‘operating rules’ means the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications as adopted for purposes of this part.

[Explanation at ¶ 145.]

2010 Amendments:
Sec. 1104(b)(1) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1171 by adding at the end new paragraph (9).

[¶ 15,191] Sec. 1173. STANDARDS FOR INFORMATION TRANSACTIONS AND DATA ELEMENTS


(a)

* * *

(1)
(B) other financial and administrative transactions determined appropriate by the Secretary, consistent with the goals of improving the operation of the health care system and reducing administrative costs, and subject to the requirements under paragraph (5).

(2)

(f) Electronic funds transfers.

(4) REQUIREMENTS FOR FINANCIAL AND ADMINISTRATIVE TRANSACTIONS.—

(A) IN GENERAL.—The standards and associated operating rules adopted by the Secretary shall—

(i) to the extent feasible and appropriate, enable determination of an individual’s eligibility and financial responsibility for specific services prior to or at the point of care;

(ii) be comprehensive, requiring minimal augmentation by paper or other communications;

(iii) provide for timely acknowledgment, response, and status reporting that supports a transparent claims and denial management process (including adjudication and appeals); and

(iv) describe all data elements (including reason and remark codes) in unambiguous terms, require that such data elements be required or conditioned upon set values in other fields, and prohibit additional conditions (except where necessary to implement State or Federal law, or to protect against fraud and abuse).

(B) REDUCTION OF CLERICAL BURDEN.—In adopting standards and operating rules for the transactions referred to under paragraph (1), the Secretary shall seek to reduce the number and complexity of forms (including paper and electronic forms) and data entry required by patients and providers.

(5) CONSIDERATION OF STANDARDIZATION OF ACTIVITIES AND ITEMS.—

(A) IN GENERAL.—For purposes of carrying out paragraph (1)(B), the Secretary shall solicit, not later than January 1, 2012, and not less than every 3 years thereafter, input from entities described in subparagraph (B) on—

(i) whether there could be greater uniformity in financial and administrative activities and items, as determined appropriate by the Secretary; and

(ii) whether such activities should be considered financial and administrative transactions (as described in paragraph (1)(B)) for which the adoption of standards and operating rules would improve the operation of the health care system and reduce administrative costs.

(B) SOLICITATION OF INPUT.—For purposes of subparagraph (A), the Secretary shall seek input from—

(i) the National Committee on Vital and Health Statistics, the Health Information Technology Policy Committee, and the Health Information Technology Standards Committee; and

(ii) standard setting organizations and stakeholders, as determined appropriate by the Secretary.

[Explanation at ¶ 145.]

2010 Amendments:

Sec. 1104(b)(2)(A) of the “Patient Protection and Affordable Care Act” (PubL No 111-148), effective March 23, 2010, amended sec. 1173(a)(2) by adding at the end new paragraph (4).

Sec. 1104(b)(2)(B) of the “Patient Protection and Affordable Care Act” (PubL No 111-148), effective March 23, 2010, amended sec. 1173(a)(1)(A) by adding at the end new paragraph (4).
Sec. 1181. COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH

(a) Definitions.—In this section:

(1) Board.—The term ‘Board’ means the Board of Governors established under subsection (f).

(2) Comparative clinical effectiveness research; research.—

(A) In general.—The terms ‘comparative clinical effectiveness research’ and ‘research’ mean research evaluating and comparing health outcomes and the clinical effectiveness, risks, and benefits of 2 or more medical treatments, services, and items described in subparagraph (B).

(B) Medical treatments, services, and items described.—The medical treatments, services, and items described in this subparagraph are health care interventions, protocols for treatment, care management, and delivery, procedures, medical devices, diagnostic tools, pharmaceuticals (including drugs and biologicals), integrative health practices, and any other strategies or items being used in the treatment, management, and diagnosis of, or prevention of illness or injury in, individuals.

(3) Conflict of interest.—The term ‘conflict of interest’ means an association, including a financial or personal association, that have the potential to bias or have the appearance of biasing an individual’s decisions in matters related to the Institute or the conduct of activities under this section.

(4) Real conflict of interest.—The term ‘real conflict of interest’ means any instance where a member of the Board, the methodology committee established under subsection (d)(6), or an advisory panel appointed under subsection (d)(4), or a close relative of such member, has received or could receive either of the following:

(A) A direct financial benefit of any amount deriving from the result or findings of a study conducted under this section.

(B) A financial benefit from individuals or companies that own or manufacture medical treatments, services, or items to be studied under this section that in the aggregate exceeds $10,000 per year. For purposes of the preceding sentence, a financial benefit includes honoraria, fees, stock, or other financial benefit and the current value of the member or close relative’s already existing stock holdings, in addition to any direct financial benefit deriving from the results or findings of a study conducted under this section.

(b) Patient-Centered Outcomes Research Institute.—

(1) Establishment.—There is authorized to be established a nonprofit corporation, to be known as the ‘Patient-Centered Outcomes Research Institute’ (referred to in this section as the ‘Institute’) which is neither an agency nor establishment of the United States Government.

(2) Application of provisions.—The Institute shall be subject to the provisions of this section, and, to the extent consistent with this section, to the District of Columbia Nonprofit Corporation Act.

(3) Funding of comparative clinical effectiveness research.—For fiscal year 2010 and each subsequent fiscal year, amounts in the Patient-Centered Outcomes Research Trust Fund (referred to in this section as the ‘PCORTF’) under section 9511 of the Internal Revenue Code of 1986 shall be available, without further appropriation, to the Institute to carry out this section.

(c) Purpose.—The purpose of the Institute is to assist patients, clinicians, purchasers, and policy-makers in making informed health decisions by advancing the quality and relevance of evidence concerning the manner in which diseases, disorders, and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed through research and evidence synthesis that considers variations in patient subpopulations, and the dissemination of research findings with respect to the relative health outcomes, clinical effectiveness, and appropriateness of the medical treatments, services, and items described in subsection (a)(2)(B).

(d) Duties.—

(1) Identifying research priorities and establishing research project agenda.—

(A) Identifying research priorities.—The Institute shall identify national priorities for research, taking into account factors of disease incidence, prevalence, and burden in the United States.
(with emphasis on chronic conditions), gaps in evidence in terms of clinical outcomes, practice variations and health disparities in terms of delivery and outcomes of care, the potential for new evidence to improve patient health, well-being, and the quality of care, the effect on national expenditures associated with a health care treatment, strategy, or health conditions, as well as patient needs, outcomes, and preferences, the relevance to patients and clinicians in making informed health decisions, and priorities in the National Strategy for quality care established under section 399H of the Public Health Service Act that are consistent with this section.

(B) ESTABLISHING RESEARCH PROJECT AGENDA.—The Institute shall establish and update a research project agenda for research to address the priorities identified under subparagraph (A), taking into consideration the types of research that might address each priority and the relative value (determined based on the cost of conducting research compared to the potential usefulness of the information produced by research) associated with the different types of research, and such other factors as the Institute determines appropriate.

(2) CARRYING OUT RESEARCH PROJECT AGENDA.—

(A) RESEARCH.—The Institute shall carry out the research project agenda established under paragraph (1)(B) in accordance with the methodological standards adopted under paragraph (9) using methods, including the following:

(i) Systematic reviews and assessments of existing and future research and evidence including original research conducted subsequent to the date of the enactment of this section.

(ii) Primary research, such as randomized clinical trials, molecularly informed trials, and observational studies.

(iii) Any other methodologies recommended by the methodology committee established under paragraph (6) that are adopted by the Board under paragraph (9).

(B) CONTRACTS FOR THE MANAGEMENT OF FUNDING AND CONDUCT OF RESEARCH.—

(i) CONTRACTS.—

(I) IN GENERAL.—In accordance with the research project agenda established under paragraph (1)(B), the Institute shall enter into contracts for the management of funding and conduct of research in accordance with the following:

(aa) Appropriate agencies and instrumentalities of the Federal Government.

(bb) Appropriate academic research, private sector research, or study-conducting entities.

(II) PREFERENCE.—In entering into contracts under subclause (I), the Institute shall give preference to the Agency for Healthcare Research and Quality and the National Institutes of Health, but only if the research to be conducted or managed under such contract is authorized by the governing statutes of such Agency or Institutes.

(ii) CONDITIONS FOR CONTRACTS.—A contract entered into under this subparagraph shall require that the agency, instrumentality, or other entity—

(I) abide by the transparency and conflicts of interest requirements under subsection (h) that apply to the Institute with respect to the research managed or conducted under such contract;

(II) comply with the methodological standards adopted under paragraph (9) with respect to such research;

(III) consult with the expert advisory panels for clinical trials and rare disease appointed under clauses (ii) and (iii), respectively, of paragraph (4)(A);

(IV) subject to clause (iv), permit a researcher who conducts original research, as described in subparagraph (A)(ii) under the contract for the agency, instrumentality, or other entity to have such research published in a peer-reviewed journal or other publication, as long as the researcher enters into a data use agreement with the Institute for use of the data from the original research, as appropriate;

(V) have appropriate processes in place to manage data privacy and meet ethical standards for the research;
(VI) comply with the requirements of the Institute for making the information available to the public under paragraph (8); and

(VII) comply with other terms and conditions determined necessary by the Institute to carry out the research agenda adopted under paragraph (2).

(iii) Coverage of Copayments or Coinsurance.—A contract entered into under this subparagraph may allow for the coverage of copayments or coinsurance, or allow for other appropriate measures, to the extent that such coverage or other measures are necessary to preserve the validity of a research project, such as in the case where the research project must be blinded.

(iv) Subsequent Use of the Data.—The Institute shall not allow the subsequent use of data from original research in work-for-hire contracts with individuals, entities, or instrumentalities that have a financial interest in the results, unless approved under a data use agreement with the Institute.

(C) Review and Update of Evidence.—The Institute shall review and update evidence on a periodic basis as appropriate.
design of the research study and determining the relative value and feasibility of conducting the research study.

(B) COMPOSITION.—An expert advisory panel appointed under subparagraph (A) shall include representatives of practicing and research clinicians, patients, and experts in scientific and health services research, health services delivery, and evidence-based medicine who have experience in the relevant topic, and as appropriate, experts in integrative health and primary prevention strategies. The Institute may include a technical expert of each manufacturer or each medical technology that is included under the relevant topic, project, or category for which the panel is established.

(5) SUPPORTING PATIENT AND CONSUMER REPRESENTATIVES.—The Institute shall provide support and resources to help patient and consumer representatives effectively participate on the Board and expert advisory panels appointed by the Institute under paragraph (4).

(6) ESTABLISHING METHODOLOGY COMMITTEE.—

(A) IN GENERAL.—The Institute shall establish a standing methodology committee to carry out the functions described in subparagraph (C).

(B) APPOINTMENT AND COMPOSITION.—The methodology committee established under subparagraph (A) shall be composed of not more than 15 members appointed by the Comptroller General of the United States. Members appointed to the methodology committee shall be experts in their scientific field, such as health services research, clinical research, comparative clinical effectiveness research, biostatistics, genomics, and research methodologies. Stakeholders with such expertise may be appointed to the methodology committee. In addition to the members appointed under the first sentence, the Directors of the National Institutes of Health and the Agency for Healthcare Research and Quality (or their designees) shall each be included as members of the methodology committee.

(C) FUNCTIONS.—Subject to subparagraph (D), the methodology committee shall work to develop and improve the science and methods of comparative clinical effectiveness research by, not later than 18 months after the establishment of the Institute, directly or through subcontract, developing and periodically updating the following:

(i) Methodological standards for research. Such methodological standards shall provide specific criteria for internal validity, generalizability, feasibility, and timeliness of research and for health outcomes measures, risk adjustment, and other relevant aspects of research and assessment with respect to the design of research. Any methodological standards developed and updated under this subclause shall be scientifically based and include methods by which new information, data, or advances in technology are considered and incorporated into ongoing research projects by the Institute, as appropriate. The process for developing and updating such standards shall include input from relevant experts, stakeholders, and decisionmakers, and shall provide opportunities for public comment. Such standards shall also include methods by which patient subpopulations can be accounted for and evaluated in different types of research. As appropriate, such standards shall build on existing work on methodological standards for defined categories of health interventions and for each of the major categories of comparative clinical effectiveness research methods (determined as of the date of enactment of the Patient Protection and Affordable Care Act).

(ii) A translation table that is designed to provide guidance and act as a reference for the Board to determine research methods that are most likely to address each specific research question.

(D) CONSULTATION AND CONDUCT OF EXAMINATIONS.—The methodology committee may consult and contract with the Institute of Medicine of the National Academies and academic, nonprofit, or other private and governmental entities with relevant expertise to carry out activities described in subparagraph (C) and may consult with relevant stakeholders to carry out such activities.

(E) REPORTS.—The methodology committee shall submit reports to the Board on the committee’s performance of the functions described in subparagraph (C). Reports shall contain recommendations for the Institute to adopt methodological standards developed and updated by the methodology committee as well as other actions deemed necessary to comply with such methodological standards.
(7) **PROVIDING FOR A PEER-REVIEW PROCESS FOR PRIMARY RESEARCH.**—

(A) **IN GENERAL.**—The Institute shall ensure that there is a process for peer review of primary research described in subparagraph (A)(ii) of paragraph (2) that is conducted under such paragraph. Under such process—

(i) evidence from such primary research shall be reviewed to assess scientific integrity and adherence to methodological standards adopted under paragraph (9); and

(ii) a list of the names of individuals contributing to any peer-review process during the preceding year or years shall be made public and included in annual reports in accordance with paragraph (10)(D).

(B) **COMPOSITION.**—Such peer-review process shall be designed in a manner so as to avoid bias and conflicts of interest on the part of the reviewers and shall be composed of experts in the scientific field relevant to the research under review.

(C) **USE OF EXISTING PROCESSES.**—

(i) **PROCESSES OF ANOTHER ENTITY.**—In the case where the Institute enters into a contract or other agreement with another entity for the conduct or management of research under this section, the Institute may utilize the peer-review process of such entity if such process meets the requirements under subparagraphs (A) and (B).

(ii) **PROCESSES OF APPROPRIATE MEDICAL JOURNALS.**—The Institute may utilize the peer-review process of appropriate medical journals if such process meets the requirements under subparagraphs (A) and (B).

(8) **RELEASE OF RESEARCH FINDINGS.**—

(A) **IN GENERAL.**—The Institute shall, not later than 90 days after the conduct or receipt of research findings under this part, make such research findings available to clinicians, patients, and the general public. The Institute shall ensure that the research findings—

(i) convey the findings of research in a manner that is comprehensible and useful to patients and providers in making health care decisions;

(ii) fully convey findings and discuss considerations specific to certain subpopulations, risk factors, and comorbidities, as appropriate;

(iii) include limitations of the research and what further research may be needed as appropriate;

(iv) do not include practice guidelines, coverage recommendations, payment, or policy recommendations; and

(v) not include any data which would violate the privacy of research participants or any confidentiality agreements made with respect to the use of data under this section.

(B) **DEFINITION OF RESEARCH FINDINGS.**—In this paragraph, the term ‘research findings’ means the results of a study or assessment.

(9) **ADOPTION.**—Subject to subsection (h)(1), the Institute shall adopt the national priorities identified under paragraph (1)(A), the research project agenda established under paragraph (1)(B), the methodological standards developed and updated by the methodology committee under paragraph (6)(C)(i), and any peer-review process provided under paragraph (7) by majority vote. In the case where the Institute does not adopt such processes in accordance with the preceding sentence, the processes shall be referred to the appropriate staff or entity within the Institute (or, in the case of the methodological standards, the methodology committee) for further review.

(10) **ANNUAL REPORTS.**—The Institute shall submit an annual report to Congress and the President, and shall make the annual report available to the public. Such report shall contain—

(A) a description of the activities conducted under this section, research priorities identified under paragraph (1)(A) and methodological standards developed and updated by the methodology committee under paragraph (6)(C)(i) that are adopted under paragraph (9) during the preceding year;

(B) the research project agenda and budget of the Institute for the following year;
(C) any administrative activities conducted by the Institute during the preceding year;

(D) the names of individuals contributing to any peer-review process under paragraph (7), without identifying them with a particular research project; and

(E) any other relevant information (including information on the membership of the Board, expert advisory panels, methodology committee, and the executive staff of the Institute, any conflicts of interest with respect to these individuals, and any bylaws adopted by the Board during the preceding year).

(e) Administration.—

(1) In General.—Subject to paragraph (2), the Board shall carry out the duties of the Institute.

(2) Nondelegable Duties.—The activities described in subsections (d)(1) and (d)(9) are nondelegable.

(f) Board of Governors.—

(1) In General.—The Institute shall have a Board of Governors, which shall consist of the following members:

(A) The Director of Agency for Healthcare Research and Quality (or the Director’s designee).

(B) The Director of the National Institutes of Health (or the Director’s designee).

(C) Seventeen members appointed, not later than 6 months after the date of enactment of this section, by the Comptroller General of the United States as follows:

(i) 3 members representing patients and health care consumers.

(ii) 7 members representing physicians and providers, including 4 members representing physicians (at least 1 of whom is a surgeon), 1 nurse, 1 State-licensed integrative health care practitioner, and 1 representative of a hospital.

(iii) 3 members representing private payers, of whom at least 1 member shall represent health insurance issuers and at least 1 member shall represent employers who self-insure employee benefits.

(iv) 3 members representing pharmaceutical, device, and diagnostic manufacturers or developers.

(v) 1 member representing quality improvement or independent health service researchers.

(vi) 2 members representing the Federal Government or the States, including at least 1 member representing a Federal health program or agency.

(2) Qualifications.—The Board shall represent a broad range of perspectives and collectively have scientific expertise in clinical health sciences research, including epidemiology, decisions sciences, health economics, and statistics. In appointing the Board, the Comptroller General of the United States shall consider and disclose any conflicts of interest in accordance with subsection (h)(4)(B). Members of the Board shall be recused from relevant Institute activities in the case where the member (or an immediate family member of such member) has a real conflict of interest directly related to the research project or the matter that could affect or be affected by such participation.

(3) Terms; Vacancies.—A member of the Board shall be appointed for a term of 6 years, except with respect to the members first appointed, whose terms of appointment shall be staggered evenly over 2-year increments. No individual shall be appointed to the Board for more than 2 terms. Vacancies shall be filled in the same manner as the original appointment was made.

(4) Chairperson and Vice-Chairperson.—The Comptroller General of the United States shall designate a Chairperson and Vice Chairperson of the Board from among the members of the Board. Such members shall serve as Chairperson or Vice Chairperson for a period of 3 years.

(5) Compensation.—Each member of the Board who is not an officer or employee of the Federal Government shall be entitled to compensation (equivalent to the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code) and expenses incurred while performing the duties of the Board. An officer or employee of the Federal government who is a member of the Board shall be exempt from compensation.
(6) **Director and Staff; Experts and Consultants.**—The Board may employ and fix the compensation of an Executive Director and such other personnel as may be necessary to carry out the duties of the Institute and may seek such assistance and support of, or contract with, experts and consultants that may be necessary for the performance of the duties of the Institute.

(7) **Meetings and Hearings.**—The Board shall meet and hold hearings at the call of the Chairperson or a majority of its members. Meetings not solely concerning matters of personnel shall be advertised at least 7 days in advance and open to the public. A majority of the Board members shall constitute a quorum, but a lesser number of members may meet and hold hearings.

(g) **Financial and Governmental Oversight.**—

(1) **Contract for Audit.**—The Institute shall provide for the conduct of financial audits of the Institute on an annual basis by a private entity with expertise in conducting financial audits.

(2) **Review and Annual Reports.**—

(A) **Review.**—The Comptroller General of the United States shall review the following:

(i) Not less frequently than on an annual basis, the financial audits conducted under paragraph (1).

(ii) Not less frequently than every 5 years, the processes established by the Institute, including the research priorities and the conduct of research projects, in order to determine whether information produced by such research projects is objective and credible, is produced in a manner consistent with the requirements under this section, and is developed through a transparent process.

(iii) Not less frequently than every 5 years, the dissemination and training activities and data networks established under section 937 of the Public Health Service Act, including the methods and products used to disseminate research, the types of training conducted and supported, and the types and functions of the data networks established, in order to determine whether the activities and data are produced in a manner consistent with the requirements under such section.

(iv) Not less frequently than every 5 years, the overall effectiveness of activities conducted under this section and the dissemination, training, and capacity building activities conducted under section 937 of the Public Health Service Act. Such review shall include an analysis of the extent to which research findings are used by health care decision-makers, the effect of the dissemination of such findings on reducing practice variation and disparities in health care, and the effect of the research conducted and disseminated on innovation and the health care economy of the United States.

(v) Not later than 8 years after the date of enactment of this section, the adequacy and use of the funding for the Institute and the activities conducted under section 937 of the Public Health Service Act, including a determination as to whether, based on the utilization of research findings by public and private payers, funding sources for the Patient-Centered Outcomes Research Trust Fund under section 9511 of the Internal Revenue Code of 1986 are appropriate and whether such sources of funding should be continued or adjusted.

(B) **Annual Reports.**—Not later than April 1 of each year, the Comptroller General of the United States shall submit to Congress a report containing the results of the review conducted under subparagraph (A) with respect to the preceding year (or years, if applicable), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(h) **Ensuring Transparency, Credibility, and Access.**—The Institute shall establish procedures to ensure that the following requirements for ensuring transparency, credibility, and access are met:

(1) **Public Comment Periods.**—The Institute shall provide for a public comment period of not less than 45 days and not more than 60 days prior to the adoption under subsection (d)(9) of the national priorities identified under subsection (d)(1)(A), the research project agenda established under subsection (d)(1)(B), the methodological standards developed and updated by the methodology committee under subsection (d)(6)(C)(i), and the peer-review process provided under paragraph (7), and after the release of draft findings with respect to systematic reviews of existing research and evidence.
(2) ADDITIONAL FORUMS.—The Institute shall support forums to increase public awareness and obtain and incorporate public input and feedback through media (such as an Internet website) on research priorities, research findings, and other duties, activities, or processes the Institute determines appropriate.

(3) PUBLIC AVAILABILITY.—The Institute shall make available to the public and disclose through the official public Internet website of the Institute the following:

(A) Information contained in research findings as specified in subsection (d)(9).

(B) The process and methods for the conduct of research, including the identity of the entity and the investigators conducting such research and any conflicts of interests of such parties, any direct or indirect links the entity has to industry, and research protocols, including measures taken, methods of research and analysis, research results, and such other information the Institute determines appropriate) concurrent with the release of research findings.

(C) Notice of public comment periods under paragraph (1), including deadlines for public comments.

(D) Subsequent comments received during each of the public comment periods.

(E) In accordance with applicable laws and processes as and the Institute determines appropriate, proceedings of the Institute.

(4) DISCLOSURE OF CONFLICTS OF INTEREST.—

(A) IN GENERAL.—A conflict of interest shall be disclosed in the following manner:

(i) By the Institute in appointing members to an expert advisory panel under subsection (d)(4), in selecting individuals to contribute to any peer-review process under subsection (d)(7), and for employment as executive staff of the Institute.

(ii) By the Comptroller General in appointing members of the methodology committee under subsection (d)(6);

(iii) By the Institute in the annual report under subsection (d)(10), except that, in the case of individuals contributing to any such peer review process, such description shall be in a manner such that those individuals cannot be identified with a particular research project.

(B) MANNER OF DISCLOSURE.—Conflicts of interest shall be disclosed as described in subparagraph (A) as soon as practicable on the Internet web site of the Institute and of the Government Accountability Office. The information disclosed under the preceding sentence shall include the type, nature, and magnitude of the interests of the individual involved, except to the extent that the individual recuses himself or herself from participating in the consideration of or any other activity with respect to the study as to which the potential conflict exists.

(i) RULES.—The Institute, its Board or staff, shall be prohibited from accepting gifts, bequeaths, or donations of services or property. In addition, the Institute shall be prohibited from establishing a corporation or generating revenues from activities other than as provided under this section.

(j) RULES OF CONSTRUCTION.—

(1) COVERAGE.—Nothing in this section shall be construed—

(A) to permit the Institute to mandate coverage, reimbursement, or other policies for any public or private payer; or

(B) as preventing the Secretary from covering the routine costs of clinical care received by an individual entitled to, or enrolled for, benefits under title XVIII, XIX, or XXI in the case where such individual is participating in a clinical trial and such costs would otherwise be covered under such title with respect to the beneficiary.

[Explanation at ¶ 1705.]
Sec. 1182. LIMITATIONS ON CERTAIN USES OF COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH

(a) The Secretary may only use evidence and findings from research conducted under section 1181 to make a determination regarding coverage under title XVIII if such use is through an iterative and transparent process which includes public comment and considers the effect on subpopulations.

(b) Nothing in section 1181 shall be construed as—

(1) superceding or modifying the coverage of items or services under title XVIII that the Secretary determines are reasonable and necessary under section 1862(l)(1); or

(2) authorizing the Secretary to deny coverage of items or services under such title solely on the basis of comparative clinical effectiveness research.

(c)(1) The Secretary shall not use evidence or findings from comparative clinical effectiveness research conducted under section 1181 in determining coverage, reimbursement, or incentive programs under title XVIII in a manner that treats extending the life of an elderly, disabled, or terminally ill individual as of lower value than extending the life of an individual who is younger, nondisabled, or not terminally ill.

(2) Paragraph (1) shall not be construed as preventing the Secretary from using evidence or findings from such comparative clinical effectiveness research in determining coverage, reimbursement, or incentive programs under title XVIII based upon a comparison of the difference in the effectiveness of alternative treatments in extending an individual’s life due to the individual’s age, disability, or terminal illness.

(d)(1) The Secretary shall not use evidence or findings from comparative clinical effectiveness research conducted under section 1181 in determining coverage, reimbursement, or incentive programs under title XVIII in a manner that precludes, or with the intent to discourage, an individual from choosing a health care treatment based on how the individual values the tradeoff between extending the length of their life and the risk of disability.

(2)(A) Paragraph (1) shall not be construed to—

(i) limit the application of differential copayments under title XVIII based on factors such as cost or type of service; or

(ii) prevent the Secretary from using evidence or findings from such comparative clinical effectiveness research in determining coverage, reimbursement, or incentive programs under such title based upon a comparison of the difference in the effectiveness of alternative health care treatments in extending an individual’s life due to that individual’s age, disability, or terminal illness.

(3) Nothing in the provisions of, or amendments made by the Patient Protection and Affordable Care Act, shall be construed to limit comparative clinical effectiveness research or any other research, evaluation, or dissemination of information concerning the likelihood that a health care treatment will result in disability.

(e) The Patient-Centered Outcomes Research Institute established under section 1181(b)(1) shall not develop or employ a dollars-per-quality adjusted life year (or similar measure that discounts the value of a life because of an individual’s disability) as a threshold to establish what type of health care is cost effective or recommended. The Secretary shall not utilize such an adjusted life year (or such a similar measure) as a threshold to determine coverage, reimbursement, or incentive programs under title XVIII.

[Explanation at ¶ 1705.]

2010 Amendments:

Sec. 6301(c) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, added new sec. 1182.
Sec. 1183. TRUST FUND TRANSFERS TO PATIENT-CENTERED OUTCOMES RESEARCH TRUST FUND

(a) IN GENERAL.—The Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841, in proportion (as estimated by the Secretary) to the total expenditures during such fiscal year that are made under title XVIII from the respective trust fund, to the Patient-Centered Outcomes Research Trust Fund (referred to in this section as the ‘PCORTF’) under section 9511 of the Internal Revenue Code of 1986, of the following:

(1) For fiscal year 2013, an amount equal to $1 multiplied by the average number of individuals entitled to benefits under part A, or enrolled under part B, of title XVIII during such fiscal year.

(2) For each of fiscal years 2014, 2015, 2016, 2017, 2018, and 2019, an amount equal to $2 multiplied by the average number of individuals entitled to benefits under part A, or enrolled under part B, of title XVIII during such fiscal year.

(b) ADJUSTMENTS FOR INCREASES IN HEALTH CARE SPENDING.—In the case of any fiscal year beginning after September 30, 2014, the dollar amount in effect under subsection (a)(2) for such fiscal year shall be equal to the sum of such dollar amount for the previous fiscal year (determined after the application of this subsection), plus an amount equal to the product of—

(1) such dollar amount for the previous fiscal year, multiplied by

(2) the percentage increase in the projected per capita amount of National Health Expenditures, as most recently published by the Secretary before the beginning of the fiscal year.

[Explanation at ¶ 1705.]

2010 Amendments:
Sec. 6301(d) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, added new sec. 1183.

Sec. 1805. Medicare Payment Advisory Commission

[42 U.S.C. §1395b-6]

(b) ***

(1) ***

(C) by not later than March 15, submit a report to Congress containing the results of such reviews and its recommendations concerning such policies; and

(D) by not later than June 15 of each year, submit a report to Congress containing an examination of issues affecting the Medicare program, including the implications of changes in health care delivery in the United States and in the market for health care services on the Medicare program and including a review of the estimate of the conversion factor submitted under section 1848(d)(1)(E)(ii), and (beginning with 2012) containing an examination of the topics described in paragraph (9), to the extent feasible.

(4) REVIEW AND COMMENT ON THE INDEPENDENT PAYMENT ADVISORY BOARD OR SECRETARIAL PROPOSAL.—If the Independent Payment Advisory Board (as established under subsection (a) of section 1899A) or the Secretary submits a proposal to the Commission under such section in a year, the Commission shall review the proposal and, not later than March 1 of that year, submit to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate written comments on such proposal. Such comments may include such recommendations as the Commission deems appropriate.

(5) AGENDA AND ADDITIONAL REVIEWS.—The Commission shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding...
the Commission’s agenda and progress towards achieving the agenda. The Commission may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under this title as may be requested by such chairmen and members and as the Commission deems appropriate.

(6) **AVAILABILITY OF REPORTS.**—The Commission shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

(7) **APPROPRIATE COMMITTEES OF CONGRESS.**—For purposes of this section, the term ‘appropriate committees of Congress’ means the Committees on Ways and Means and Commerce of the House of Representatives and the Committee on Finance of the Senate.

(8) **VOTING AND REPORTING REQUIREMENTS.**—With respect to each recommendation contained in a report submitted under paragraph (1), each member of the Commission shall vote on the recommendation, and the Commission shall include, by member, the results of that vote in the report containing the recommendation.

Caution: Sec. 2801(b)(3) and 3403(c) of the Patient Protection and Affordable Care Act (P.L. 111-148) both added new sec. 1805(b)(9); the text of both sections appears below.

(9) **EXAMINATION OF BUDGET CONSEQUENCES.**—Before making any recommendations, the Commission shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities.

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

Caution: Sec. 2801(b)(3) of the Patient Protection and Affordable Care Act (P.L. 111-148) referred to section 2081; sec. 2602 is the likely correct reference and the text below reflects this.

(10) **COORDINATE AND CONSULT WITH THE FEDERAL COORDINATED HEALTH CARE OFFICE.**—The Commission shall coordinate and consult with the Federal Coordinated Health Care Office established under section 2602 of the Patient Protection and Affordable Care Act before making any recommendations regarding dual eligible individuals.

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

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[Explanation at ¶570 and ¶1385].

2010 Amendments:

Sec. 2801(b)(1) of the “Patient Protection and Affordable Care Act” (Pub.L No 111-148), effective March 23, 2010, amended sec. 1805(b)(1)(C) by striking “March 1 of each year (beginning with 1998)” and inserting “March 15”.

Sec. 2801(b)(2) of the “Patient Protection and Affordable Care Act” (Pub.L No 111-148), effective March 23, 2010, amended sec. 1805(b) by inserting “, and (beginning with 2012) containing an examination of the topics described in paragraph (9), to the extent feasible” before the period.

Sec. 2801(b)(3) of the “Patient Protection and Affordable Care Act” (Pub.L No 111-148), effective March 23, 2010, amended sec. 1805(b) by adding at the end new paragraphs (9), (10) and (11).

Sec. 3403(c) of the “Patient Protection and Affordable Care Act” (Pub.L No 111-148), effective March 23, 2010, amended sec. 1805(b) by redesignating paragraphs (4) through (8) as paragraphs (5) through (9), respectively and inserting after paragraph (8) new paragraph (4).
Sec. 1814. Requirement of Requests and Certifications

[42 U.S.C. §1395f(a)]

(a)  


Caution: In the case of services furnished before January 1, 2010, a bill or request for payment under section 1814(a)(1), shall be filed not later than December 31, 2010.

(1) written request, signed by such individual, except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner, and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the period ending 1 calendar year after the date of service;

Caution: Code Sec. 1814(a)(2) below, has been amended by Act Sec. 6405(b), which was further amended by Act Sec. 10604.

(2) a physician, or in the case of services described in subparagraph (B), a physician, or a nurse practitioner, a clinical nurse specialist, or a physician assistant (as those terms are defined in section 1861(aa)(5)) who does not have a direct or indirect employment relationship with the facility but is working in collaboration with a physician, or, in the case of services described in subparagraph (C), a physician enrolled under section 1866(j), certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations, except that the first of such recertifications shall be required in each case of inpatient hospital services not later than the 20th day of such period) that—


Caution: In the case of hospice care services, a written plan for providing hospice care with respect to such individual has been established (before such care is provided by, or under arrangements made by, that hospice program) and is periodically reviewed by the individual’s attending physician and by the medical director (and the interdisciplinary group described in section 1861(dd)(2)(B)) of the hospice program;


(D) on and after January 1, 2011—
(i) a hospice physician or nurse practitioner has a face-to-face encounter with the individual to determine continued eligibility of the individual for hospice care prior to the 180th-day recertification and each subsequent recertification under subparagraph (A)(ii) and attests that such visit took place (in accordance with procedures established by the Secretary); and

(ii) in the case of hospice care provided an individual for more than 180 days by a hospice program for which the number of such cases for such program comprises more than a percent (specified by the Secretary) of the total number of such cases for all programs under this title, the hospice care provided to such individual is medically reviewed (in accordance with procedures established by the Secretary); and

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To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician, nurse practitioner, clinical nurse specialist, or physician assistant (as the case may be) makes certification of the kind provided in subparagraph (A), (B), (C), or (D) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations. With respect to the physician certification required by paragraph (2) for home health services furnished to any individual by a home health agency (other than an agency which is a governmental entity) and with respect to the establishment and review of a plan for such services, the Secretary shall prescribe regulations which shall become effective no later than July 1, 1981, and which prohibit a physician who has a significant ownership interest in, or a significant financial or contractual relationship with, such home health agency from performing such certification and from establishing or reviewing such plan, except that such prohibition shall not apply with respect to a home health agency which is a sole community home health agency (as determined by the Secretary). For purposes of the preceding sentence, service by a physician as an uncompensated officer or director of a home health agency shall not constitute having a significant ownership interest in, or a significant financial or contractual relationship with, such agency. For purposes of paragraph (2)(C), an individual shall be considered to be “confined to his home” if the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered “confined to his home,” the condition of the individual should be such that there exists a normal inability to leave home and that leaving home requires a considerable and taxing effort by the individual. Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited, to furnish adult day-care services in the State shall not disqualify an individual from being considered to be “confined to his home”. Any other absence of an individual from the home shall not so disqualify an individual if the absence is of infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration. In applying paragraph (1), the Secretary may specify exceptions to the 1 calendar year period specified in such paragraph.

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(i)

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(ii) With respect to routine home care and other services included in hospice care furnished during a subsequent fiscal year (before the first fiscal year in which the payment revisions described in paragraph (6)(D) are implemented), the payment rates for such care and services shall be the payment rates in effect under this subparagraph during the previous fiscal year increased by—
(VII) for a subsequent fiscal year, (before the first fiscal year in which the payment revisions described in paragraph (6)(D) are implemented), subject to clause (iv), the market basket percentage increase for the fiscal year.

(iii) With respect to routine home care and other services included in hospice care furnished during fiscal years subsequent to the first fiscal year in which payment revisions described in paragraph (6)(D) are implemented, the payment rates for such care and services shall be the payment rates in effect under this clause during the preceding fiscal year increased by, subject to clause (iv), the market basket percentage increase (as defined in section 1886(b)(3)(B)(iii)) for the fiscal year.

(iv) After determining the market basket percentage increase under clause (ii)(VII) or (iii), as applicable, with respect to fiscal year 2013 and each subsequent fiscal year, the Secretary shall reduce such percentage—

(I) for 2013 and each subsequent fiscal year, by the productivity adjustment described in section 1886(b)(3)(B)(xii)(II); and

(II) subject to clause (v), for each of fiscal years 2013 through 2019, by 0.3 percentage point.

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

(v) Clause (iv)(II) shall be applied with respect to any of fiscal years 2014 through 2019 by substituting '0.0 percentage points' for '0.3 percentage point', if for such fiscal year—

(I) the excess (if any) of

(aa) the total percentage of the non-elderly insured population for the preceding fiscal year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

(bb) the total percentage of the non-elderly insured population for such preceding fiscal year (as estimated by the Secretary); exceeds

(II) 5 percentage points.

(5) Quality Reporting.—

(A) Reduction in update for failure to report.—

(i) In general.—For purposes of fiscal year 2014 and each subsequent fiscal year, in the case of a hospice program that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a fiscal year, after determining the market basket percentage increase under paragraph (1)(C)(ii)(VII) or paragraph (1)(C)(iii), as applicable, and after application of paragraph (1)(C)(iv), with respect to the fiscal year, the Secretary shall reduce such market basket percentage increase by 2 percentage points.

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

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

(C) Submission of quality data.—For fiscal year 2014 and each subsequent fiscal year, each hospice program shall submit to the Secretary data on quality measures specified under subparagraph

¶15,251 §1814(i)(1)(C)(ii)(VII)
(D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

(D) QUALITY MEASURES.—

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

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

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

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

614(i)(6)(A) The Secretary shall collect additional data and information as the Secretary determines appropriate to revise payments for hospice care under this subsection pursuant to subparagraph (D) and for other purposes as determined appropriate by the Secretary. The Secretary shall begin to collect such data by not later than January 1, 2011.

(B) The additional data and information to be collected under subparagraph (A) may include data and information on—

(i) charges and payments;

(ii) the number of days of hospice care which are attributable to individuals who are entitled to, or enrolled for, benefits under part A; and

(iii) with respect to each type of service included in hospice care—

(I) the number of days of hospice care attributable to the type of service;

(II) the cost of the type of service; and

(III) the amount of payment for the type of service;

(iv) charitable contributions and other revenue of the hospice program;

(v) the number of hospice visits;

(vi) the type of practitioner providing the visit; and

(vii) the length of the visit and other basic information with respect to the visit.

(C) The Secretary may collect the additional data and information under subparagraph (A) on cost reports, claims, or other mechanisms as the Secretary determines to be appropriate.

(D)(i) Notwithstanding the preceding paragraphs of this subsection, not earlier than October 1, 2013, the Secretary shall, by regulation, implement revisions to the methodology for determining the payment rates for routine home care and other services included in hospice care under this part, as the Secretary determines to be appropriate. Such revisions may be based on an analysis of data and information collected under subparagraph (A). Such revisions may include adjustments to per diem payments that reflect changes in resource intensity in providing such care and services during the course of the entire episode of hospice care.

(ii) Revisions in payment implemented pursuant to clause (i) shall result in the same estimated amount of aggregate expenditures under this title for hospice care furnished in the fiscal year in which such revisions in payment are implemented as would have been made under this title for such care in such fiscal year if such revisions had not been implemented.

(E) The Secretary shall consult with hospice programs and the Medicare Payment Advisory Commission regarding the additional data and information to be collected under subparagraph (A) and the payment revisions under subparagraph (D).
(7) In the case of hospice care provided by a hospice program under arrangements under section 1861(dd)(5)(D) made by another hospice program, the hospice program that made the arrangements shall bill and be paid for the hospice care.

[Explanation at ¶ 717, ¶ 820, ¶ 1010, ¶ 1335, ¶ 1833, ¶ 1835 and ¶ 1839.]

2010 Amendments:

Sec. 6404(a)(1) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1814(a) by striking “or clinical nurse specialist” and inserting “a clinical nurse specialist, or a physician assistant as those terms are defined in section 1861(aa)(5)” after “nurse practitioner”.

Sec. 6407(a)(1) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1814(a)(2) by striking “or clinical nurse specialist” and inserting “clinical nurse specialist, or physician assistant” after “nurse practitioner.”

Sec. 3132(b) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1814(a)(7) in subparagraph (B), by striking “and” at the end and by adding at the end, new subparagraph (D).

Sec. 3132a(1) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1814(b) by redesignating paragraph (6) as paragraph (7) and inserting after paragraph (5) a new paragraph (6).

Sec. 3132a(2) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1814(i)(1)(C) in clause (ii) in the matter preceding subclause (I), by inserting “before the first fiscal year in which the payment revisions described in paragraph (6)(D) are implemented” after “subsequent fiscal year”, by inserting “(before the first fiscal year in which the payment revisions described in paragraph (6)(D) are implemented)” after “subsequent fiscal year”, by adding at the end the new clause (iii).

Sec. 3401(g) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1814(i)(1)(C) by adding at the end new clauses (iv) and (v).

Sec. 6404a(a)(1) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective for services furnished on or after Jan. 1, 2010, amended sec. 1814(a) by striking “period of 3 calendar years” and all that follows through the semicolon and inserting “period ending 1 calendar year after the date of service,” and adding at the end the following new sentence: “In applying paragraph (1), the Secretary may specify exceptions to the 1 calendar year period specified in such paragraph.”

Sec. 6407a(1) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1814(a)(2) by inserting after “care of a physician” the following: “, and, in the case of a certification made by a physician after January 1, 2010, prior to making such certification the physician must document that the physician himself or herself has had a face-to-face encounter (including through use of telehealth, subject to the requirements in section 1834(m), and other than with respect to encounters that are incident to services involved) with the individual within a reasonable timeframe as determined by the Secretary”.

Sec. 10319(f) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1814(i)(1)(C) by adding at the end new clauses (iv) and (v).
(VIII) for fiscal year 2007, not less than $160,000,000, increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over the previous year; and

(IX) for each fiscal year after fiscal year 2007, not less than the amount required under this clause for the preceding fiscal year, increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over the previous year.

(B)

(vii) for each of fiscal years 2003, 2004, 2005, and 2006, $114,000,000; and

(viii) for each fiscal year after fiscal year 2006, the amount to be appropriated under this subparagraph for the preceding fiscal year, increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over the previous year.

(C)

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

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

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

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

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

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

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

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

Sec. 6402(o)(1)(A) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1817(k) by adding at the end the new paragraph (7).

Sec. 6402(o)(1)(B) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1817(k)(4)(A) by inserting “until expended” after “appropriation”.

Sec. 6402(o)(2)(A) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1817(k)(3)(A)(ii) in subclause (III), by inserting “and” at the end; in subclause (IV) by striking “for each of fiscal years 2007, 2008, 2009, and 2010” and inserting “for each fiscal year after fiscal year 2006” and by striking “; and” and inserting a period; and by striking original sub-clause (V) which previously read as follows: “(V) for each fiscal year after fiscal year 2010, the limit under this clause for fiscal year 2010.”

Sec. 6402(o)(2)(B) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1817(k)(3)(A)(ii) in subclause (VIII), by inserting “and” at the end; in subclause (IX) by striking “for each of fiscal years 2008, 2009, and 2010” and inserting “for each fiscal year after fiscal year 2007” and by striking “; and” and inserting a period; and by striking original sub-clause (X) which previously read as follows: “for each fiscal year after fiscal year 2010, not less than the amount required under this clause for fiscal year 2010.”.

Sec. 6402(o)(2)(C) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1817(k)(3)(B) in clause (vii), by inserting “and” at the end; in clause (viii) by striking “for each of fiscal years 2007, 2008, 2009, and 2010” and inserting “for each fiscal year after fiscal year 2006” and by striking “; and” and inserting a period; and by striking clause (ix) which previously read as follows: “(ix) for each fiscal year after fiscal year 2010, the amount to be appropriated under this subparagraph for fiscal year 2010.”.

Sec. 6402(o)(2)(D) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1817(k)(4)(C) by adding at the end the new clause (ii).

Sec. 1303(a)(1)(A) of the “Health Care Reconciliation Act of 2010” (PubLNo 111-152), effective March 30, 2010, amended sec. 1817(k)(5)(A) by adding at the end the new clause (ii).

Sec. 1303(a)(1)(B) of the “Health Care Reconciliation Act of 2010” (PubLNo 111-152), effective March 30, 2010, amended sec. 1817(k)(5)(B) by inserting “for activities described in paragraph (3)(C) and” after “necessary”.

SEC. 1819. REQUIREMENTS FOR, AND ASSURING QUALITY OF CARE IN, SKILLED NURSING FACILITIES

[42 U.S.C. §1395i-3]

(b) Such term includes an individual who provides such services through an agency or under a contract with the facility.

(d) REQUIREMENTS RELATING TO ADMINISTRATION AND OTHER MATTERS.—

(1) ADMINISTRATION.—

(B) SKILLED NURSING FACILITY ADMINISTRATOR.—The administrator of a skilled nursing facility must meet standards established by the Secretary under subsection (f)(4).

(C) AVAILABILITY OF SURVEY, CERTIFICATION, AND COMPLAINT INVESTIGATION REPORTS.—A skilled nursing facility must—

(i) have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years available for any individual to review upon request; and

(ii) post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.
The facility shall not make available under clause (i) identifying information about complainants or residents.

(f)

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(i) requirements for the approval of nurse aide training and competency evaluation programs, including requirements relating to (I) the areas to be covered in such a program (including at least basic nursing skills, personal care skills, recognition of mental health and social service needs, care of cognitively impaired residents, basic restorative services, and residents' rights) and content of the curriculum (including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training, and patient abuse prevention training, (II) minimum hours of initial and ongoing training and retraining (including not less than 75 hours in the case of initial training), (III) qualifications of instructors, and (IV) procedures for determination of competency;

(8) SPECIAL FOCUS FACILITY PROGRAM.—

(A) IN GENERAL.—The Secretary shall conduct a special focus facility program for enforcement of requirements for skilled nursing facilities that the Secretary has identified as having substantially failed to meet applicable requirement of this Act.

(B) PERIODIC SURVEYS.—Under such program the Secretary shall conduct surveys of each facility in the program not less than once every 6 months.

(g)

(5)

(E) SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION TO THE SECRETARY.—In order to improve the timeliness of information made available to the public under subparagraph (A) and provided on the Nursing Home Compare Medicare website under subsection (i), each State shall submit information respecting any survey or certification made respecting a nursing facility (including any enforcement actions taken by the State) to the Secretary not later than the date on which the State sends such information to the facility. The Secretary shall use the information submitted under the preceding sentence to update the information provided on the Nursing Home Compare Medicare website as expeditiously as practicable but not less frequently than quarterly.

(h)

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(B)

(ii) AUTHORITY WITH RESPECT TO CIVIL MONEY PENALTIES.—(I) IN GENERAL.—Subject to subclause (II), the Secretary may impose a civil money penalty in an amount not to exceed

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$10,000 for each day of noncompliance. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(II) REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.—Subject to subclause (III), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under this clause not later than 10 calendar days after the date of such imposition, the Secretary may reduce the amount of the penalty imposed by not more than 50 percent.

(III) PROHIBITIONS ON REDUCTION FOR CERTAIN DEFICIENCIES.—

(aa) REPEAT DEFICIENCIES.—The Secretary may not reduce the amount of a penalty under subclause (II) if the Secretary had reduced a penalty imposed on the facility in the preceding year under such subclause with respect to a repeat deficiency.

(bb) CERTAIN OTHER DEFICIENCIES.—The Secretary may not reduce the amount of a penalty under subclause (II) if the penalty is imposed on the facility for a deficiency that is found to result in a pattern of harm or widespread harm, immediately jeopardizes the health or safety of a resident or residents of the facility, or results in the death of a resident of the facility.

(IV) COLLECTION OF CIVIL MONEY PENALTIES.—In the case of a civil money penalty imposed under this clause, the Secretary shall issue regulations that—

(aa) subject to item (cc), not later than 30 days after the imposition of the penalty, provide for the facility to have the opportunity to participate in an independent informal dispute resolution process which generates a written record prior to the collection of such penalty;

(bb) in the case where the penalty is imposed for each day of noncompliance, provide that a penalty may not be imposed for any day during the period beginning on the initial day of the imposition of the penalty and ending on the day on which the informal dispute resolution process under item (aa) is completed;

(cc) may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the Secretary on the earlier of the date on which the informal dispute resolution process under item (aa) is completed or the date that is 90 days after the date of the imposition of the penalty;

(dd) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

(ee) in the case where the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

(ff) in the case where all such appeals are unsuccessful, may provide that some portion of such amounts collected may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities implementing quality assurance programs, the appointment of temporary management firms, and other activities approved by the Secretary).

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(4) IMMEDIATE TERMINATION OF PARTICIPATION FOR FACILITY WHERE SECRETARY FINDS NONCOMPLIANCE AND IMMEDIATE JEOPARDY.—If the Secretary finds that a skilled nursing facility has not met a requirement of subsection (b), (c), or (d), and finds that the failure immediately jeopardizes the health or safety of its residents, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in paragraph (2)(B)(iii), or the Secretary, subject to section 1128I(h), shall terminate the facility’s participation under this title. If the facility’s participation under this title is terminated, the State shall provide for the safe and orderly
transfer of the residents eligible under this title consistent with the requirements of subsection (c)(2) and section 1128I(h).

(5) CONSTRUCTION.—The remedies provided under this subsection are in addition to those otherwise available under State or Federal law and shall not be construed as limiting such other remedies, including any remedy available to an individual at common law. The remedies described in clauses (i), (ii)(IV), and (iii) of paragraph (2)(B) may be imposed during the pendency of any hearing.

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(i) NURSING HOME COMPARE WEBSITE.—

(1) INCLUSION OF ADDITIONAL INFORMATION.—

(A) IN GENERAL.—The Secretary shall ensure that the Department of Health and Human Services includes, as part of the information provided for comparison of nursing homes on the official Internet website of the Federal Government for Medicare beneficiaries (commonly referred to as the 'Nursing Home Compare' Medicare website) (or a successor website), the following information in a manner that is prominent, updated on a timely basis, easily accessible, readily understandable to consumers of long-term care services, and searchable:

(i) Staffing data for each facility (including resident census data and data on the hours of care provided per resident per day) based on data submitted under section 1128I(g), including information on staffing turnover and tenure, in a format that is clearly understandable to consumers of long-term care services and allows such consumers to compare differences in staffing between facilities and State and national averages for the facilities. Such format shall include—

(I) concise explanations of how to interpret the data (such as a plain English explanation of data reflecting 'nursing home staff hours per resident day');

(II) differences in types of staff (such as training associated with different categories of staff);

(III) the relationship between nurse staffing levels and quality of care; and

(IV) an explanation that appropriate staffing levels vary based on patient case mix.

(ii) Links to State Internet websites with information regarding State survey and certification programs, links to Form 2567 State inspection reports (or a successor form) on such websites, information to guide consumers in how to interpret and understand such reports, and the facility plan of correction or other response to such report. Any such links shall be posted on a timely basis.

(iii) The standardized complaint form developed under section 1128I(f), including explanatory material on what complaint forms are, how they are used, and how to file a complaint with the State survey and certification program and the State long-term care ombudsman program.

(iv) Summary information on the number, type, severity, and outcome of substantiated complaints.

(v) The number of adjudicated instances of criminal violations by a facility or the employees of a facility—

(I) that were committed inside the facility;

(II) with respect to such instances of violations or crimes committed inside of the facility that were the violations or crimes of abuse, neglect, and exploitation, criminal sexual abuse, or other violations or crimes that resulted in serious bodily injury; and

(III) the number of civil monetary penalties levied against the facility, employees, contractors, and other agents.

(B) DEADLINE FOR PROVISION OF INFORMATION.—

(i) IN GENERAL.—Except as provided in clause (ii), the Secretary shall ensure that the information described in subparagraph (A) is included on such website (or a successor website) not later than 1 year after the date of the enactment of this subsection.

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(ii) EXCEPTION.—The Secretary shall ensure that the information described in subparagraph (A)(i) is included on such website (or a successor website) not later than the date on which the requirements under section 1128I(g) are implemented.

(2) REVIEW AND MODIFICATION OF WEBSITE.—
   (A) IN GENERAL.—The Secretary shall establish a process—
      (i) to review the accuracy, clarity of presentation, timeliness, and comprehensiveness of information reported on such website as of the day before the date of the enactment of this subsection; and
      (ii) not later than 1 year after the date of the enactment of this subsection, to modify or repurpose such website in accordance with the review conducted under clause (i).
   (B) CONSULTATION.—In conducting the review under subparagraph (A)(i), the Secretary shall consult with—
      (i) State long-term care ombudsman programs;
      (ii) consumer advocacy groups;
      (iii) provider stakeholder groups; and
      (iv) any other representatives of programs or groups the Secretary determines appropriate.

(j) CONSTRUCTION.—Where requirements or obligations under this section are identical to those provided under section 1919 of this Act, the fulfillment of those requirements or obligations under section 1919 shall be considered to be the fulfillment of the corresponding requirements or obligations under this section.

[Explanation at ¶ 513.]

2010 Amendments:
Sec. 6103(a)(3) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective one year after March 23, 2010, amended sec. 1819(b) by adding at the end the new subparagraph (B).
Sec. 6103(c)(1) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective one year after March 23, 2010, the date of enactment, amended sec. 1819(h)(2)(B)(ii) by striking “PENALTIES.—The Secretary” and inserting “PENALTIES.—and then subclause (I) and by adding at the end the new subclauses (II), (III), and (IV).”
Sec. 6111(a)(2) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective one year after March 23, 2010, the date of enactment, amended sec. 1819(i)(1)(B)(ii) by inserting “subsection (c)(2)” and inserting “subsection (c)(2) and section 1128I(h).”
Sec. 6121(a)(1) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective one year after March 23, 2010, the date of enactment, amended sec. 1819(g)(5) by adding at the end the new subparagraph (F).
Social Security Act, As Amended

[¶ 15,281] Sec. 1820. Medicare Rural Hospital Flexibility Program

[42 U.S.C. § 1395i-4]

***(g) GRANTS.—***

**(3) UPGRADING DATA SYSTEMS.—** The Secretary may award grants to hospitals that have submitted applications in accordance with subparagraph (C) to assist eligible small rural hospitals in meeting the costs of implementing data systems required to meet requirements established under the medicare program pursuant to amendments made by the Balanced Budget Act of 1997 and to assist such hospitals in participating in delivery system reforms under the provisions of and amendments made by the Patient Protection and Affordable Care Act, such as value-based purchasing programs, accountable care organizations under section 1899, the National pilot program on payment bundling under section 1866D, and other delivery system reform programs determined appropriate by the Secretary.

***(E) USE OF FUNDS.—** A hospital receiving a grant under this paragraph may use the funds for the purchase of computer software and hardware, the education and training of hospital staff on computer information systems, to offset costs related to the implementation of prospective payment systems and to participate in delivery system reforms under the provisions of and amendments made by the Patient Protection and Affordable Care Act, such as value-based purchasing programs, accountable care organizations under section 1899, the National pilot program on payment bundling under section 1866D, and other delivery system reform programs determined appropriate by the Secretary.

***(j) AUTHORIZATION OF APPROPRIATIONS.—** There are authorized to be appropriated from the Federal Hospital Insurance Trust Fund for making grants to all States under subsection (g), $25,000,000 in each of fiscal years 1998 through 2002, for making grants to all States under paragraphs (1) and (2) of subsection (g), $35,000,000 in each of fiscal years 2003 through 2008, for making grants to all States under paragraphs (1) and (2) of subsection (g), $55,000,000 in each of fiscal years 2009 and 2010, for making grants to all States under paragraph (6) of subsection (g), $50,000,000 in each of fiscal years 2009 and 2010, to remain available until expended and for making grants to all States under subsection (g), such sums as may be necessary in each of fiscal years 2011 and 2012, to remain available until expended.

[Explanation at ¶ 945].

2010 Amendments:

Sec. 3129(a) of the “Patient Protection and Affordable Care Act” (Pub.L.No 111-148), effective for grants made on or after Jan. 1, 2010, amended sec. 1820(j) by striking “2010, and for” and inserting “2010, for” and by inserting “and for making grants to all States under subsection (g), such sums as may be necessary in each of fiscal years 2011 and 2012, to remain available until expended” before the period at the end.

Sec. 3129(b) of the “Patient Protection and Affordable Care Act” (Pub.L.No 111-148), effective for grants made on or after Jan. 1, 2011, amended sec. 1820(g)(3) in subparagraph (A), by inserting “and to assist such hospitals in participating in delivery system reforms under the provisions of and amendments made by the Patient Protection and Affordable Care Act, such as value-based purchasing programs, accountable care organizations under section 1899, the National pilot program on payment bundling under section 1866D, and other delivery system reform programs determined appropriate by the Secretary” before the period at the end.
[¶ 15,291] Sec. 1833. Payment of Benefits

[42 U.S.C. § 1395l]

(a) ***

(K) with respect to certified nurse-midwife services under section 1861(s)(2)(L), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph (but in no event shall such fee schedule exceed 65 percent of the prevailing charge that would be allowed for the same service performed by a physician, or, for services furnished on or after January 1, 1992, 65 percent (or 100 percent for services furnished on or after January 1, 2011) of the fee schedule amount provided under section 1848 for the same service performed by a physician).

(N) with respect to expenses incurred for physicians’ services (as defined in section 1848(j)(3)) other than personalized prevention plan services (as defined in section 1861(hhh)(1)), the amounts paid shall be 80 percent of the payment basis determined under section 1848(a)(1),

(T) with respect to medical nutrition therapy services (as defined in section 1861(vv)), the amount paid shall be 80 percent (or 100 percent if such services are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population and are appropriate for the individual) of the lesser of the actual charge for the services or 85 percent of the amount determined under the fee schedule established under section 1848(b) for the same services if furnished by a physician,

(V) notwithstanding subparagraphs (I) (relating to durable medical equipment), (M) (relating to prosthetic devices and orthotics and prosthetics), and (Q) (relating to items), with respect to competitively priced items and services (described in section 1847(a)(2)) that are furnished in a competitive area, the amounts paid shall be the amounts described in section 1847(b)(5),

(W) with respect to additional preventive services (as defined in section 1861(ddd)(1)), the amount paid shall be (i) in the case of such services which are clinical diagnostic laboratory tests, the amount determined under subparagraph (D) (if such subparagraph were applied, by substituting “100 percent” for “80 percent”), and (ii) in the case of all other such services, 100 percent of the lesser of the actual charge for the service or the amount determined under a fee schedule established by the Secretary for purposes of this subparagraph,

(X) with respect to personalized prevention plan services (as defined in section 1861(hhh)(1)), the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined under the payment basis determined under section 1848,

(Y) with respect to preventive services described in subparagraphs (A) and (B) of section 1861(ddd)(3) that are appropriate for the individual and, in the case of such services described in subparagraph (A), are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population, the amount paid shall be 100 percent of (i) except as provided in clause (ii), the lesser of the actual charge for the services or the amount determined under the fee schedule that applies to such services under this part, and (ii) in the case of such services that are covered OPD services (as defined in subsection (t)(1)(B)), the amount determined under subsection (t), and

(Z) with respect to Federally qualified health center services for which payment is made under section 1834(o), the amounts paid shall be 80 percent of the lesser of the actual charge or the amount determined under such section;
(F) with respect to a covered osteoporosis drug (as defined in section 1861(kk)) furnished by a home health agency, 80 percent of the reasonable cost of such service, as determined under section 1861(v);

(G) ***

(ii) the customary charges with respect to such services;

(H) with respect to personalized prevention plan services (as defined in section 1861(hhh)(1)) furnished by an outpatient department of a hospital, the amount determined under paragraph (1)(X); and

(I) with respect to preventive services described in subparagraphs (A) and (B) of section 1861(ddd)(3) that are appropriate for the individual and are furnished by an outpatient department of a hospital and, in the case of such services described in subparagraph (A), are recommended with a grade A or B by the United States Preventive Services Task Force for any indication or population, the amount determined under paragraph (1)(W) or (1)(Y),

(3)

(B)(i) the amount of payment that would have otherwise been provided

(I) under subparagraph (A) (calculated as if “100 percent” were substituted for “80 percent” in such subparagraph) for such services if the individual had not been so enrolled, or

(II) in the case of such services furnished on or after the implementation date of the prospective payment system under section 1834(o), under such section (calculated as if ‘100 percent’ were substituted for ‘80 percent’ in such section) for such services if the individual had not been so enrolled; exceeds

Paragraph (3)(A) shall not apply to Federally qualified health center services furnished on or after the implementation date of the prospective payment system under section 1834(o). [sic] [CCH note: There is no section 1834(0); there is a section 1834(o).]

(b)

(1) such total amount shall not include expenses incurred for preventive services described in subparagraph (A) of section 1861(ddd)(3) that are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population and are appropriate for the individual.

(8) such deductible shall not apply with respect to colorectal cancer screening tests (as described in section 1861(pp)(1)),
reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence. The deductible under the previous sentence for blood or blood cells furnished an individual in a year shall be reduced to the extent that a deductible has been imposed under section 1813(a)(2) of this title to blood or blood cells furnished the individual in the year. Paragraph (1) of the first sentence of this subsection shall apply with respect to a colorectal cancer screening test regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as the screening test.

(g)

(5) With respect to expenses incurred during the period beginning on January 1, 2006, and ending on December 31, 2010, for services, the Secretary shall implement a process under which an individual enrolled under this part may, upon request of the individual or a person on behalf of the individual, obtain an exception from the uniform dollar limitation specified in paragraph (2), for services described in paragraphs (1) and (3) if the provision of such services is determined to be medically necessary. Under such process, if the Secretary does not make a decision on such a request for an exception within 10 business days of the date of the Secretary’s receipt of the request, the Secretary shall be deemed to have found the services to be medically necessary.

(h)

(2)(A)(i) Except as provided in paragraph (4), the Secretary shall set the fee schedules at 60 percent (or, in the case of a test performed by a qualified hospital laboratory (as defined in paragraph (1)(D)) for outpatients of such hospital, 62 percent) of the prevailing charge level determined pursuant to the third and fourth sentences of section 1842(b)(3) for similar clinical diagnostic laboratory tests for the applicable region, State, or area for the 12-month period beginning July 1, 1984, adjusted annually (to become effective on January 1 of each year) by, subject to clause (iv), a percentage increase or decrease equal to the percentage increase or decrease in the Consumer Price Index for All Urban Consumers (United States city average), minus, for each of the years 2009 and 2010, 0.5 percentage points and subject to such other adjustments as the Secretary determines are justified by technological changes.

(iv) After determining the adjustment to the fee schedules under clause (i), the Secretary shall reduce such adjustment—

(I) for 2011 and each subsequent year, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

(II) for each of 2011 through 2015, by 1.75 percentage points.

Subclause (I) shall not apply in a year where the adjustment to the fee schedules determined under clause (i) is 0.0 or a percentage decrease for a year. The application of the productivity adjustment under subclause (I) shall not result in an adjustment to the fee schedules under clause (i) being less than 0.0 for a year. The application of subclause (II) may result in an adjustment to the fee schedules under clause (i) being less than 0.0 for a year, and may result in payment rates for a year being less than such payment rates for the preceding year.

(i)
In implementing the system described in clause (i) for 2011 and each subsequent year, any annual update under such system for the year, after application of clause (iv), shall be reduced by the productivity adjustment described in section 1886(b)(3)(B)(ix)(II). The application of the preceding sentence may result in such update being less than 0.0 for a year, and may result in payment rates under the system described in clause (i) for a year being less than such payment rates for the preceding year.

There shall be no administrative or judicial review under section 1869, 1878, or otherwise, of the classification system, the relative weights, payment amounts, and the geographic adjustment factor, if any, under this subparagraph.

Prospective Payment for Hospital Outpatient Department Services.—

(iv) does not include any therapy services described in subsection (a)(8) or ambulance services, for which payment is made under a fee schedule described in section 1834(k) or section 1834(l) and does not include screening mammography (as defined in section 1861(jj)), diagnostic mammography, personalized prevention plan services (as defined in section 1861(hhh)(1)), or preventive services described in subparagraphs (A) and (B) of section 1861(ddd)(3) that are appropriate for the individual and, in the case of such services described in subparagraph (A), are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population.

subject to paragraph (19), the Secretary shall determine a wage adjustment factor to adjust the portion of payment and coinsurance attributable to labor-related costs for relative differences in labor and labor-related costs across geographic regions in a budget neutral manner;

OPD Fee Schedule Increase Factor.—For purposes of this subparagraph, subject to paragraph (17) and subparagraph (F) of this paragraph, the "OPD fee schedule increase factor" for services furnished in a year is equal to the market basket percentage increase applicable under section 1886(b)(3)(B)(iii) to hospital discharges occurring during the fiscal year ending in such year, reduced by 1 percentage point for such factor for services furnished in each of 2000 and 2002. In applying the previous sentence for years beginning with 2000, the Secretary may substitute for the market basket percentage increase an annual percentage increase that is computed and applied with respect to covered OPD services furnished in a year in the same manner as the market basket percentage increase is determined and applied to inpatient hospital services for discharges occurring in a fiscal year.
(F) **PRODUCTIVITY AND OTHER ADJUSTMENT.**—After determining the OPD fee schedule increase factor under subparagraph (C)(iv), the Secretary shall reduce such increase factor—

(i) for 2012 and subsequent years, by the productivity adjustment described in section 1886(b)(3)(B)(ii)(II); and

(ii) for each of 2010 through 2019, by the adjustment described in subparagraph (G).

The application of this subparagraph may result in the increase factor under subparagraph (C)(iv) being less than 0.0 for a year, and may result in payment rates under the payment system under this subsection for a year being less than such payment rates for the preceding year.

(G) **OTHER ADJUSTMENT.**—

For purposes of subparagraph (F)(ii), the adjustment described in this subparagraph is—

(i) for each of 2010 and 2011, 0.25 percentage point;

(ii) for each of 2012 and 2013, 0.1 percentage point

(iii) for 2014, 0.3 percentage point;

(iv) for each of 2015 and 2016, 0.2 percentage point; and

(v) for each of 2017, 2018, and 2019, 0.75 percentage point.

***

(7) ***

(D) ***

(i) ***

(II) In the case of a hospital located in a rural area and that has not more than 100 beds and that is not a sole community hospital (as defined in section 1886(d)(5)(D)(iii)), for covered OPD services furnished on or after January 1, 2006, and before January 1, 2011, for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the applicable percentage of the amount of such difference. For purposes of the preceding sentence, the applicable percentage shall be 95 percent with respect to covered OPD services furnished in 2006, 90 percent with respect to such services furnished in 2007, and 85 percent with respect to such services furnished in 2008, 2009, or 2010.

(III) In the case of a sole community hospital (as defined in section 1886(d)(5)(D)(iii)) that has not more than 100 beds, for covered OPD services furnished on or after January 1, 2009, and before January 1, 2011, for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by 85 percent of the amount of such difference. In the case of covered OPD services furnished on or after January 1, 2010, and before January 1, 2011, the preceding sentence shall be applied without regard to the 100-bed limitation.

***

(18) **AUTHORIZATION OF ADJUSTMENT FOR CANCER HOSPITALS.**—

(A) **STUDY.**—The Secretary shall conduct a study to determine if, under the system under this subsection, costs incurred by hospitals described in section 1886(d)(1)(B)(v) with respect to ambulatory payment classification groups exceed those costs incurred by other hospitals furnishing services under this subsection (as determined appropriate by the Secretary). In conducting the study under this subparagraph, the Secretary shall take into consideration the cost of drugs and biologicals incurred by such hospitals.

(B) **AUTHORIZATION OF ADJUSTMENT.**—Insofar as the Secretary determines under subparagraph (A) that costs incurred by hospitals described in section 1886(d)(1)(B)(v) exceed those costs incurred by other hospitals furnishing services under this subsection, the Secretary shall provide for an
appropriate adjustment under paragraph (2)(E) to reflect those higher costs effective for services furnished on or after January 1, 2011.

(19) **Floor on Area Wage Adjustment Factor for Hospital Outpatient Department Services in Frontier States.**—

(A) **In General.**—Subject to subparagraph (B), with respect to covered OPD services furnished on or after January 1, 2011, the area wage adjustment factor applicable under the payment system established under this subsection to any hospital outpatient department which is located in a frontier State (as defined in section 1886(d)(3)(E)(iii)(II)) may not be less than 1.00. The preceding sentence shall not be applied in a budget neutral manner.

(B) **Limitation.**—This paragraph shall not apply to any hospital outpatient department located in a State that receives a non-labor related share adjustment under section 1886(d)(5)(H).

(x) **Incentive Payments for Primary Care Services.**—

(1) **In General.**—In the case of primary care services furnished on or after January 1, 2011, and before January 1, 2016, by a primary care practitioner, in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid (on a monthly or quarterly basis) an amount equal to 10 percent of the payment amount for the service under this part.

(2) **Definitions.**—In this subsection:

(A) **Primary Care Practitioner.**—The term 'primary care practitioner' means an individual—

(i) who—

(I) is a physician (as described in section 1861(r)(1)) who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or

(II) is a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in section 1861(aa)(5)); and

(ii) for whom primary care services accounted for at least 60 percent of the allowed charges under this part for such physician or practitioner in a prior period as determined appropriate by the Secretary.

(B) **Primary Care Services.**—The term 'primary care services' means services identified, as of January 1, 2009, by the following HCPCS codes (and as subsequently modified by the Secretary):

(i) 99201 through 99215.

(ii) 99304 through 99340.

(iii) 99341 through 99350.

(3) **Coordination with Other Payments.**—The amount of the additional payment for a service under this subsection and subsection (m) shall be determined without regard to any additional payment for the service under subsection (m) and this subsection, respectively.

(4) **Limitation on Review.**—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting the identification of primary care practitioners under this subsection.

(y) **Incentive Payments for Major Surgical Procedures Furnished in Health Professional Shortage Areas.**—

(1) **In General.**—In the case of major surgical procedures furnished on or after January 1, 2011, and before January 1, 2016, by a general surgeon in an area that is designated (under section 332(a)(1)(A) of the Public Health Service Act) as a health professional shortage area as identified by the Secretary prior to the beginning of the year involved, in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid (on a monthly or quarterly basis) an amount equal to 10 percent of the payment amount for the service under this part.

(2) **Definitions.**—In this subsection:
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(A) GENERAL SURGEON.—In this subsection, the term 'general surgeon' means a physician (as described in section 1861(r)(1)) who has designated CMS specialty code 02-General Surgery as their primary specialty code in the physician's enrollment under section 1866(i).

(B) MAJOR SURGICAL PROCEDURES.—The term 'major surgical procedures' means physicians’ services which are surgical procedures for which a 10-day or 90-day global period is used for payment under the fee schedule under section 1848(b).

(3) COORDINATION WITH OTHER PAYMENTS.—The amount of the additional payment for a service under this subsection and subsection (m) shall be determined without regard to any additional payment for the service under subsection (m) and this subsection, respectively.

(4) APPLICATION.—The provisions of paragraph (2) and (4) of subsection (m) shall apply to the determination of additional payments under this subsection in the same manner as such provisions apply to the determination of additional payments under subsection (m).

[Explanation at ¶ 840, ¶ 850, ¶ 905, ¶ 950, ¶ 1040, ¶ 1345, ¶ 1355, ¶ 1417, ¶ 1419 and ¶ 1577.]

2010 Amendments:

Sec. 4103(c)(1) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148) amended sec. 1833(a)(1) in subparagraph (N) by inserting “other than personalized prevention plan services (as defined in section 1861(hhh)(1))” after “as defined in section 1848(b)(1)”; by striking “and” before “(W)”; and by inserting new clause (X).

The amendment at 4104(b)(1) was superseded by amendments made by secs. 10406, and 10501(i)(3)(B) and (C) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148).

Sec. 10406 of the “Patient Protection and Affordable Care Act” (PubLNo 111-148) amended sec. 1833(a)(1) in subparagraph (T) by inserting “(or 100 percent if such services are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population and are appropriate for the individual)”; in subparagraph (W), in clause (i) by inserting “(if such subparagraph were applied, by substituting “100 percent” for “80 percent”)” after subparagraph (D) and in clause (ii), by striking “80 percent” and inserting “100 percent”;

by striking “and” before “(X)”; and inserting the text of new clause (Y).

Sec. 10501(i)(3)(B) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148) amended sec. 1833(a)(1) by striking “and” before “(Y)”; and inserting new clause (Z).

Sec. 10501(i)(3)(C) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148) amended sec. 1833(a)(1) in paragraph (3)(B)(i), by inserting “(I)” after “otherwise been provided”; by inserting “, or (B) in the case of such services furnished on or after the implementation date of the prospective payment system under section 1834(o), under such section (calculated as if “100 percent” were substituted for “80 percent” in such section) for such services if the individual had not been so enrolled” after “been so enrolled”; and, by adding at the end [just before (4) starts] the following flush left sentence: “Paragraph (3)(A) shall not apply to Federally qualified health center services furnished on or after the implementation date of the prospective payment system under section 1834(o).”

Sec. 4103(c)(3)(B) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective for services furnished on or after Jan. 1, 2011, amended sec. 1833(a)(2) by making following changes:

in subparagraph (F), by striking “and” at the end;

in subparagraph (G)(ii), by striking the comma at the end and inserting “; ”;

by inserting after subparagraph (G)(ii) new subparagraph (H).

Sec. 4104(b)(2)(B) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective for services furnished on or after Jan. 1, 2011, amended sec. 1833(a)(2) by making following changes:

in subparagraph (G)(ii), by striking “and” after the semicolon at the end;

in subparagraph (H), by striking the comma at the end and inserting “; ”;

by inserting after subparagraph (H) new subparagraph (I).

Sec. 4104(c)(4) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective for services furnished on or after Jan. 1, 2011, amended sec. 1833(b) by making following changes:

by striking “and” before “(9)”;

by inserting before the period the following: “, subject to clause (iv),” after “year) by”;

by inserting after subparagraph (H) new subparagraph (I).

Sec. 10406 of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective for services furnished on or after Jan. 1, 2011, amended sec. 1833(b) by making following changes:

in paragraph (1), by striking “items and services described in section 1861(ddd)(3) that are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population and are appropriate for the individual”;

by adding at the end the following new sentence: “Paragraph (1) of the first sentence of this subsection shall apply with respect to a colorectal cancer screening test regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as the screening test.”

Sec. 3401(i) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1833(h)(2)(A) by making following changes:

in clause (i), by inserting “, subject to clause (iv),” after “year) by”;

by striking “through 2013” and inserting “and 2010”;

by adding at the end new clause (iv) after clause (iii).
Sec. 3121(a)(2) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1833(t)(19)(C)(i) by striking “and diagnostic mammography” and inserting “or personalized prevention plan services (as defined in section 1861(jj)(1))”.

Sec. 3121(b) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1833(t)(3)(G)(ii). Prior to removal, clause (ii) read as follows: “(ii) Reduction of other adjustment. Clause (i)(II) shall be applied with respect to any of 2014 through 2019 by substituting ‘0.0 percentage points’ for ‘0.2 percentage point’, if for such year——

“(I) the excess (if any) of——

“(AA) the total percentage of the non-elderly insured population for the preceding year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); or——

“(BB) the total percentage of the non-elderly insured population for the preceding year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over——

“(II) 5 percentage points.”.

Sec. 1105(e)(3) of the “Health Care Reconciliation Act of 2010” (PubLNo 111-152), effective March 30, 2010, removed sec. 1833(t)(3)(G)(ii) by striking “and” at the end; redesignating subclause (II) as subclause (III); and, in the case of such services described in subparagraph (A), are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population”.

Sec. 3121(b)(1) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1833 by adding new subsection (y) after (x).

Sec. 1105(e)(1) of the “Health Care Reconciliation Act of 2010” (PubLNo 111-152), effective March 30, 2010, amended sec. 1833(t)(7)(D)(i)(III) by adding at the end the following new sentence: “In the case of covered OPD services furnished on or after January 1, 2010, and before January 1, 2011, the preceding sentence shall be applied without regard to the 100-bed limitation.”.

Sec. 5501(a)(1) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1833 by adding new subsection (s) after (w).

Sec. 5501(b)(1) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1833 by adding new subsection (s) after (w).

Sec. 3121(a)(2) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1833(t)(3)(G)(ii) by striking “and diagnostic mammography” and inserting “or personalized prevention plan services (as defined in section 1861(jj)(1))”.

Sec. 3121(b) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1833(t)(3)(G)(ii) by striking “and” at the end of clause (ii) and by striking subclause (III) and inserting new subclauses (III) - (V). Prior to replacement, subclause (III) read as follows: “subject to clause (ii), for each of 2014 through 2019, 0.2 percentage point.”.

Sec. 1105(e)(2) of the “Health Care Reconciliation Act of 2010” (PubLNo 111-152), effective March 30, 2010, amended sec. 1833(t)(3)(G)(ii) by striking “and” at the end of clause (ii) and by striking subclause (III) and inserting new subclauses (III) - (V). Prior to replacement, subclause (III) read as follows: “(ii) Reduction of other adjustment. Clause (i) shall be applied with respect to any of 2014 through 2019 by substituting ‘0.0 percentage points’ for ‘0.2 percentage point’, if for such year——

“(I) the excess (if any) of——

“(AA) the total percentage of the non-elderly insured population for the preceding year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over——

“(BB) the total percentage of the non-elderly insured population for the preceding year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over——

“(II) 5 percentage points.”.

Sec. 1105(e)(3) of the “Health Care Reconciliation Act of 2010” (PubLNo 111-152), effective March 30, 2010, removed sec. 1833(t)(3)(G)(ii) by striking “and” at the end; redesignating subclauses (I) through (V) as clauses (i) through (v).
(i) the payment basis under this subsection for such items and services furnished in such area shall be the payment basis determined under such competitive acquisition program;

(ii) the Secretary may (and, in the case of covered items furnished on or after January 1, 2016, subject to clause (iii), shall) use information on the payment determined under such competitive acquisition programs to adjust the payment amount otherwise recognized under subparagraph (B) for an area that is not a competitive acquisition area under section 1847 and in the case of such adjustment, paragraph (10)(B) shall not be applied; and

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

***

Caution: The amendments made by sec. 3136(a) of the Patient Protection and Affordable Care Act (PubL No 111-148) shall not apply to payment made for items and services furnished pursuant to contracts entered into under section 1847 of the Social Security Act prior to January 1, 2011, pursuant to the implementation of subsection (a)(1)(B)(i)(I) of such section 1847.

(7)(A) ***

(i) ***

(II) PAYMENT AMOUNT.—Subject to subclause (III) and subparagraph (B), the amount recognized for the item, for each of the first 3 months of such period, is 10 percent of the purchase price recognized under paragraph (8) with respect to the item, and, for each of the remaining months of such period, is 7.5 percent of such purchase price.

(III) SPECIAL RULE FOR POWERDRIVEN WHEELCHAIRS.—For purposes of payment for power-driven wheelchairs, subclause (II) shall be applied by substituting '15 percent' and '6 percent' for '10 percent' and '7.5 percent', respectively.

***

(iii) PURCHASE AGREEMENT OPTION FOR COMPLEX, REHABILITATIVE POWER-DRIVEN WHEELCHAIRS.—In the case of a complex, rehabilitative power-driven wheelchair, at the time the supplier furnishes the item, the supplier shall offer the individual the option to purchase the item, and payment for such item shall be made on a lump-sum basis if the individual exercises such option.

***

(C) ***

(ii) ***

(II) in the case of an item for which a purchase agreement has been entered into under subparagraph (A)(iii), in a lump-sum amount for the purchase of the item.

***

(11) ***

(B) REQUIREMENT OF PHYSICIAN ORDER.—(i) IN GENERAL.—The Secretary is authorized to require, for specified covered items, that payment may be made under this subsection with
(ii) Requirement for Face to Face Encounter.—The Secretary shall require that such an order be written pursuant to the physician documenting that a physician, a physician assistant, a nurse practitioner, or a clinical nurse specialist (as those terms are defined in section 1861(aa)(5)) has had a face-to-face encounter (including through use of telehealth under subsection (m) and other than with respect to encounters that are incident to services involved) with the individual involved during the 6-month period preceding such written order, or other reasonable timeframe as determined by the Secretary.

(K) for 2010, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year; and (L) for 2011 and each subsequent year—

(i) the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year, reduced by—

(ii) the productivity adjustment described in section 1886(b)(3)(B)(xi)(II).

The application of subparagraph (L)(ii) may result in the covered item update under this paragraph being less than 0.0 for a year, and may result in payment rates under this subsection for a year being less than such payment rates for the preceding year.

(B) with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000 that the Secretary determines is commensurate with the volume of the billing of the supplier.

(i) subject to clause (ii) and subparagraph (G), the Secretary shall require suppliers furnishing items and services described in subparagraph (D) on or after October 1, 2009, directly or as a subcontractor for another entity, to have submitted to the Secretary evidence of accreditation by an accreditation organization designated under subparagraph (B) as meeting applicable quality standards, except that the Secretary shall not require under this clause pharmacies to obtain such accreditation before January 1, 2010, except that the Secretary shall not require a pharmacy to have submitted to the Secretary such evidence of accreditation prior to January 1, 2011; and

(G) Application of Accreditation Requirement to Certain Pharmacies.—

(i) In General.—

With respect to items and services furnished on or after January 1, 2011, in implementing quality standards under this paragraph—

(I) subject to subclause (II), in applying such standards and the accreditation requirement of subparagraph (F)(i) with respect to pharmacies described in clause (ii) furnishing such items and services, such standards and accreditation requirement shall not apply to such pharmacies; and
(II) the Secretary may apply to such pharmacies an alternative accreditation require-
ment established by the Secretary if the Secretary determines such alternative accreditation
requirement is more appropriate for such pharmacies.

(ii) PHARMACIES DESCRIBED.—

A pharmacy described in this clause is a pharmacy that meets each of the following criteria:

(I) The total billings by the pharmacy for such items and services under this title are
less than 5 percent of total pharmacy sales, as determined based on the average total
pharmacy sales for the previous 3 calendar years, 3 fiscal years, or other yearly period
specified by the Secretary.

(II) The pharmacy has been enrolled under section 1866(j) as a supplier of durable
medical equipment, prosthetics, orthotics, and supplies, has been issued (which may include
the renewal of) a provider number for at least 5 years, and for which a final adverse action
(as defined in section 424.57(a) of title 42, Code of Federal Regulations) has not been
imposed in the past 5 years.

(III) The pharmacy submits to the Secretary an attestation, in a form and manner, and
at a time, specified by the Secretary, that the pharmacy meets the criteria described in
subclauses (I) and (II). Such attestation shall be subject to section 1001 of title 18, United
States Code.

(IV) The pharmacy agrees to submit materials as requested by the Secretary, or during
the course of an audit conducted on a random sample of pharmacies selected annually, to
verify that the pharmacy meets the criteria described in subclauses (I) and (II). Materials
submitted under the preceding sentence shall include a certification by an accountant on
behalf of the pharmacy or the submission of tax returns filed by the pharmacy during the
relevant periods, as requested by the Secretary.

***

(g) ***

(2) ***

(A) FACILITY FEE.—With respect to facility services, not including any services for which
payment may be made under subparagraph (B), 101 percent of the reasonable costs of the
critical access hospital in providing such services.

(B) FEE SCHEDULE FOR PROFESSIONAL SERVICES.—With respect to professional services other-
wise included within outpatient critical access hospital services, 115 percent of such
amounts as would otherwise be paid under this part if such services were not included in
outpatient critical access hospital services. Subsections (x) and (y) of section 1833 shall not be
taken into account in determining the amounts that would otherwise be paid pursuant to the
preceding sentence.

***

(h) ***

(4) ***

(A) ***

(ix) for 2004, 2005, and 2006, 0 percent;

(x) for each of 2007 through 2010, the percentage increase in the consumer price
index for all urban consumers (United States city average) for the 12-month period
ending with June of the previous year; and
(xi) for 2011 and each subsequent year—

(I) the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year, reduced by—

(II) the productivity adjustment described in section 1886(b)(3)(B)(xi)(II).

***

The application of subparagraph (A)(xi)(II) may result in the applicable percentage increase under subparagraph (A) being less than 0.0 for a year, and may result in payment rates under this subsection for a year being less than such payment rates for the preceding year.

***

(3)

(A) ensure that the aggregate amount of payments made for ambulance services under this part during 2000 does not exceed the aggregate amount of payments which would have been made for such services under this part during such year if the amendments made by section 4531(a) of the Balanced Budget Act of 1997 continued in effect, except that in making such determination the Secretary shall assume an update in such payments for 2002 equal to the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year reduced in the case of 2002 by 1.0 percentage points;

(B) set the payment amounts provided under the fee schedule for services furnished in 2001 and each subsequent year at amounts equal to the payment amounts under the fee schedule for services furnished during the previous year, increased, subject to subparagraph (C) and the succeeding sentence of this paragraph, by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year reduced in the case of 2002 by 1.0 percentage points; and

(C) for 2011 and each subsequent year, after determining the percentage increase under subparagraph (B) for the year, reduce such percentage increase by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II).

The application of subparagraph (C) may result in the percentage increase under subparagraph (B) being less than 0.0 for a year, and may result in payment rates under the fee schedule under this subsection for a year being less than such payment rates for the preceding year.

***

(8) SERVICES FURNISHED BY CRITICAL ACCESS HOSPITALS.—Notwithstanding any other provision of this subsection, the Secretary shall pay 101 percent of the reasonable costs incurred in furnishing ambulance services if such services are furnished—

***

(12)(A) IN GENERAL.—In the case of ground ambulance services furnished on or after July 1, 2004, and before January 1, 2011, for which the transportation originates in a qualified rural area (identified under subparagraph (B)(iii)), the Secretary shall provide for a percent increase in the base rate of the fee schedule for a trip established under this subsection. In establishing such percent increase, the Secretary shall estimate the average cost per trip for such services (not taking into account mileage) in the lowest quartile as compared to the average cost per trip for such services (not taking into account mileage) in the highest quartile of all rural county populations.

(13) TEMPORARY INCREASE FOR GROUND AMBULANCE SERVICES.—

(A) IN GENERAL.—After computing the rates with respect to ground ambulance services under the other applicable provisions of this subsection, in the case of such services...
furnished on or after July 1, 2004, and before January 1, 2007, and for such services furnished on or after July 1, 2008, and before January 1, 2011, for which the transportation originates in—

(i) a rural area described in paragraph (9) or in a rural census tract described in such paragraph, the fee schedule established under this section shall provide that the rate for the service otherwise established, after the application of any increase under paragraphs (11) and (12), shall be increased by 2 percent (or 3 percent if such service is furnished on or after July 1, 2008, and before January 1, 2011); and

(ii) an area not described in clause (i), the fee schedule established under this subsection shall provide that the rate for the service otherwise established, after the application of any increase under paragraph (11), shall be increased by 1 percent (or 2 percent if such service is furnished on or after July 1, 2008, and before January 1, 2011).

Caution: Secs. 4105(a) and 5502(b) of the Patient Protection and Affordable Care Act (PubLNo 111-148) both added a new Social Security Act sec. 1834(n). Both new subsections are added below.

(n) AUTHORITY TO MODIFY OR ELIMINATE COVERAGE OF CERTAIN PREVENTIVE SERVICES.—Notwithstanding any other provision of this title, effective beginning on January 1, 2010, if the Secretary determines appropriate, the Secretary may—

(1) modify—

(A) the coverage of any preventive service described in subparagraph (A) of section 1861(ddd)(3) to the extent that such modification is consistent with the recommendations of the United States Preventive Services Task Force; and

(B) the services included in the initial preventive physical examination described in subparagraph (B) of such section; and

(2) provide that no payment shall be made under this title for a preventive service described in subparagraph (A) of such section that has not received a grade of A, B, C, or I by such Task Force.

(n) DEVELOPMENT AND IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.—

(1) DEVELOPMENT.—

(A) IN GENERAL.—The Secretary shall develop a prospective payment system for payment for Federally qualified health services furnished by Federally qualified health centers under this title. Such system shall include a process for appropriately describing the services furnished by Federally qualified health centers.

(B) COLLECTION OF DATA AND EVALUATION.—The Secretary shall require Federally qualified health centers to submit to the Secretary such information as the Secretary may require in order to develop and implement the prospective payment system under this paragraph and paragraph (2), respectively, including the reporting of services using HCPCS codes.

(2) IMPLEMENTATION.—

(A) IN GENERAL.—Notwithstanding section 1833(a)(3)(B), the Secretary shall provide, for cost reporting periods beginning on or after October 1, 2014, for payments for Federally qualified health services furnished by Federally qualified health centers under this title in accordance with the prospective payment system developed by the Secretary under paragraph (1).

(B) PAYMENTS.—

(i) INITIAL PAYMENTS.—The Secretary shall implement such prospective payment system so that the estimated amount of expenditures under this title for Federally qualified health services in the first year that the prospective payment system is implemented is equal to 103 percent of the estimated amount of expenditures under this title that would have occurred for such services in such year if the system had not been implemented.

(ii) PAYMENTS IN SUBSEQUENT YEARS.—In the year after the first year of implementation of such system, and in each subsequent year, the payment rate for Federally qualified health
services furnished in the year shall be equal to the payment rate established for such services furnished in the preceding year under this subparagraph increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year involved.

(o) Development and Implementation of Prospective Payment System.—

(1) Development.—

(A) In general.—The Secretary shall develop a prospective payment system for payment for Federally qualified health center services furnished by Federally qualified health centers under this title. Such system shall include a process for appropriately describing the services furnished by Federally qualified health centers and shall establish payment rates for specific payment codes based on such appropriate descriptions of services. Such system shall be established to take into account the type, intensity, and duration of services furnished by Federally qualified health centers. Such system may include adjustments, including geographic adjustments, determined appropriate by the Secretary.

(B) Collection of Data and Evaluation.—By not later than January 1, 2011, the Secretary shall require Federally qualified health centers to submit to the Secretary such information as the Secretary may require in order to develop and implement the prospective payment system under this subsection, including the reporting of services using HCPCS codes.

(2) Implementation.—

(A) In general.—Notwithstanding section 1833(a)(3)(A), the Secretary shall provide, for cost reporting periods beginning on or after October 1, 2014, for payments of prospective payment rates for Federally qualified health center services furnished by Federally qualified health centers under this title in accordance with the prospective payment system developed by the Secretary under paragraph (1).

(B) Payments.—

(i) Initial Payments.—The Secretary shall implement such prospective payment system so that the estimated aggregate amount of prospective payment rates (determined prior to the application of section 1833(a)(1)(Z)) under this title for Federally qualified health center services in the first year that such system is implemented is equal to 100 percent of the estimated amount of reasonable costs (determined without the application of a per visit payment limit or productivity screen and prior to the application of section 1866(a)(2)(A)(ii)) that would have occurred for such services under this title in such year if the system had not been implemented.

(ii) Payments in Subsequent Years.—Payment rates in years after the year of implementation of such system shall be the payment rates in the previous year increased—

(I) in the first year after implementation of such system, by the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year involved; and

(II) in subsequent years, by the percentage increase in a market basket of Federally qualified health center goods and services as promulgated through regulations, or if such an index is not available, by the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year involved.

(C) Preparation for PPS Implementation.—Notwithstanding any other provision of law, the Secretary may establish and implement by program instruction or otherwise the payment codes to be used under the prospective payment system under this section.

[Explanation at ¶830, ¶855, ¶940, ¶1030, ¶1165, ¶1421, ¶1817, ¶1835, ¶1839, ¶1845, ¶1577 and ¶1578.]

2010 Amendments:

Sec. 6410(b) of the “Patient Protection and Affordable Care Act” (Pub.L. No. 111–148), effective March 23, 2010, amended sec. 1834(a)(1)(F), in clause (i), by striking “and” at the end; in clause (ii) by striking “and, in the case of covered items furnished on or after January 1, 2016, subject to clause (iii), shall” after “may”, striking the period at the end and inserting “; and”, and adding at the end new clause (iii). Sec. 6405(a) of the “Patient Protection and Affordable Care Act” (Pub.L. No. 111–148), effective for written orders and certifications made on or after July 1, 2010, amended sec. 1834(a)(11)(B), by striking “physician” and inserting “physician enrolled under section 1866(j) or an eligible pro-
fessional under section 1848(k)(3)(B) that is enrolled under section 1866(j)

Sec. 6407(b) of the "Patient Protection and Affordable Care Act" (PubLNo 111-148), effective March 23, 2010, amended sec. 1834(a)(11)(B), by striking "ORDER—The Secretary" and inserting "ORDER—(i) IN GENERAL.—The Secretary” and adding at the end new clause (ii).

Sec. 3401(m) of the "Patient Protection and Affordable Care Act" (PubLNo 111-148), effective March 23, 2010, amended sec. 1834(a)(14), in subparagraph (K) by striking “2011, 2012, and 2013,” and by inserting “and” after the semicolon at the end and by striking original subparagraphs (L) and (M) and inserting a new subparagraph (L) and a new flush sentence. Prior to amendment, sec. 1834(a)(14)(L) and (M) previously read as follows:

Sec. 6402(g)(1) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1834(a)(16)(B), by inserting “that the Secretary determines is commensurate with the volume of the billing of the supplier” before the period at the end.

Sec. 3109(a)(1) of the "Patient Protection and Affordable Care Act" (PubLNo 111-148), effective March 23, 2010, amended sec. 1834(a)(14)(G) after “clause (ii);” and by inserting “except that the Secretary shall not require a pharmacy to have submitted to the Secretary such evidence of accreditation prior to January 1, 2011” before the semicolon at the end.

Sec. 3109(a)(2) of the "Patient Protection and Affordable Care Act" (PubLNo 111-148), effective March 23, 2010, amended sec. 1834(a)(20), by adding at the end new subparagraph (C).

Sec. 3136(a) of the "Patient Protection and Affordable Care Act” (PubLNo 111-148), effective Jan. 1, 2011, for power-driven wheelchairs furnished on or after that date, amended sec. 1834(a)(7)(A), by making following changes: in subclause (ii)(I), by inserting "subject to;” by adding at the end new subclause (III); in the heading of clause (ii), by inserting "COMPLEX, REHABILITATIVE” before "POWER-DRIVEN” and by inserting “complex, rehabilitative” before "power-driven”.

Sec. 3136(b) of the "Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1834(a)(7)(C)(ii)(II), by striking "(A)(ii)” or.

Sec. 3128 of the "Patient Protection and Affordable Care Act” (PubLNo 111-148), effective for payments for services furnished during cost reporting periods beginning on or after January 1, 2004, amended sec. 1834(g)(2)(A), by inserting "101 percent of” before "the reasonable costs”.

Sec. 5501(a)(2) of the "Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1834(g)(23)(B), by adding at the end new sentence "Section 1833(x) shall not be taken into account in determining the amounts that would otherwise be paid pursuant to the preceding sentence.”

Sec. 5501(b)(2) of the "Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1834(g)(22)(B), by striking "Section 1833(x)" and inserting "Subsections (s) and (y) of section 1833” in the last sentence.

Sec. 3401(n) of the "Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1834(h)(4), in clause (ix) of sec. 1834(h)(4)(A), by striking “and” at the end; in clause (s) of sec. 1834(h)(4)(A) by striking “a subsequent year” and inserting “for each of 2007 through 2010” and by inserting “and” after the semicolon at the end; in sec. 1834(h)(4)(A), by adding at the end new clause (s); and by adding at the end a new flush sentence.

Sec. 3128 of the "Patient Protection and Affordable Care Act” (PubLNo 111-148), effective for payments for services furnished during cost reporting periods beginning on or after January 1, 2004, amended sec. 1834(g)(2)(A), by inserting "101 percent of” before "the reasonable costs”.

Sec. 3105(c) of the "Patient Protection and Affordable Care Act” (PubLNo 111-148), effective for items and services furnished on or after Jan. 1, 2011, amended sec. 1834(i)(12)(A), by striking "2010” and inserting "2010, and on or after April 1, 2010, and before January 1, 2011”.

Sec. 1031(s) of the "Patient Protection and Affordable Care Act” (PubLNo 111-148), effective for items and services furnished on or after Jan. 1, 2011, amended sec. 1834(i)(13)(A), by striking "2010” and inserting "2010, and for such services furnished on or after April 1, 2010, and before January 1, 2011,’ and in each of clauses (i) and (ii), by inserting “, and on or after April 1, 2010, and before January 1, 2011” after “January 1, 2010” each place it applies.

Sec. 1031(a) of the "Patient Protection and Affordable Care Act” (PubLNo 111-148), effective for items and services furnished on or after Jan. 1, 2011, amended sec. 1834(i)(13)(A), by striking “2010” and inserting “2010,” in each of clauses (i) and (ii), by striking “, and on or after April 1, 2010, and before January 1, 2011” each place it appears; and by striking “January 1, 2010” and inserting “January 1, 2011” each place it appears.

Sec. 3401(o) of the "Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1834(i)(3), in subparagraph (B) of sec. 1834(i)(3), by inserting “subject to subparagraph (C) and the succeeding sentence of this paragraph,” after “increased,” by striking the period at the end and inserting “,” and, by adding at the end new subparagraph (C), and by adding at the end a new flush sentence.

Sec. 3128 of the "Patient Protection and Affordable Care Act” (PubLNo 111-148), effective for cost reporting periods beginning on or after Jan. 1, 2004, amended sec. 1834(h)(6), by inserting “101 percent of” before "the reasonable costs”.

Sec. 4105(a) of the "Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1834, by adding at the end new subsection (n).

Sec. 5502(b) of the "Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1834, by adding at the end new subsection (n).

Sec. 10503(i)(3)(A) of the "Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1834, by adding at the end new subsection (o).
Caution: In the case of services furnished before January 1, 2010, a bill or request for payment under section 1835(a), shall be filed not later than December 31, 2010.

(a) ***

(1) written request, signed by such individual, except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the period ending 1 calendar year after the date of service; and

(2) a physician, or, in the case of services described in subparagraph (A), a physician enrolled under section 1866(j), certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations) that—

(A) in the case of home health services (i) such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7)) and needs or needed skilled nursing care (other than solely venipuncture for the purpose of obtaining a blood sample) on an intermittent basis or physical or speech therapy or, in the case of an individual who has been furnished home health services based on such a need and who no longer has such a need for such care or therapy, continues or continued to need occupational therapy, (ii) a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician, (iii) such services are or were furnished while the individual is or was under the care of a physician, and (iv) in the case of a certification after January 1, 2010, prior to making such certification the physician must document that the physician, or a nurse practitioner or clinical nurse specialist (as those terms are defined in section 1861(aa)(5)) who is working in collaboration with the physician in accordance with State law, or a certified nurse-midwife (as defined in section 1861(gg)) as authorized by State law, or a physician assistant (as defined in section 1861(aa)(5)) under the supervision of the physician, has had a face-to-face encounter (including through use of telehealth and other than with respect to encounters that are incident to services involved) with the individual during the 6-month period preceding such certification, or other reasonable timeframe as determined by the Secretary;

***

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician makes a certification of the kind provided in subparagraph (A) or (B) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations. For purposes of this section, the term "provider of services" shall include a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1861(p)(4)(A) (or meets the requirements of such section through the operation of subsection (g) or (ll)(2) of section 1861), or if, in the case of a public health agency, such agency meets the requirements of section 1861(p)(4)(B) (or meets the requirements of such section through the operation of subsection (g) or (ll)(2) of section 1861), but only with respect to the furnishing of outpatient physical therapy services (as therein defined) or (through the operation of subsection (g) or (ll)(2) of section 1861) with respect to the furnishing of outpatient occupational therapy services or outpatient speech-language pathology services, respectively. With respect to the physician certification required by paragraph (2) for home health services furnished to any individual by a home health agency (other than an agency which is a governmental entity) and with respect to the establishment and review of a plan for such services, the Secretary shall prescribe regulations which shall become effective no later than July 1, 1981, and which prohibit a physician who has a significant ownership interest in, or a significant financial or contractual relationship with, such home health agency from performing such certification and from establishing or reviewing such plan, except that such prohibition shall not apply with respect to a home health agency which is a sole community home health agency (as determined by the Secretary). For purposes of the preceding sentence, service by a physician as an uncompensated officer or director of a home health agency

§1835(a)(2)(A) ¶15,311
shall not constitute having a significant ownership interest in, or a significant financial or contractual relationship with, such agency. For purposes of paragraph (2)(A), an individual shall be considered to be "confined to his home" if the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered "confined to his home", the condition of the individual should be such that there exists a normal inability to leave home and that leaving home requires a considerable and taxing effort by the individual. Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited, to furnish adult day-care services in the State shall not disqualify an individual from being considered to be "confined to his home". Any other absence of an individual from the home shall not so disqualify an individual if the absence is of infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration. In applying paragraph (1), the Secretary may specify exceptions to the 1 calendar year period specified in such paragraph.

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[Explanation at ¶ 1833, ¶ 1835, ¶ 1839 and ¶ 1859.]

2010 Amendments:

Sec. 6404(a)(2)(B) of the "Patient Protection and Affordable Care Act" (PubLNo 111-148), effective for services furnished on or after Jan. 1, 2010, amended sec. 1835(a) in paragraph (1), by striking "period of 3 calendar years" and all that follows through the semicolon and inserting "period ending 1 calendar year after the date of service," and by adding at the end the following new sentence: "In applying paragraph (1), the Secretary may specify exceptions to the 1 calendar year period specified in such paragraph."

Sec. 6407(a)(2) of the "Patient Protection and Affordable Care Act" (PubLNo 111-148), effective March 23, 2010, amended sec. 1835(a)(2)(A) by striking "and" before "((iii))" and by inserting after "care of a physician" the following: "; and (iv) in the case of a certification after January 1, 2010, prior to making such certification the physician must document that the physician has had a face-to-face encounter (including through use of telehealth and other than with respect to encounters that are incident to services involved) with the individual during the 6-month period preceding such certification, or other reasonable timeframe as determined by the Secretary".

Sec. 10604 of the "Patient Protection and Affordable Care Act" (PubLNo 111-148), effective for written orders and certifications made on or after July 1, 2010, amended sec. 1835(a)(2) in the matter preceeding subparagraph (A) by inserting ", or, in the case of services described in subparagraph (A), a physician enrolled under section 1866(j)," after "a physician".

Sec. 10605(b) of the "Patient Protection and Affordable Care Act" (PubLNo 111-148), effective March 23, 2010, amended sec. 1835(a)(2)(A) by inserting ", or a nurse practitioner or clinical nurse specialist (as those terms are defined in section 1861(aa)(5)) or a certified nurse-midwife (as defined in section 1861(gg)) as authorized by State law, or a physician assistant (as defined in section 1861(aa)(5)) under the supervision of the physician," after "must document that the physician".

¶15,321 Sec. 1837. ENROLLMENT PERIODS

[42 U.S.C. §1395p]

* * *

(1)(1) In the case of any individual who is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code) at the time the individual is entitled to part A under section 226(b) or section 226A and who is eligible to enroll but who has elected not to enroll (or to be deemed enrolled) during the individual’s initial enrollment period, there shall be a special enrollment period described in paragraph (2).

(2) The special enrollment period described in this paragraph, with respect to an individual, is the 12-month period beginning on the day after the last day of the initial enrollment period of the individual or, if later, the 12-month period beginning with the month the individual is notified of enrollment under this section.

(3) In the case of an individual who enrolls during the special enrollment period provided under paragraph (1), the coverage period under this part shall begin on the first day of the month in which the individual enrolls, or, at the option of the individual, the first month after the end of the individual’s initial enrollment period.

(4) An individual may only enroll during the special enrollment period provided under paragraph (1) one time during the individual’s lifetime.

¶15,321 §
(5) The Secretary shall ensure that the materials relating to coverage under this part that are provided to an individual described in paragraph (1) prior to the individual’s initial enrollment period contain information concerning the impact of not enrolling under this part, including the impact on health care benefits under the TRICARE program under chapter 55 of title 10, United States Code.

(6) The Secretary of Defense shall collaborate with the Secretary of Health and Human Services and the Commissioner of Social Security to provide for the accurate identification of individuals described in paragraph (1). The Secretary of Defense shall provide such individuals with notification with respect to this subsection. The Secretary of Defense shall collaborate with the Secretary of Health and Human Services and the Commissioner of Social Security to ensure appropriate follow up pursuant to any notification provided under the preceding sentence.

[Explanation at ¶ 835.]

March 23, 2010, amended sec. 1837 by adding at the end new subsection (l).

[¶ 15,331] Sec. 1839. Amounts of Premiums

[42 U.S.C. §1395r]

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(b) In the case of an individual whose coverage period began pursuant to an enrollment after his initial enrollment period (determined pursuant to subsection (c) or (d) of section 1837) and not pursuant to a special enrollment period under subsection (i)(4) or (l) of section 1837, the monthly premium determined under subsection (a) (without regard to any adjustment under subsection (i)) of this section shall be increased by 10 percent of the monthly premium so determined for each full 12 months (in the same continuous period of eligibility) in which he could have been but was not enrolled. For purposes of the preceding sentence, there shall be taken into account (1) the months which elapsed between the close of his initial enrollment period and the close of the enrollment period in which he enrolled, plus (in the case of an individual who reenrolls) (2) the months which elapsed between the date of termination of a previous coverage period and the close of the enrollment period in which he reenrolled, but shall not be taken into account months for which the individual can demonstrate that the individual was enrolled in a group health plan described in section 1862(b)(1)(A)(v) by reason of the individual’s (or the individual’s spouse’s) current employment status or months during which the individual has not attained the age of 65 and for which the individual can demonstrate that the individual was enrolled in a large group health plan (as that term is defined in section 1862(b)(1)(B)(iii)) by reason of the individual’s current employment status or the current employment status of a family member of the individual or months for which the individual can demonstrate that the individual was an individual described in section 1837(k)(3). Any increase in an individual’s monthly premium under the first sentence of this subsection with respect to a particular continuous period of eligibility shall not be applicable with respect to any other continuous period of eligibility which such individual may have. No increase in the premium shall be effected for a month in the case of an individual who enrolls under this part during 2001, 2002, 2003, or 2004 and who demonstrates to the Secretary before December 31, 2004, that the individual is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code). The Secretary of Health and Human Services shall consult with the Secretary of Defense in identifying individuals described in the previous sentence.

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(i)

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(2) THRESHOLD AMOUNT.—For purposes of this subsection, subject to paragraph (6), the threshold amount is—

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§1839(i)(3)(A) ¶15,331
(i) SLIDING SCALE PERCENTAGE.—Subject to paragraph (6), the applicable percentage specified in the table in subparagraph (C) for the individual minus 25 percentage points.

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(6) TEMPORARY ADJUSTMENT TO INCOME THRESHOLDS.—Notwithstanding any other provision of this subsection, during the period beginning on January 1, 2011, and ending on December 31, 2019—

(A) the threshold amount otherwise applicable under paragraph (2) shall be equal to such amount for 2010; and

(B) the dollar amounts otherwise applicable under paragraph (3)(C)(i) shall be equal to such dollar amounts for 2010.

(7) JOINT RETURN DEFINED.—For purposes of this subsection, the term “joint return” has the meaning given to such term by section 7701(a)(38) of the Internal Revenue Code of 1986.

[Explanation at ¶ 835 and ¶ 1380.]

2010 Amendments:
Sec. 3110(b) of the “Patient Protection and Affordable Care Act” (PubL No. 111–148), effective March 23, 2010, amended sec. 1839(b) by striking “section 1837(i)(4)” and inserting “subsection (i)(4) or (l) of section 1837”.
Sec. 3402 of the “Patient Protection and Affordable Care Act” (PubL No. 111–148), effective March 23, 2010, amended sec. 1839(i) in paragraph (2), in the matter preceding subparagraph (A), by inserting “subject to paragraph (6),” after “subsection,”; in paragraph (3)(A)(i), by striking “The applicable” and inserting “subject to paragraph (6), the applicable”; by redesignating paragraph (6) as paragraph (7), and by inserting after paragraph (5) new paragraph (6)

¶15,341 Sec. 1842. PROVISIONS RELATING TO THE ADMINISTRATION OF PART B

(b)(3) ***

(B) ***

but (in the case of bills submitted, or requests for payment made, after March 1968) only if the bill is submitted, or a written request for payment is made in such other form as may be permitted under regulations, no later than the period ending 1 calendar year after the date of service. In applying subparagraph (B), the Secretary may specify exceptions to the 1 calendar year period specified in such subparagraph.

(h) ***

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

(8)(1)(A) Subject to paragraph (3), the Secretary may implement a statewide or other area-wide fee schedule to be used for payment of any item or service described in paragraph (2) which is paid on a reasonable charge basis.

(B) Any fee schedule established under this paragraph for such item or service shall be updated—

(i) for years before 2011—

(I) subject to subclause (II), by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the preceding year; and

¶15,341 §1839(i)(3)(A)(i)
(II) for items and services described in paragraph (2)(D) for 2009, section 1834(a)(14)(J) shall apply under this paragraph instead of the percentage increase otherwise applicable; and

(ii) for 2011 and subsequent years—

(I) the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year, reduced by—

(II) the productivity adjustment described in section 1886(b)(3)(B)(xi)(II).

The application of subparagraph (B)(ii)(II) may result in the update under this paragraph being less than 0.0 for a year, and may result in payment rates under any fee schedule established under this paragraph for a year being less than such payment rates for the preceding year.

[Explanation at ¶ 1375, ¶ 1833 and ¶ 1837.]

2010 Amendments:

Sec. 6404(a)(2)(A) of the "Patient Protection and Affordable Care Act" (PubLNo 111-148), effective for services furnished on or after Jan. 1, 2010, amended sec. 1842(b)(3) in subparagraph (B), in the flush language following clause (ii), by striking "close of the calendar year following the year in which such service is furnished (deeming any service furnished in the last 3 months of any calendar year to have been furnished in the succeeding calendar year)" and inserting "period ending 1 calendar year after the date of service" and by adding at the end the following new sentence: "In applying subparagraph (B), the Secretary may specify exceptions to the 1 calendar year period specified in such subparagraph."

Sec. 6406(a) of the "Patient Protection and Affordable Care Act" (PubLNo 111-148), effective for orders, certifications, and referrals made on or after Jan. 1, 2010, amended sec. 1842(b) by adding at the end new paragraph (9).

Sec. 3401(o) of the "Patient Protection and Affordable Care Act" (PubLNo 111-148), effective for services furnished on or after Jan. 1, 2010, amended sec. 1842(s)(1) in the first sentence, by striking "Subject to" and inserting "(A) Subject to"; by striking the second sentence and inserting new subparagraph (B); by adding at the end flush sentence: "The application of subparagraph (B)(ii)(II) may result in the update under this paragraph being less than 0.0 for a year, and may result in payment rates under any fee schedule established under this paragraph for a year being less than such payment rates for the preceding year.".

¶15,351 Sec. 1847. Competitive Acquisition of Certain Items and Services

[42 U.S.C. §1395w-3]

(a)(1)  

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(B)  

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(i)  

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(II) an additional 91 of the largest metropolitan statistical areas in 2011; and  

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(D)  

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(ii)  

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(I) the metropolitan statistical areas to be included shall be those metropolitan statistical areas selected by the Secretary for such round as of June 1, 2008;

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

(II) the Secretary may subdivide metropolitan statistical areas with populations (based upon the most recent data from the Census Bureau) of at least 8,000,000 into separate areas for competitive acquisition purposes.
b)(1) In general.—Subject to paragraph (7) and subsections (d)(3)(C) and (e), the amount of payment determined under this section for the billing and payment code for a drug or biological (based on a minimum dosage unit) is, subject to applicable deductible and coinsurance—

(A) in the case of a multiple source drug (as defined in subsection (c)(6)(C)), 106 percent of the amount determined under paragraph (3) for a multiple source drug furnished before April 1, 2008, or 106 percent of the amount determined under paragraph (6) for a multiple source drug furnished on or after April 1, 2008;

(B) in the case of a single source drug or biological (as defined in subsection (c)(6)(D)), 106 percent of the amount determined under paragraph (4); or

(C) in the case of a biosimilar biological product (as defined in subsection (c)(6)(H)), the amount determined under paragraph (8).

(8) BIOSIMILAR BIOLOGICAL PRODUCT.—The amount specified in this paragraph for a biosimilar biological product described in paragraph (1)(C) is the sum of—

(A) the average sales price as determined using the methodology described under paragraph (6) applied to a biosimilar biological product for all National Drug Codes assigned to such product in the same manner as such paragraph is applied to drugs described in such paragraph; and

(B) 6 percent of the amount determined under paragraph (4) for the reference biological product (as defined in subsection (c)(6)(I)).

(c)

(6)

(H) BIOSIMILAR BIOLOGICAL PRODUCT.—The term ‘biosimilar biological product’ means a biological product approved under an abbreviated application for a license of a biological product that relies in part on data or information in an application for another biological product licensed under section 351 of the Public Health Service Act.

(I) REFERENCE BIOLOGICAL PRODUCT.—The term ‘reference biological product’ means the biological product licensed under such section 351 that is referred to in the application described in subparagraph (H) of the biosimilar biological product.

[Explanation at ¶ 1045 and ¶ 1845.]
(8) INCENTIVES FOR QUALITY REPORTING.—

(A) ADJUSTMENT.—

(i) IN GENERAL.—With respect to covered professional services furnished by an eligible professional during 2015 or any subsequent year, if the eligible professional does not satisfactorily submit data on quality measures for covered professional services for the quality reporting period for the year (as determined under subsection (m)(3)(A)), the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraphs (3), (5), and (7), but without regard to this paragraph).

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

(I) for 2015, 98.5 percent; and

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

(B) APPLICATION.—

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

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

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

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

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

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

(b) ***

(1) IN GENERAL.—Before November 1 of the preceding year, for each year beginning with 1998, subject to subsection (p), the Secretary shall establish, by regulation, fee schedules that establish payment amounts for all physicians’ services furnished in all fee schedule areas (as defined in subsection (j)(2)) for the year. Except as provided in paragraph (2), each such payment amount for a service shall be equal to the product of—

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(4) ***

(B) IMAGING SERVICES DESCRIBED.—For purposes of subparagraph (A), imaging services described in this subparagraph are imaging and computer-assisted imaging services, including X-ray, ultrasound (including echocardiography), nuclear medicine (including positron emission tomography), magnetic resonance imaging, computed tomography, and fluoroscopy, but excluding diagnostic and screening mammography, and for 2010 and 2011, dual-energy x-ray absorptiometry services (as described in paragraph (6)).

§1848(b)(4)(B) ¶15,371
(C) **ADJUSTMENT IN IMAGING UTILIZATION RATE.**—With respect to fee schedules established for 2011 and subsequent years, in the methodology for determining practice expense relative value units for expensive diagnostic imaging equipment under the final rule published by the Secretary in the Federal Register on November 25, 2009 (42 CFR 410 et al.), the Secretary shall use a 75 percent assumption instead of the utilization rates otherwise established in such final rule.

(D) **ADJUSTMENT IN TECHNICAL COMPONENT DISCOUNT ON SINGLE-SESSION IMAGING INVOLVING CONSECUTIVE BODY PARTS.**—For services furnished on or after July 1, 2010, the Secretary shall increase the reduction in payments attributable to the multiple procedure payment reduction applicable to the technical component for imaging under the final rule published by the Secretary in the Federal Register on November 21, 2005 (part 405 of title 42, Code of Federal Regulations) from 25 percent to 50 percent.

(6) **TREATMENT OF BONE MASS SCANS.**—For dual-energy x-ray absorptiometry services (identified in 2006 by HCPCS codes 76075 and 76077 (and any succeeding codes)) furnished during 2010 and 2011, instead of the payment amount that would otherwise be determined under this section for such years, the payment amount shall be equal to 70 percent of the product of—

(A) the relative value for the service (as determined in subsection (c)(2)) for 2006;

(B) the conversion factor (established under subsection (d)) for 2006; and

(C) the geographic adjustment factor (established under subsection (e)(2)) for the service for the fee schedule area for 2010 and 2011, respectively.

(c)

(2)

(B)

(iv)

(II) subparagraph (I) insofar as it relates to a physician fee schedule for 2005 or 2006 shall not be taken into account in applying clause (ii)(II) for drug administration services under the fee schedule for such year for a specialty described in subparagraph (I)(ii)(II); and

(III) subparagraph (I) insofar as it relates to a physician fee schedule for 2005 or 2006 shall not be taken into account in applying clause (ii)(II) for drug administration services under the fee schedule for such year;

(IV) subsection (b)(6) shall not be taken into account in applying clause (ii)(II) for 2010 or 2011.

(v)

(III) **CHANGE IN UTILIZATION RATE FOR CERTAIN IMAGING SERVICES.**—Effective for fee schedules established beginning with 2011, reduced expenditures attributable to the change in the utilization rate applicable to 2011, as described in subsection (b)(4)(C).

(VI) **ADDITIONAL REDUCED PAYMENT FOR MULTIPLE IMAGING PROCEDURES.**—Effective for fee schedules established beginning with 2010 (but not applied for services furnished prior to July 1, 2010), reduced expenditures attributable to the increase in the multiple procedure payment reduction from 25 to 50 percent (as described in subsection (b)(4)(D)).
(K) POTENTIALLY MISVALUED CODES.—

(i) IN GENERAL.—The Secretary shall—

(I) periodically identify services as being potentially misvalued using criteria specified in clause (ii); and

(II) review and make appropriate adjustments to the relative values established under this paragraph for services identified as being potentially misvalued under subclause (I).

(ii) IDENTIFICATION OF POTENTIALLY MISVALUED CODES.—For purposes of identifying potentially misvalued services pursuant to clause (i)(I), the Secretary shall examine (as the Secretary determines to be appropriate) codes (and families of codes as appropriate) for which there has been the fastest growth; codes (and families of codes as appropriate) that have experienced substantial changes in practice expenses; codes for new technologies or services within an appropriate period (such as 3 years) after the relative values are initially established for such codes; multiple codes that are frequently billed in conjunction with furnishing a single service; codes with low relative values, particularly those that are often billed multiple times for a single treatment; codes which have not been subject to review since the implementation of the RBRVS (the so-called 'Harvard-valued codes'); and such other codes determined to be appropriate by the Secretary.

(iii) REVIEW AND ADJUSTMENTS.—

(I) The Secretary may use existing processes to receive recommendations on the review and appropriate adjustment of potentially misvalued services described in clause (i)(II).

(II) The Secretary may conduct surveys, other data collection activities, studies, or other analyses as the Secretary determines to be appropriate to facilitate the review and appropriate adjustment described in clause (i)(II).

(III) The Secretary may use analytic contractors to identify and analyze services identified under clause (i)(I), conduct surveys or collect data, and make recommendations on the review and appropriate adjustment of services described in clause (i)(II).

(IV) The Secretary may coordinate the review and appropriate adjustment described in clause (i)(II) with the periodic review described in subparagraph (B).

(V) As part of the review and adjustment described in clause (i)(II), including with respect to codes with low relative values described in clause (ii), the Secretary may make appropriate coding revisions (including using existing processes for consideration of coding changes) which may include consolidation of individual services into bundled codes for payment under the fee schedule under subsection (b).

(VI) The provisions of subparagraph (B)(ii)(II) shall apply to adjustments to relative value units made pursuant to this subparagraph in the same manner as such provisions apply to adjustments under subparagraph (B)(ii)(II).

* * *

(e)

* * *

(1)

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(A) IN GENERAL.—Subject to subparagraphs (B), (C), (E), (F), (G), (H), and (I) the Secretary shall establish—

* * *

(E) FLOOR AT 1.0 ON WORK GEOGRAPHIC INDEX.—After calculating the work geographic index in subparagraph (A)(iii), for purposes of payment for services furnished on or after January 1, 2004, and before January 1, 2011, the Secretary shall increase the work geographic index to 1.00 for any locality for which such work geographic index is less than 1.00.

* * *
(H) PRACTICE EXPENSE GEOGRAPHIC ADJUSTMENT FOR 2010 AND SUBSEQUENT YEARS.—

Caution: Sec. 1848(e)(1)(H)(i), below, as added by sec. 3102(b)(2) of the Patient Protection and Affordable Care Act (Pub.L. No. 111-148), and amended by sec. 1108 of the Health Care and Education Reconciliation Act of 2010 (Pub.L. No. 111-152), shall take effect as if included in the enactment of the Patient Protection and Affordable Care Act.

(i) FOR 2010.—Subject to clause (iii), for services furnished during 2010, the employee wage and rent portions of the practice expense geographic index described in subparagraph (A)(i) shall reflect $\frac{1}{2}$ of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national average of such employee wages and rents.

(ii) FOR 2011.—Subject to clause (iii), for services furnished during 2011, the employee wage and rent portions of the practice expense geographic index described in subparagraph (A)(i) shall reflect 1.2 of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national average of such employee wages and rents.

(iii) HOLD HARMLESS.—The practice expense portion of the geographic adjustment factor applied in a fee schedule area for services furnished in 2010 or 2011 shall not, as a result of the application of clause (i) or (ii), be reduced below the practice expense portion of the geographic adjustment factor under subparagraph (A)(i) (as calculated prior to the application of such clause (i) or (ii), respectively) for such area for such year.

(iv) ANALYSIS.—The Secretary shall analyze current methods of establishing practice expense geographic adjustments under subparagraph (A)(i) and evaluate data that fairly and reliably establishes distinctions in the costs of operating a medical practice in the different fee schedule areas. Such analysis shall include an evaluation of the following:

(I) The feasibility of using actual data or reliable survey data developed by medical organizations on the costs of operating a medical practice, including office rents and non-physician staff wages, in different fee schedule areas.

(II) The office expense portion of the practice expense geographic adjustment described in subparagraph (A)(i), including the extent to which types of office expenses are determined in local markets instead of national markets.

(III) The weights assigned to each of the categories within the practice expense geographic adjustment described in subparagraph (A)(i).

(v) REVISION FOR 2012 AND SUBSEQUENT YEARS.—As a result of the analysis described in clause (iv), the Secretary shall, not later than January 1, 2012, make appropriate adjustments to the practice expense geographic adjustment described in subparagraph (A)(i) to ensure accurate geographic adjustments across fee schedule areas, including—

(I) basing the office rents component and its weight on office expenses that vary among fee schedule areas; and

(II) considering a representative range of professional and non-professional personnel employed in a medical office based on the use of the American Community Survey data or other reliable data for wage adjustments.

Such adjustments shall be made without regard to adjustments made pursuant to clauses (i) and (ii) and shall be made in a budget neutral manner.

(I) FLOOR FOR PRACTICE EXPENSE INDEX FOR SERVICES FURNISHED IN FRONTIER STATES.—

(i) IN GENERAL.—Subject to clause (ii), for purposes of payment for services furnished in a frontier State (as defined in section 1886(d)(3)(E)(iii)(II)) on or after January 1, 2011, after calculating the practice expense index in subparagraph (A)(i), the Secretary shall increase any such index to 1.00 if such index would otherwise be less that 1.00. The preceding sentence shall not be applied in a budget neutral manner.

(ii) LIMITATION.—This subparagraph shall not apply to services furnished in a State that receives a non-labor related share adjustment under section 1886(d)(5)(H).

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(j) ***

(3) PHYSICIANS’ SERVICES.—The term “physicians’ services” includes items and services described in paragraphs (1), (2)(A), (2)(D), (2)(G), (2)(P) (with respect to services described in subparagraphs (A) and (C) of section 1861(oo)(2)), (2)(R) (with respect to services described in subparagraphs (B), (C), and (D) of section 1861(pp)(1)), (2)(S), (2)(W), (2)(AA), (2)(DD), (2)(EE), (2)(FF) (including administration of the health risk assessment), (3), (4), (13), (14) (with respect to services described in section 1861(nn)(2)), and (15) of section 1861(s) (other than clinical diagnostic laboratory tests and such other items and services as the Secretary may specify).

(k) ***

(4) USE OF REGISTRY-BASED REPORTING.—As part of the publication of proposed and final quality measures for 2008 under clauses (ii) and (iii) of paragraph (2)(B), the Secretary shall address a mechanism whereby an eligible professional may provide data on quality measures through an appropriate medical registry (such as the Society of Thoracic Surgeons National Database) or through a Maintenance of Certification program operated by a specialty body of the American Board of Medical Specialties that meets the criteria for such a registry, as identified by the Secretary.

(m) ***

(1) ***

(A) IN GENERAL.—For 2007 through 2014, with respect to covered professional services furnished during a reporting period by an eligible professional, if --

***(B)(i) for 2007 and 2008, 1.5 percent;

(ii) for 2009 and 2010, 2.0 percent;

(iii) for 2011, 1.0 percent; and

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

(C) IN GENERAL.—For purposes of paragraph (1), an eligible professional shall be treated as satisfactorily submitting data on quality measures for covered professional services for a reporting period (or, for purposes of subsection (a)(8), for the quality reporting period for the year) if quality measures have been reported as follows:

***(C)(i) In General. By January 1, 2010, the Secretary shall establish and have in place a process under which eligible professionals in a group practice (as defined by the Secretary) shall be treated as satisfactorily submitting data on quality measures under subparagraph (A) and as meeting the requirement described in subparagraph (B)(ii) for covered professional services for a reporting period (or, for purposes of subsection (a)(5), for a reporting period for a year, or, for purposes of subsection (a)(8), for a quality reporting period for the year) if, in lieu of reporting measures under subsection (k)(2)(C), the group practice reports measures determined appropriate by the Secretary, such as measures that target high-cost chronic conditions and preventive care, in a form and manner, and at a time, specified by the Secretary.
(E) LIMITATIONS ON REVIEW.—

Except as provided in subparagraph (I), there shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

(iv) the determination of any incentive payment under this subsection and the payment adjustment under paragraphs (5)(A) and (8)(A) of subsection (a).

(H) FEEDBACK.—The Secretary shall provide timely feedback to eligible professionals on the performance of the eligible professional with respect to satisfactorily submitting data on quality measures under this subsection.

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

(C) REFERENCE.—Any reference in this subsection to a reporting period with respect to the application of subsection (a)(5) and (a)(8) shall be deemed a reference to the reporting period under subsection (a)(5)(D)(iii) or the quality reporting period under subsection (a)(8)(D)(iii), respectively.
(I) satisfactorily submit data on quality measures for purposes of paragraph (1) for a year; and

(II) have such data submitted on their behalf through a Maintenance of Certification Program (as defined in subparagraph (C)(i)) that meets—

(aa) the criteria for a registry (as described in subsection (k)(4)); or

(bb) an alternative form and manner determined appropriate by the Secretary.

(ii) The eligible professional, more frequently than is required to qualify for or maintain board certification status—

(I) participates in such a Maintenance of Certification program for a year; and

(II) successfully completes a qualified Maintenance of Certification Program practice assessment (as defined in subparagraph (C)(ii)) for such year.

(iii) A Maintenance of Certification program submits to the Secretary, on behalf of the eligible professional, information—

(I) in a form and manner specified by the Secretary, that the eligible professional has successfully met the requirements of clause (ii) (which may be in the form of a structural measure);

(II) if requested by the Secretary, on the survey of patient experience with care (as described in subparagraph (C)(ii)(II)); and

(III) as the Secretary may require, on the methods, measures, and data used under the Maintenance of Certification Program and the qualified Maintenance of Certification Program practice assessment.

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

(i) The term ‘Maintenance of Certification Program’ means a continuous assessment program, such as qualified American Board of Medical Specialties Maintenance of Certification program or an equivalent program (as determined by the Secretary), that advances quality and the lifelong learning and self-assessment of board certified specialty physicians by focusing on the competencies of patient care, medical knowledge, practice-based learning, interpersonal and communication skills and professionalism. Such a program shall include the following:

(I) The program requires the physician to maintain a valid, unrestricted medical license in the United States.

(II) The program requires a physician to participate in educational and self-assessment programs that require an assessment of what was learned.

(III) The program requires a physician to demonstrate, through a formalized, secure examination, that the physician has the fundamental diagnostic skills, medical knowledge, and clinical judgment to provide quality care in their respective specialty.

(IV) The program requires successful completion of a qualified Maintenance of Certification Program practice assessment as described in clause (ii).

(ii) The term ‘qualified Maintenance of Certification Program practice assessment’ means an assessment of a physician’s practice that—

(I) includes an initial assessment of an eligible professional’s practice that is designed to demonstrate the physician’s use of evidence-based medicine;

(II) includes a survey of patient experience with care; and

(III) requires a physician to implement a quality improvement intervention to address a practice weakness identified in the initial assessment under subclause (I) and then to remeasure to assess performance improvement after such intervention.

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(iii) **Inclusion of Certain Information.**—If determined appropriate by the Secretary, the Secretary may include information on the quality of care furnished to individuals under this title by the physician (or group of physicians) in such reports.

(B) **Resource Use.**—The resources described in subparagraph (A)(ii) may be measured—

(4) **Authority to Focus Initial Application.**—The Secretary may focus the initial application of the Program as appropriate, such as focusing the Program on—

(6) **Adjustment of Data.**—To the extent practicable, the Secretary shall make appropriate adjustments to the data used in preparing reports under the Program, such as adjustments to take into account variations in health status and other patient characteristics. For adjustments for reports on utilization under paragraph (9), see subparagraph (D) of such paragraph.

(10) **Coordination with Other Value-Based Purchasing Reforms.**—The Secretary shall coordinate the Program with the value-based payment modifier established under subsection (p) and, as the Secretary determines appropriate, other similar provisions of this title.

(p) **Establishment of Value-Based Payment Modifier.**—

(1) **In General.**—The Secretary shall establish a payment modifier that provides for differential payment to a physician or a group of physicians under the fee schedule established under subsection (b) based upon the quality of care furnished compared to cost (as determined under paragraphs (2) and (3), respectively) during a performance period. Such payment modifier shall be separate from the geographic adjustment factors established under subsection (e).

(2) **Quality.**—

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

(B) **Measures.**—

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

(ii) The Secretary shall seek endorsement of the measures established under this subparagraph by the entity with a contract under section 1890(a).

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

(4) **Implementation.**—

(A) **Publication of Measures, Dates of Implementation, Performance Period.**—Not later than January 1, 2012, the Secretary shall publish the following:

(i) The measures of quality of care and costs established under paragraphs (2) and (3), respectively.
(ii) The dates for implementation of the payment modifier (as determined under subparagraph (B)).

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

(B) Deadlines for implementation.—

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

(ii) Initial performance period.—

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

(II) Provision of information during initial performance period.—During the initial performance period, the Secretary shall, to the extent practicable, provide information to physicians and groups of physicians about the quality of care furnished by the physician or group of physicians to individuals enrolled under this part compared to cost (as determined under paragraphs (2) and (3), respectively) with respect to the performance period.

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

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

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

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

(5) System-based care.—The Secretary shall, as appropriate, apply the payment modifier established under this subsection in a manner that promotes system-based care.

(6) Consideration of special circumstances of certain providers.—In applying the payment modifier under this subsection, the Secretary shall, as appropriate, take into account the special circumstances of physicians or groups of physicians in rural areas and other underserved communities.

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

(8) Definitions.—For purposes of this subsection:

(A) Costs.—The term ‘costs’ means expenditures per individual as determined appropriate by the Secretary. In making the determination under the preceding sentence, the Secretary may take into account the amount of growth in expenditures per individual for a physician compared to the amount of such growth for other physicians.

(B) Performance period.—The term ‘performance period’ means a period specified by the Secretary.

(9) Coordination with other value-based purchasing reforms.—The Secretary shall coordinate the value-based payment modifier established under this subsection with the Physician Feedback Program under subsection (n) and, as the Secretary determines appropriate, other similar provisions of this title.

(10) Limitations on review.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

(A) the establishment of the value-based payment modifier under this subsection;
(B) the evaluation of quality of care under paragraph (2), including the establishment of appropriate measures of the quality of care under paragraph (2)(B); (C) the evaluation of costs under paragraph (3), including the establishment of appropriate measures of costs under such paragraph; (D) the dates for implementation of the value-based payment modifier; (E) the specification of the initial performance period and any other performance period under paragraphs (4)(B)(ii) and (8)(B), respectively; (F) the application of the value-based payment modifier under paragraph (7); and (G) the determination of costs under paragraph (8)(A). [Explanation at ¶ 709, ¶ 710, ¶ 713, ¶ 805, ¶ 865, ¶ 950, ¶ 1020, ¶ 1025, ¶ 1417, and ¶ 1577.]

2010 Amendments:

Sec. 3002(b) of the “Patient Protection and Affordable Care Act” (Pub.L.No 111-148), effective March 23, 2010, amended sec. 1848(a), by adding at the end new paragraph (B).

Sec. 3007(1) of the “Patient Protection and Affordable Care Act” (Pub.L.No 111-148), effective March 23, 2010, amended sec. 1848(b)(1) by inserting “subject to subsection (p),” after “1999.”

Sec. 3111(a)(1)(A) of the “Patient Protection and Affordable Care Act” (Pub.L.No 111-148), effective March 23, 2010, amended sec. 1848(b)(4), by inserting “,” and for 2010 and 2011, dual-energy x-ray absorptiometry services (as described in paragraph (6))” before the period at the end, and adding at the end new paragraph (6).

Sec. 3135(a)(1) of the “Patient Protection and Affordable Care Act” (Pub.L.No 111-148), effective March 23, 2010, amended sec. 1848(b)(4) is making the following changes: in subparagraph (B), by striking “subparagraph (A)” and inserting “this paragraph.”

Sec. 3135(b)(1) of the “Patient Protection and Affordable Care Act” (Pub.L.No 111-148), effective March 23, 2010, amended sec. 1848(b)(4), by adding at the end new subparagraph (D).

Sec. 3133(a) of the “Patient Protection and Affordable Care Act” (Pub.L.No 111-148), effective March 23, 2010, amended sec. 1848(c)(2), by adding at the end new subparagraphs (K).


Sec. 3111(a)(1)(B) of the “Patient Protection and Affordable Care Act” (Pub.L.No 111-148), effective March 23, 2010, amended clause 1848(c)(2)(B)(i)(IV), by striking the period at the end and inserting “; and”.


Sec. 3135(a)(2) of the “Patient Protection and Affordable Care Act” (Pub.L.No 111-148), effective March 23, 2010, amended sec. 1848(c)(2)(B), by adding at the end new subclauses (III), (IV), and (V).

Sec. 3135(b)(2) of the “Patient Protection and Affordable Care Act” (Pub.L.No 111-148), effective March 23, 2010, amended sec. 1848(c)(2)(B), by adding at the end new subclause (VI).


Sec. 3102(b) of the “Patient Protection and Affordable Care Act” (Pub.L.No 111-148), effective March 23, 2010, amended sec. 1848(e)(1), in subparagraph (A), by striking “and (G)” and inserting “(G), and (H)”, and adding at the end the new subparagraph (I).

Sec. 3102(c) of the “Patient Protection and Affordable Care Act” (Pub.L.No 111-148), effective March 23, 2010, amended sec. 1848(e)(1), in subparagraph (A), by striking “(2)(EE),” after “(2)(EE),”.

Sec. 3102(c)(1) of the “Patient Protection and Affordable Care Act” (Pub.L.No 111-148), effective for years after 2010, amended sec. 1848(e)(4), by inserting “or through a Maintenance of Certification program operated by a specialty body of the American Board of Medical Specialties that meets the criteria for such a registry” after “Database”.

Sec. 3102(d) of the “Patient Protection and Affordable Care Act” (Pub.L.No 111-148), effective March 23, 2010, amended sec. 1848(m), by adding at the end new paragraph (7).

Sec. 3102(a)(1) of the “Patient Protection and Affordable Care Act” (Pub.L.No 111-148), effective March 23, 2010, amended sec. 1848(m)(1), by making following changes: in subparagraph (A), in the matter preceding clause (i), by striking “2010” and inserting “2014”.

in clause (B)(ii), by striking “and” at the end.

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

in subparagraph (B) by adding at the end new clauses (iii) and (iv).

Sec. 3102(a)(2) of the “Patient Protection and Affordable Care Act” (Pub.L.No 111-148), effective March 23, 2010, amended sec. 1848(m)(3), in subparagraph (A), in the matter preceding clause (i), by inserting “(or, for purposes of subsection (a)(8), for the quality reporting period for the year)” after “(a)(5), for a reporting period for a year”.

Sec. 3102(e) of the “Patient Protection and Affordable Care Act” (Pub.L.No 111-148), effective March 23, 2010, amended sec. 1848(m)(5), by adding at the end new subparagraph (H).

Sec. 3102(f) of the “Patient Protection and Affordable Care Act” (Pub.L.No 111-148), effective March 23, 2010, amended sec. 1848(m)(5), by making following changes:
in subparagraph (F), by striking “There shall” and inserting “Except as provided in subparagraph (I), there shall.”

by adding at the end of section 1848(m)(5) new subparagraph (I).


Sec. 3037(a) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended 1848(m), by adding at the end new paragraph (7).

Sec. 3002(a)(1) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1848(m), in the heading, by inserting “INITIAL” after “FOCUS”.

in the matter preceding subparagraph (A) of sec. 1848(m)(4), by inserting “initial” after “focus the”.

Sec. 3002(a)(3) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1848(m) in paragraph (6), by adding at the end the following new sentence:

“[C] Adjustment in practice expense to reflect higher presumed utilization. Consistent with the methodology for computing the number of practice expense relative value units under subsection (c)(2)(C)(i) with respect to advanced diagnostic imaging services (as defined in section 1834(e)(1)(B) furnished on or after January 1, 2010, the Secretary shall adjust such number of units so it reflects—”

“(i) in the case of services furnished on or after January 1, 2010, and before January 1, 2013, a 65 percent (rather than 50 percent) presumed rate of utilization of imaging equipment;”

“(ii) in the case of services furnished on or after January 1, 2013, and before January 1, 2014, a 70 percent (rather than 50 percent) presumed rate of utilization of imaging equipment;”

“(iii) in the case of services furnished on or after January 1, 2014, a 75 percent (rather than 50 percent) presumed rate of utilization of imaging equipment.”


Sec. 3014 of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1848(n)(1)(A), by striking “GENERAL.—The Secretary” and inserting “GENERAL—”

“(i) ESTABLISHMENT.—The Secretary.

in clause (i), as added by clause (i), by striking “the “Program” and all that follows through the period at the end of the second sentence and inserting “the ‘Program’.”

by adding at the end new clauses (ii) and (iii).

in subparagraph (B), by striking “subparagraph (A)” and inserting “subparagraph (A)(ii).”

Sec. 3012(a)(2) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1848(n)(4), in the heading, by inserting “INITIAL” after “FOCUS”.

in the matter preceding subparagraph (A) of sec. 1848(n)(4), by inserting “initial” after “focus the”.

Sec. 3001(a)(3) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1848(m) in paragraph (6), by adding at the end the following new sentence:

“[C] Adjustment in practice expense to reflect higher presumed utilization. Consistent with the methodology for computing the number of practice expense relative value units under subsection (c)(2)(C)(i) with respect to advanced diagnostic imaging services (as defined in section 1834(e)(1)(B) furnished on or after January 1, 2010, the Secretary shall adjust such number of units so it reflects—”

“(i) in the case of services furnished on or after January 1, 2010, and before January 1, 2013, a 65 percent (rather than 50 percent) presumed rate of utilization of imaging equipment;”

“(ii) in the case of services furnished on or after January 1, 2013, and before January 1, 2014, a 70 percent (rather than 50 percent) presumed rate of utilization of imaging equipment;”

“(iii) in the case of services furnished on or after January 1, 2014, a 75 percent (rather than 50 percent) presumed rate of utilization of imaging equipment.”

Sec. 3012(a)(3) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1848(n)(4), by inserting “initial” after “focus the”.

Sec. 3021(a)(4) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1848(n)(5), by adding at the end new paragraphs (I).

Sec. 3007(2) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1848(n), by adding at the end new paragraphs (I).

Sec. 3011(2) of the “Health Care and Education Reconciliation Act of 2010” (PubLNo 111-152), effective March 30, 2010, amended sec. 1848 in subsection (c)(2)(B)(v) by striking “subparagraphs (III), (IV), and (V) and inserting new subparagraph (III). Prior to amendment, subparagraphs (III), (IV), and (V) read as follows:

“(III) Change in presumed utilization level of certain advanced diagnostic imaging services for 2010 through 2012. Effective for fee schedules established for 2010 and ending with 2012, reduced expenditures attributable to the presumed rate of utilization of imaging equipment of 65 percent under subsection (b)(4)(C)(i) instead of a presumed rate of utilization of such equipment of 50 percent.

“(IV) Change in presumed utilization level of certain advanced diagnostic imaging services for 2013. Effective for fee schedules established for 2013, reduced expenditures attributable to the presumed rate of utilization of imaging equipment of 70 percent under subsection (b)(4)(C)(ii) instead of a presumed rate of utilization of such equipment of 50 percent.

“(V) Change in presumed utilization level of certain advanced diagnostic imaging services for 2014 and subsequent years. Effective for fee schedules established beginning with 2014, reduced expenditures attributable to the presumed rate of utilization of imaging equipment of 75 percent under subsection (b)(4)(C)(iii) instead of a presumed rate of utilization of such equipment of 50 percent.”

Sec. 3011(2) of the “Health Care and Education Reconciliation Act of 2010” (PubLNo 111-152), effective March 30, 2010, amended sec. 1848(n), by adding at the end new paragraphs (I).


Sec. 3022(a)(4)(B) of the Patient Protection and Affordable Care Act (P.L. 111-148) amended sec. 1848(m)(6)(C)(iii) by inserting “and” after “(a)(8)” and “(a)(15)” [CCH note: “and” was added to make sense of this amendment] and by striking “under subparagraph (D)(iii) of such subsection” and inserting “under subsection (a)(8)(D)(iii) or the quality reporting period under subsection (a)(8)(D)(iii), respectively”.

Prior to amendment, sec. 1848(m)(6)(C)(iii) read as follows: “Any reference in this subsection to a reporting period with respect to the application of subsection (a)(5) shall be deemed a reference to the reporting period under subparagraph (D)(iii) of such subsection.”

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Sec. 1851. ELIGIBILITY, ELECTION, AND ENROLLMENT

(C) ANNUAL 45-DAY PERIOD FOR DISENROLLMENT FROM MA PLANS TO ELECT TO RECEIVE BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM.—Subject to subparagraph (D), at any time during the first 45 days of a year (beginning with 2011), an individual who is enrolled in a Medicare Advantage plan may change the election under subsection (a)(1), but only with respect to coverage under the original Medicare fee-for-service program under parts A and B, and may elect qualified prescription drug coverage in accordance with section 1860D-1.

(B) with respect to 2006, the period beginning on November 15, 2005, and ending on May 15, 2006;

(iv) with respect to 2007, 2008, 2009, and 2010, the period beginning on November 15 and ending on December 31 of the year before such year; and

(v) with respect to 2012 and succeeding years, the period beginning on October 15 and ending on December 7 of the year before such year.

[Explanation at ¶1120 and ¶1155.]

2010 Amendments:

Sec. 3204(a)(1) of the “Patient Protection and Affordable Care Act” (Pub.L. No. 111-148), effective for 2011 and succeeding years, amended sec. 1851(e)(2)(C).

Prior to amendment, sec. 1851(e)(2)(C) read as follows:

“(C) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT FOR FIRST 3 MONTHS IN SUBSEQUENT YEARS.—"

“(i) IN GENERAL.—Subject to clauses (ii) and (iii) and subparagraph (D), at any time during the first 3 months of a year after 2006, or, if the individual first becomes a Medicare+Choice eligible individual during a year after 2006, during the first 3 months of such year in which the individual is a Medicare+Choice eligible individual, a Medicare+Choice eligible individual may change the election under subsection (a)(1).”

“(ii) LIMITATION ON EXERCISE OF RIGHT WITH RESPECT TO PRESCRIPTION DRUG COVERAGE—Effective for plan years beginning on or after January 1, 2006, in applying clause (i) only once during the applicable 3-month period described in such clause in each year. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under paragraph (4).”

“(iii) LIMITATION ON EXERCISE OF RIGHT WITH RESPECT TO PRESCRIPTION DRUG COVERAGE—Effective for plan years beginning on or after January 1, 2011, in applying clause (i) and clause (i) of subparagraph (B) in the case of an individual who—”

“(I) is enrolled in an MA plan that does provide qualified prescription drug coverage, the individual may exercise the right under such clause only with respect to coverage under the original fee-for-service plan or coverage under another MA plan that does not provide such coverage and may not exercise such right to obtain coverage under an MA-PD plan or under a prescription drug plan under part D; or"

“(II) is enrolled in an MA-PD plan, the individual may exercise the right under such clause only with respect to coverage under another MA-PD plan (and not an MA plan that does not provide qualified prescription drug coverage) or under the original fee-for-service plan and coverage under a prescription drug plan under part D.”

Sec. 3204(b) of the “Patient Protection and Affordable Care Act” (Pub.L. No. 111-148), effective March 23, 2010, amended sec. 1851(e)(3)(B), in clause (iii), by striking “and” at the end; in clause (iv), by striking “and succeeding years” and inserting “, 2008, 2009, and 2010” and by striking the period at the end of clause (iv) and inserting “, and”; and adding at the end new clause (v).

Sec. 1102(a) of the “Health Care and Education Reconciliation Act of 2010”, (Pub.L. No. 111-152), effective as if included in the enactment of the “Patient Protection and Affordable Care Act” (Pub.L. No. 111-148) repealed sec. 3201 of the “Affordable Care Act.”
Sec. 1852. Benefits and Beneficiary Protections

(a)(1)

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(B)(i) IN GENERAL.—For purposes of this part, the term “benefits under the original medicare fee-for-service program option” means those items and services (other than hospice care) for which benefits are available under parts A and B to individuals entitled to benefits under part A and enrolled under part B, with cost-sharing for those services as required under parts A and B or, subject to clause (iii), an actuarially equivalent level of cost-sharing as determined in this part.

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(iii) LIMITATION ON VARIATION OF COST SHARING FOR CERTAIN BENEFITS.—Subject to clause (v), cost-sharing for services described in clause (iv) shall not exceed the cost-sharing required for those services under parts A and B.

(iv) SERVICES DESCRIBED.—The following services are described in this clause:
   (I) Chemotherapy administration services.
   (II) Renal dialysis services (as defined in section 1881(b)(14)(B)).
   (III) Skilled nursing care.
   (IV) Such other services that the Secretary determines appropriate (including services that the Secretary determines require a high level of predictability and transparency for beneficiaries).

(v) EXCEPTION.—In the case of services described in clause (iv) for which there is no cost-sharing required under parts A and B, cost-sharing may be required for those services in accordance with clause (i).

[Explanation at ¶1145.]

2010 Amendments:
Sec. 3202(a)(1) of the “Patient Protection and Affordable Care Act” (Pub.L. No. 111-148), effective for plan years beginning on or after Jan. 1 2011, amended sec. 1852(a)(1)(B), in clause (i), by inserting “, subject to clause (iii),” after “and B or” and by adding at the end new clauses (iii), (iv) and (v).

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(a)(1)

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(B)

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(iv) AUTHORITY TO APPLY FRAILTY ADJUSTMENT UNDER PACE PAYMENT RULES FOR CERTAIN SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.—

(I) IN GENERAL.—Notwithstanding the preceding provisions of this paragraph, for plan year 2011 and subsequent plan years, in the case of a plan described in subclause (II), the Secretary may apply the payment rules under section 1894(d) (other than paragraph (3) of such section) rather than the payment rules that would otherwise apply under this part, but only to the extent necessary to reflect the costs of treating high concentrations of frail individuals.

(II) PLAN DESCRIBED.—A plan described in this subclause is a specialized MA plan for special needs individuals described in section 1859(b)(6)(B)(ii) that is fully integrated with capitated contracts with States for Medicaid benefits, including long-term care, and that have similar average levels of frailty (as determined by the Secretary) as the PACE program.
(C)

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(ii) APPLICATION of coding adjustment.—For 2006 and each subsequent year:

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(II) In order to ensure payment accuracy, the Secretary shall annually conduct an analysis of the differences described in subclause (I). The Secretary shall complete such analysis by a date necessary to ensure that the results of such analysis are incorporated on a timely basis into the risk scores for 2008 and subsequent years. In conducting such analysis, the Secretary shall use data submitted with respect to 2004 and subsequent years, as available and updated as appropriate.

(III) In calculating each year's adjustment, the adjustment factor shall be for 2014, not less than the adjustment factor applied for 2010, plus 1.3 percentage points; for each of years 2015 through 2018, not less than the adjustment factor applied for the previous year, plus 0.25 percentage point; and for 2019 and each subsequent year, not less than 5.7 percent.

(IV) Such adjustment shall be applied to risk scores until the Secretary implements risk adjustment using Medicare Advantage diagnostic, cost, and use data.

(iii) IMPROVEMENTS TO RISK ADJUSTMENT FOR SPECIAL NEEDS INDIVIDUALS WITH CHRONIC HEALTH CONDITIONS.—

(I) IN GENERAL.—For 2011 and subsequent years, for purposes of the adjustment under clause (i) with respect to individuals described in subclause (II), the Secretary shall use a risk score that reflects the known underlying risk profile and chronic health status of similar individuals. Such risk score shall be used instead of the default risk score for new enrollees in Medicare Advantage plans that are not specialized MA plans for special needs individuals (as defined in section 1859(b)(6)).

(II) INDIVIDUALS DESCRIBED.—An individual described in this subclause is a special needs individual described in subsection (b)(6)(B)(iii) who enrolls in a specialized MA plan for special needs individuals on or after January 1, 2011.

(III) EVALUATION.—For 2011 and periodically thereafter, the Secretary shall evaluate and revise the risk adjustment system under this subparagraph in order to, as accurately as possible, account for higher medical and care coordination costs associated with frailty, individuals with multiple, comorbid chronic conditions, and individuals with a diagnosis of mental illness, and also to account for costs that may be associated with higher concentrations of beneficiaries with those conditions.

(IV) PUBLICATION OF EVALUATION AND REVISIONS.—The Secretary shall publish, as part of an announcement under subsection (b), a description of any evaluation conducted under subclause (III) during the preceding year and any revisions made under such subclause as a result of such evaluation.

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(j) COMPUTATION OF BENCHMARK AMOUNTS.—For purposes of this part, subject to subsection (o), the term "MA area-specific non-drug monthly benchmark amount" means for a month in a year—

(1) with respect to—

(A) a service area that is entirely within an MA local area, subject to section 1860C-1(d)(2)(A), an amount equal to 1/12 of the annual MA capitation rate under section 1853(c)(1) for the area for the year (or, for 2007, 2008, 2009, and 2010, 1/12 of the applicable amount determined under subsection (k)(1) for the area for the year; for 2011, 1/12 of the applicable amount determined under subsection (k)(1) for the area for 2010; and, beginning with 2012, 1/12 of the blended benchmark amount determined under subsection (n)(1) for the area for the year), adjusted as appropriate (for years before 2007) for the purpose of risk adjustment; or

***
(n) Determination of Blended Benchmark Amount.—(1) In General

For purposes of subsection (j), subject to paragraphs (3), (4), and (5), the term 'blended benchmark amount' means for an area—

(A) for 2012 the sum of—

(i) 1/2 of the applicable amount for the area and year; and

(ii) 1/2 of the amount specified in paragraph (2)(A) for the area and year; and

(B) for a subsequent year the amount specified in paragraph (2)(A) for the area and year.

(2) Specified Amount.—(A) In General.—The amount specified in this subparagraph for an area and year is the product of—

(i) the base payment amount specified in subparagraph (E) for the area and year adjusted to take into account the phase-out in the indirect costs of medical education from capitation rates described in subsection (k)(4); and

(ii) the applicable percentage for the area for the year specified under subparagraph (B).

(B) Applicable Percentage.—Subject to subparagraph (D), the applicable percentage specified in this subparagraph for an area for a year in the case of an area that is ranked—

(i) in the highest quartile under subparagraph (C) for the previous year is 95 percent;

(ii) in the second highest quartile under such subparagraph for the previous year is 100 percent;

(iii) in the third highest quartile under such subparagraph for the previous year is 107.5 percent; or

(iv) in the lowest quartile under such subparagraph for the previous year is 115 percent.

(C) Periodic Ranking.—For purposes of this paragraph in the case of an area located—

(i) in 1 of the 50 States or the District of Columbia, the Secretary shall rank such area in each year specified under subsection (c)(1)(D)(ii) based upon the level of the amount specified in subparagraph (A)(i) for such areas; or

(ii) in a territory, the Secretary shall rank such areas in each such year based upon the level of the amount specified in subparagraph (A)(i) for such area relative to quartile rankings computed under clause (i).

(D) 1-Year Transition for Changes in Applicable Percentage.—If, for a year after 2012, there is a change in the quartile in which an area is ranked compared to the previous year, the applicable percentage for the area in the year shall be the average of—

(i) the applicable percentage for the area for the previous year; and

(ii) the applicable percentage that would otherwise apply for the area for the year.

(E) Base Payment Amount.—Subject to subparagraph (F), the base payment amount specified in this subparagraph—

(i) for 2012 is the amount specified in subsection (c)(1)(D) for the area for the year; or

(ii) for a subsequent year that—

(I) is not specified under subsection (c)(1)(D)(ii), is the base amount specified in this subparagraph for the area for the previous year, increased by the national per capita MA growth percentage, described in subsection (c)(6) for that succeeding year, but not taking into account any adjustment under subparagraph (C) of such subsection for a year before 2004; and

(II) is specified under subsection (c)(1)(D)(ii), is the amount specified in subsection (c)(1)(D) for the area for the year.
(F) APPLICATION OF INDIRECT MEDICAL EDUCATION PHASE-OUT.—The base payment amount specified in subparagraph (E) for a year shall be adjusted in the same manner under paragraph (4) of subsection (k) as the applicable amount is adjusted under such subsection.

(3) ALTERNATIVE PHASE-INS.—(A) 4-YEAR PHASE-IN FOR CERTAIN AREAS.—If the difference between the applicable amount (as defined in subsection (k)) for an area for 2010 and the projected 2010 benchmark amount (as defined in subparagraph (C)) for the area is at least $30 but less than $50, the blended benchmark amount for the area is—

(i) for 2012 the sum of—
  (I) ¾ of the applicable amount for the area and year; and
  (II) ¼ of the amount specified in paragraph (2)(A) for the area and year;

(ii) for 2013 the sum of—
  (I) ¾ of the applicable amount for the area and year; and
  (II) ¼ of the amount specified in paragraph (2)(A) for the area and year;

(iii) for 2014 the sum of—
  (I) ¾ of the applicable amount for the area and year; and
  (II) ¼ of the amount specified in paragraph (2)(A) for the area and year;

(iv) for a subsequent year the amount specified in paragraph (2)(A) for the area and year.

(B) 6-YEAR PHASE-IN FOR CERTAIN AREAS.—If the difference between the applicable amount (as defined in subsection (k)) for an area for 2010 and the projected 2010 benchmark amount (as defined in subparagraph (C)) for the area is at least $50, the blended benchmark amount for the area is—

(i) for 2012 the sum of—
  (I) ⅚ of the applicable amount for the area and year; and
  (II) ⅙ of the amount specified in paragraph (2)(A) for the area and year;

(ii) for 2013 the sum of—
  (I) ⅔ of the applicable amount for the area and year; and
  (II) ⅓ of the amount specified in paragraph (2)(A) for the area and year;

(iii) for 2014 the sum of—
  (I) ½ of the applicable amount for the area and year; and
  (II) ½ of the amount specified in paragraph (2)(A) for the area and year;

(iv) for 2015 the sum of—
  (I) ⅔ of the applicable amount for the area and year; and
  (II) ⅓ of the amount specified in paragraph (2)(A) for the area and year;

(v) for 2016 the sum of—
  (I) ⅚ of the applicable amount for the area and year; and
  (II) ⅙ of the amount specified in paragraph (2)(A) for the area and year;

(vi) for a subsequent year the amount specified in paragraph (2)(A) for the area and year.

(C) PROJECTED 2010 BENCHMARK AMOUNT.—The projected 2010 benchmark amount described in this subparagraph for an area is equal to the sum of—

(i) ½ of the applicable amount (as defined in subsection (k)) for the area for 2010; and

(ii) ½ of the amount specified in paragraph (2)(A) for the area for 2010 but determined as if there were substituted for the applicable percentage specified in clause (ii) of such paragraph the sum of—
(I) the applicable percent that would be specified under subparagraph (B) of paragraph (2) (determined without regard to subparagraph (D) of such paragraph) for the area for 2010 if any reference in such paragraph to 'the previous year' were deemed a reference to 2010; and

(II) the applicable percentage increase that would apply to a qualifying plan in the area under subsection (o) as if any reference in such subsection to 2012 were deemed a reference to 2010 and as if the determination of a qualifying county under paragraph (3)(B) of such subsection were made for 2010.

(4) **CAP ON BENCHMARK AMOUNT.**—In no case shall the blended benchmark amount for an area for a year (determined taking into account subsection (o)) be greater than the applicable amount that would (but for the application of this subsection) be determined under subsection (k)(1) for the area for the year.

(5) **NON-APPLICATION TO PACE PLANS.**—This subsection shall not apply to payments to a PACE program under section 1894.

(o) **Applicable Percentage Quality Increases.**—(I) **IN GENERAL**

Subject to the succeeding paragraphs, in the case of a qualifying plan with respect to a year beginning with 2012, the applicable percentage under subsection (n)(2)(B) shall be increased on a plan or contract level, as determined by the Secretary—

(A) for 2012, by 1.5 percentage points;
(B) for 2013, by 3.0 percentage points; and
(C) for 2014 or a subsequent year, by 5.0 percentage points.

(2) **INCREASE FOR QUALIFYING PLANS IN QUALIFYING COUNTIES.**—The increase applied under paragraph (1) for a qualifying plan located in a qualifying county for a year shall be doubled.

(3) **QUALIFYING PLANS AND QUALIFYING COUNTY DEFINED; APPLICATION OF INCREASES TO LOW ENROLLMENT AND NEW PLANS.**—For purposes of this subsection:

(A) **QUALIFYING PLAN.**—(i) **IN GENERAL**

The term ‘qualifying plan’ means, for a year and subject to paragraph (4), a plan that had a quality rating under paragraph (4) of 4 stars or higher based on the most recent data available for such year.

(ii) **APPLICATION OF INCREASES TO LOW ENROLLMENT PLANS**

(I) **2012**

For 2012, the term ‘qualifying plan’ includes an MA plan that the Secretary determines is not able to have a quality rating under paragraph (4) because of low enrollment.

(II) **2013 AND SUBSEQUENT YEARS**

For 2013 and subsequent years, for purposes of determining whether an MA plan with low enrollment (as defined by the Secretary) is included as a qualifying plan, the Secretary shall establish a method to apply to MA plans with low enrollment (as defined by the Secretary) the computation of quality rating and the rating system under paragraph (4).

(iii) **APPLICATION OF INCREASES TO NEW PLANS**

(I) **IN GENERAL**

A new MA plan that meets criteria specified by the Secretary shall be treated as a qualifying plan, except that in applying paragraph (I), the applicable percentage under subsection (n)(2)(B) shall be increased

(aa) for 2012, by 1.5 percentage points;
(bb) for 2013, by 2.5 percentage points; and
(cc) for 2014 or a subsequent year, by 3.5 percentage points.

(II) NEW MA PLAN DEFINED

The term “new MA plan” means, with respect to a year, a plan offered by an organization or sponsor that has not had a contract as a Medicare Advantage organization in the preceding 3-year period.

(B) QUALIFYING COUNTY.—The term “qualifying county” means, for a year, a county

(i) that has an MA capitation rate that, in 2004, was based on the amount specified in subsection (c)(1)(B) for a Metropolitan Statistical Area with a population of more than 250,000;

(ii) for which, as of December 2009, of the Medicare Advantage eligible individuals residing in the county at least 25 percent of such individuals were enrolled in Medicare Advantage plans; and

(iii) that has per capita fee-for-service spending that is lower than the national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year.

(4) QUALITY DETERMINATIONS FOR APPLICATION OF INCREASE.—(A) QUALITY DETERMINATION.—The quality rating for a plan shall be determined according to a 5-star rating system (based on the data collected under section 1852(c)).

(B) PLANS THAT FAILED TO REPORT.—An MA plan which does not report data that enables the Secretary to rate the plan for purposes of this paragraph shall be counted as having a rating of fewer than 3.5 stars.

(5) EXCEPTION FOR PACE PLANS.—This subsection shall not apply to payments to a PACE program under section 1894.
(C) REJECTION OF BIDS.—

(i) IN GENERAL.—Nothing in this section shall be construed as requiring the Secretary to accept any or every bid submitted by an MA organization under this subsection.

(ii) AUTHORITY TO DENY BIDS THAT PROPOSE SIGNIFICANT INCREASES IN COST SHARING OR DECREASES IN BENEFITS.—The Secretary may deny a bid submitted by an MA organization for an MA plan if it proposes significant increases in cost sharing or decreases in benefits offered under the plan.

(6) ***

(A) ***

(v) With respect to qualified prescription drug coverage, the information required under section 1860D-4, as incorporated under section 1860D-11(b)(2), with respect to such coverage.

In the case of a specialized MA plan for special needs individuals, the information described in this subparagraph is such information as the Secretary shall specify.

(B) ***

(i) AUTHORITY.—Subject to clauses (iii) and (iv), the Secretary has the authority to negotiate regarding monthly bid amounts submitted under subparagraph (A) (and the proportions described in subparagraph (A)(ii)), including supplemental benefits provided under subsection (b)(1)(C)(ii)(I) and in exercising such authority the Secretary shall have authority similar to the authority of the Director of the Office of Personnel Management with respect to health benefits plans under chapter 89 of title 5, United States Code.

***

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(b) ***

(1) ***

(C) ***

(ii) FORM OF REBATE FOR PLAN YEARS BEFORE 2012.—For plan years before 2012, a rebate required under this subparagraph shall be provided through the application of the amount of the rebate toward one or more of the following:

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(iii) FORM OF REBATE FOR PLAN YEAR 2012 AND SUBSEQUENT PLAN YEARS.—For plan years beginning on or after January 1, 2012, a rebate required under this subparagraph may not be used for the purpose described in clause (ii)(III) and shall be provided through the application of the amount of the rebate in the following priority order:

(I) First, to use the most significant share to meaningfully reduce cost-sharing otherwise applicable for benefits under the original medicare fee-for-service program under parts A and B and for qualified prescription drug coverage under part D, including the reduction of any deductibles, copayments, and maximum limitations on out-of-pocket expenses otherwise applicable. Any reduction of maximum limitations on out-of-pocket expenses under the preceding sentence shall apply to all benefits under the original medicare fee-for-service program option. The Secretary may provide guidance on meaningfully

§1854(b)(1)(C)(iii)(I) ¶15,411
reducing cost-sharing under this subclause, except that such guidance may not require a particular amount of cost-sharing or reduction in cost-sharing.

(II) Second, to use the next most significant share to meaningfully provide coverage of preventive and wellness health care benefits (as defined by the Secretary) which are not benefits under the original Medicare fee-for-service program, such as smoking cessation, a free flu shot, and an annual physical examination.

(III) Third, to use the remaining share to meaningfully provide coverage of other health care benefits which are not benefits under the original Medicare fee-for-service program, such as eye examinations and dental coverage, and are not benefits described in subclause (II).

(iv) Disclosure relating to rebates.—The plan shall disclose to the Secretary information on the form and amount of the rebate provided under this subparagraph or the actuarial value in the case of supplemental health care benefits.

(v) Application of Part B premium reduction.—Insofar as an MA organization elects to provide a rebate under this subparagraph under a plan as a credit toward the Part B premium under clause (ii)(III), the Secretary shall apply such credit to reduce the premium under section 1839 of each enrollee in such plan as provided in section 1840(i).

[Explanation at ¶1105, ¶1115, ¶1120 ¶1145 and ¶1180.]

Sec. 3202(b)(3) of the “Patient Protection and Affordable Care Act” (PubL No 111-148), effective March 23, 2010, amended sec. 1854(b)(1)(C) by striking “PREMIUM.—The term” and inserting “PREMIUM.—The term” and adding at the end new clause (i).

Sec. 3209(a) of the “Patient Protection and Affordable Care Act” (PubL No 111-148), effective for bids submitted for plan years beginning on or after January 1, 2012, any MA monthly supplementary beneficiary premium charged to an individual enrolled in an MA plan shall be used for the purposes, and in the priority order, described in subclauses (I) through (III) of paragraph (1)(C)(iii).
Sec. 3201 of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), which amended sec. 1854, has been repealed by sec. 1102(a) of the “Health Care and Education Reconciliation Act of 2010” (PubLNo 111-152), and shall take effect as if included in the enactment of the “Patient Protection and Affordable Care Act”.

[¶15,421] Sec. 1857. Contracts with Medicare+Choice Organizations

[42 U.S.C. §1395w-27]

(d)

(2)

(A) shall have the right to timely inspect or otherwise evaluate (i) the quality, appropriateness, and timeliness of services performed under the contract, and (ii) the facilities of the organization when there is reasonable evidence of some need for such inspection, and

(B) shall have the right to timely audit and inspect any books and records of the Medicare+Choice organization that pertain (i) to the ability of the organization to bear the risk of potential financial losses, or (ii) to services performed or determinations of amounts payable under the contract.

(e)

(4) REQUIREMENT FOR MINIMUM MEDICAL LOSS RATIO.—If the Secretary determines for a contract year (beginning with 2014) that an MA plan has failed to have a medical loss ratio of at least .85—

(A) the MA plan shall remit to the Secretary an amount equal to the product of—

(i) the total revenue of the MA plan under this part for the contract year; and

(ii) the difference between .85 and the medical loss ratio;

(B) for 3 consecutive contract years, the Secretary shall not permit the enrollment of new enrollees under the plan for coverage during the second succeeding contract year; and

(C) the Secretary shall terminate the plan contract if the plan fails to have such a medical loss ratio for 5 consecutive contract years.

(g)(1)

(F) fails to comply with the applicable requirements of section 1852(j)(3) or 1852(k)(2)(A)(ii);

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

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

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

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

The Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2). The Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2), if the Secretary determines that any employee or

§1857(g)(1)(K) ¶15,421
agent of such organization, or any provider or supplier who contracts with such organization, has engaged
in any conduct described in subparagraphs (A) through (K) of this paragraph.

(2)

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(A) civil money penalties of not more than $25,000 for each determination under
paragraph (1) or, with respect to a determination under subparagraph (D) or (E)(i) of such
paragraph, of not more than $100,000 for each such determination, except with respect to a
determination under subparagraph (E), an assessment of not more than the amount claimed by such
plan or plan sponsor based upon the misrepresentation or falsified information involved, plus, with
respect to a determination under paragraph (1)(B), double the excess amount charged in
violation of such paragraph (and the excess amount charged shall be deducted from the
penalty and returned to the individual concerned), and plus, with respect to a determination
under paragraph (1)(D), $15,000 for each individual not enrolled as a result of the practice
involved,

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[Explanation at ¶ 1195 and ¶ 1841.]

2010 Amendments:

Sec. 6408(b)(1) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1857(d)(2) in subparagraph (A), by inserting “timely” before “inspect” in subparagraph (B), by inserting “(E)” before “audit and inspect”.

Sec. 6408(b)(2) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective for acts committed on or after Jan. 1, 2010, amended sec. 1857(g)(1) in subparagraph (F), by striking “or” at the end; inserting after subparagraph (G) new subparagraphs (H), (I), (J), and (K); and by adding at the end a new sentence.

Sec. 6408(b)(3) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective for acts committed on or after Jan. 1, 2010, amended sec. 1857(g)(2)(A) by inserting “except with respect to a determination under subparagraph (E), an assessment of not more than the amount claimed by such plan or plan sponsor based upon the misrepresentation or falsified information involved,” after “for each such determination”,.

Sec. 1103 of the “Health Care Reconciliation Act of 2010” (PubLNo 111-152), effective March 30, 2010, amended sec. 1857(e) by adding at the end new paragraph (4).

[15,431] Sec. 1858. Special Rules for MA Regional Plans

[42 U.S.C. 1395w-27a]

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[Explanation at ¶ 710, ¶ 1125 and ¶ 1135.]

2010 Amendments:

Sec. 10327(c)(1) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1858(e), by striking subsection (e). Prior to amendment, sec. 1858(e) previously read as follows:

“(e) STABILIZATION FUND.”

“(1) ESTABLISHMENT. The Secretary shall establish under this subsection an MA Regional Plan Stabilization Fund (in this subsection referred to as the ‘Fund’) which shall be available for 2 purposes:"

“(A) PLAN ENTRY. To provide incentives to have MA regional plans offered in each MA region under paragraph (3).”

“(B) PLAN RETENTION. To provide incentives to retain MA regional plans in certain MA regions with below-national-average MA market penetration under paragraph (4).”

“(2) FUNDING.”

“(A) INITIAL FUNDING.”

“(i) IN GENERAL. There shall be available to the Fund during 2014, $1.”

“(ii) PAYMENT FROM TRUST FUNDS. Such amount shall be available to the Fund, as expenditures are made from the Fund, from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in the proportion specified in section 1853(f).”

“(B) ADDITIONAL FUNDING FROM SAVINGS.”

“(i) IN GENERAL. There shall also be made available to the Fund, 50 percent of savings described in clause (ii).”

“(ii) SAVINGS. The savings described in this clause are 25 percent of the average per capita savings described in section 1854(b)(4)(C) for which monthly rebates are provided under section 1854(b)(1)(C) in the fiscal year involved that are attributable to MA regional plans.”

“(iii) AVAILABILITY. Funds made available under this subparagraph shall be transferred into a special account in the Treasury from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in the proportion specified in section 1853(f) on a monthly basis.”

“(C) OBLIGATIONS. Amounts in the Fund shall be available in advance of appropriations to MA regional plans in qualifying MA regions only in accordance with paragraph (5).”

“(D) ORDERING. Expenditures from the Fund shall first be made from amounts made available under subparagraph (A).”

“(3) PLAN ENTRY FUNDING.”
"(A) IN GENERAL. Funding is available under this para-
graph for a year only as follows:"

"(i) NATIONAL PLAN. For a national bonus payment
described in subparagraph (B) for the offering by a single
MA organization of an MA regional plan in each MA region
in the year, but only if there was not such a plan offered in
each such region in the previous year. Funding under this
clause is only available with respect to any individual MA
organization for a single year, but may be made available to
more than one such organization in the same year.

(ii) REGIONAL PLANS. Subject to clause (iii), for an
increased amount under subparagraph (C) for an MA re-
gional plan offered in an MA region which did not have any
MA regional plan offered in the prior year.

(iii) APPLICATION TO ALL PLANS IN A RE-
GION. Funding under this subparagraph shall be treated as if it were an addition to the benchmark amount
otherwise applicable to such plan and year, but shall not be
taken into account in the computation of any benchmark
amount for any subsequent year.

(iv) LIMITATION ON AVAILABILITY OF PLAN
RETENTION FUNDING IN NEXT YEAR. If an increased
amount is made available under this subparagraph with
respect to an MA region for a period determined by the
Secretary under clause (iii)(l), in no case shall funding be
available under paragraph (4) with respect to MA regional
plans offered in the region in the year following such period.

"(D) APPLICATION. Any additional payment under this
paragraph provided for an MA regional plan for a year shall be
treated as if it were an addition to the benchmark amount
otherwise applicable to such plan and year, but shall not be

"(E) 2-CONSECUTIVE-YEAR LIMITATION."
“(A) IN GENERAL. The total amount expended from the Fund as a result of the application of this subsection through the end of a calendar year may not exceed the amount available to the Fund as of the first day of such year. For purposes of this subsection, amounts that are expended under this title insofar as such amounts would not have been expended but for the application of this subsection shall be counted as amounts expended as a result of such application.”

“(B) APPLICATION OF LIMITATION. The Secretary may obligate funds from the Fund for a year only if the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services and the appropriate budget officer certify) that there are available in the Fund at the beginning of the year sufficient amounts to cover all such obligations incurred during the year consistent with subparagraph (A). The Secretary shall take such steps, in connection with computing additional payment amounts under paragraphs (3) and (4) and including limitations on enrollment in MA regional plans receiving such payments, as will ensure that sufficient funds are available to make such payments for the entire year. Funds shall only be made available from the Fund pursuant to an apportionment made in accordance with applicable procedures.”

“(C) If applicable, the plan meets the requirement described in paragraph (7).

“(D) If applicable, the plan meets the requirement described in paragraph (7).

“(E) If applicable, the plan meets the requirement described in paragraph (7).

“(A) IN GENERAL.—Subject to subparagraph (C), the Secretary shall establish procedures for the transition of applicable individuals to—

(i) a Medicare Advantage plan that is not a specialized MA plan for special needs individuals (as defined in subsection (b)(6)); or

Sec. 1859. Definitions; Miscellaneous Provisions
[42 U.S.C. §1395w-28]
(ii) the original medicare fee-for-service program under parts A and B.

(B) APPLICABLE INDIVIDUALS.—For purposes of clause (i), the term ‘applicable individual’ means an individual who—

(i) is enrolled under a specialized MA plan for special needs individuals (as defined in subsection (b)(6)); and

(ii) is not within the 1 or more of the classes of special needs individuals to which enrollment under the plan is restricted to.

(C) EXCEPTION.—The Secretary shall provide for an exception to the transition described in subparagraph (A) for a limited period of time for individuals enrolled under a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(ii) who are no longer eligible for medical assistance under title XIX.

(D) TIMELINE FOR INITIAL TRANSITION.—The Secretary shall ensure that applicable individuals enrolled in a specialized MA plan for special needs individuals described in subsection (b)(6) prior to January 1, 2010, are transitioned to a plan or the program described in subparagraph (A) by not later than January 1, 2013.

(7) AUTHORITY TO REQUIRE SPECIAL NEEDS PLANS BE NCQA APPROVED.—For 2012 and subsequent years, the Secretary shall require that a Medicare Advantage organization offering a specialized MA plan for special needs individuals be approved by the National Committee for Quality Assurance (based on standards established by the Secretary).

(g) SPECIAL RULES FOR SENIOR HOUSING FACILITY PLANS.—

(1) IN GENERAL.—In the case of a Medicare Advantage senior housing facility plan described in paragraph (2), notwithstanding any other provision of this part to the contrary and in accordance with regulations of the Secretary, the service area of such plan may be limited to a senior housing facility in a geographic area.

(2) MEDICARE ADVANTAGE SENIOR HOUSING FACILITY PLAN DESCRIBED.—For purposes of this subsection, a Medicare Advantage senior housing facility plan is a Medicare Advantage plan that—

(A) restricts enrollment of individuals under this part to individuals who reside in a continuing care retirement community (as defined in section 1852(l)(4)(B));

(B) provides primary care services onsite and has a ratio of accessible physicians to beneficiaries that the Secretary determines is adequate;

(C) provides transportation services for beneficiaries to specialty providers outside of the facility; and

(D) has participated (as of December 31, 2009) in a demonstration project established by the Secretary under which such a plan was offered for not less than 1 year.

[Explanation at ¶ 1160 and ¶ 1175.]

2010 Amendments:

Sec. 3205(a) of the “Patient Protection and Affordable Care Act” (Pub.L.No 111-148), effective March 23, 2010, amended sec. 1859(f)(1), by striking “2011” and inserting “2014”.

Sec. 3205(c) of the “Patient Protection and Affordable Care Act” (Pub.L.No 111-148), effective March 23, 2010, amended sec. 1859(f), by adding at the end new paragraph (6).

Sec. 3205(e) of the “Patient Protection and Affordable Care Act” (Pub.L.No 111-148), effective March 23, 2010, amended sec. 1859(h), in paragraph (2), by adding at the end the new subparagraph (C), in paragraph (3), by adding at the end the new subparagraph (E), in paragraph (4), by adding at the end the new subparagraph (C), and by adding at the end the new paragraph (7).

Sec. 3205(g) of the “Patient Protection and Affordable Care Act” (Pub.L.No 111-148), effective March 23, 2010, amended sec. 1859(h)(5), by striking “described in subsection (b)(6)(B)(ii)”.

Sec. 3208(a) of the “Patient Protection and Affordable Care Act” (Pub.L.No 111-148), effective Jan. 1, 2010, for plan years beginning on or after that date, amended sec. 1859, by adding at the end the new subsection (g).

¶ 15,451 Sec. 1860C-1. Comparative Cost Adjustment (CCA) Program

[42 U.S.C. § 1395w-29]

§ 1860C-1 ¶15,451

[Repealed]
[Explanation at ¶1070 and ¶1105.]

Sec. 3201 of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), which amended sec. 1860C-1(d)(1)(A), was repealed by the Health Care and Education Reconciliation Act of 2010 (PubLNo 111-152), and shall take effect as if included in the enactment of the Patient Protection and Affordable Care Act.

Sec. 1102(d) of the “Health Care and Education Reconciliation Act of 2010” (PubLNo 111-152), effective March 30, 2010, repealed sec. 1860C-1.

¶15,461 Sec. 1860D-1. ELIGIBILITY, ENROLLMENT, AND INFORMATION
[42 U.S.C. § 1395w-101]

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(b)(1)

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(C) SPECIAL RULE.—The process established under subparagraph (A) shall include, except as provided in subparagraph (D), in the case of a part D eligible individual who is a full-benefit dual eligible individual (as defined in section 1935(c)(6)) who has failed to enroll in a prescription drug plan or an MA-PD plan, for the enrollment in a prescription drug plan that has a monthly beneficiary premium that does not exceed the premium assistance available under section 1860D-14(a)(1)(A)). If there is more than one such plan available, the Secretary shall enroll such an individual on a random basis among all such plans in the PDP region. Nothing in the previous sentence shall prevent such an individual from declining or changing such enrollment.

(D) SPECIAL RULE FOR PLANS THAT WAIVE DE MINIMIS PREMIUMS.—The process established under subparagraph (A) may include, in the case of a part D eligible individual who is a subsidy eligible individual (as defined in section 1860D-14(a)(3)) who has failed to enroll in a prescription drug plan or an MA-PD plan, for the enrollment in a prescription drug plan or MA-PD plan that has waived the monthly beneficiary premium for such subsidy eligible individual under section 1860D-14(a)(5). If there is more than one such plan available, the Secretary shall enroll such an individual under the preceding sentence on a random basis among all such plans in the PDP region. Nothing in the previous sentence shall prevent such an individual from declining or changing such enrollment.

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[Explanation at ¶1225.]

Sec. 3303(b) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective for premiums for months, and enrollment for plan years, beginning on or after Jan. 1, 2011, amended sec. 1860D-1(b)(1), in subparagraph (C), by inserting “except as provided in subparagraph (D),” after “shall include,” and by adding at the end new subparagraph (D).

¶15,471 Sec. 1860D-2. Prescription Drug Benefits
[42 U.S.C. § 1395w-102]

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(b)

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(2) BENEFIT STRUCTURE.—

(A) 25 PERCENT COINSURANCE.—Subject to subparagraphs (C) and (D), the coverage has coinsurance (for costs above the annual deductible specified in paragraph (1) and up to the initial coverage limit under paragraph (3)) that is—

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(B) USE OF TIERS.—Nothing in this part shall be construed as preventing a PDP sponsor or an MA organization from applying tiered copayments under a plan, so long as such tiered copayments are consistent with subparagraphs (A)(ii), (C), and (D).
(C) Coverage For Generic Drugs In Coverage Gap.——(i) In General.——Except as provided in paragraph (4), the coverage for an applicable beneficiary (as defined in section 1860D-14A(g)(1)) has coinsurance (for costs above the initial coverage limit under paragraph (3) and below the out-of-pocket threshold) for covered part D drugs that are not applicable drugs under section 1860D-14A(g)(2) that is—

(I) equal to the generic-gap co-insurance percentage (specified in clause (ii)) for the year; or

(II) actuarially equivalent (using processes and methods established under section 1860D-11(c)) to an average expected payment of such percentage of such costs for covered part D drugs that are not applicable drugs under section 1860D-14A(g)(2).

(ii) Generic-Gap Coinsurance Percentage.——The generic-gap co-insurance percentage specified in this clause for—

(I) 2011 is 93 percent;

(II) 2012 and each succeeding year before 2020 is the generic-gap co-insurance percentage under this clause for the previous year decreased by 7 percentage points; and

(III) 2020 and each subsequent year is 25 percent.

(D) Coverage For Applicable Drugs In Coverage Gap.——(i) In General.——Except as provided in paragraph (4), the coverage for an applicable beneficiary (as defined in section 1860D-14A(g)(1)) has coinsurance (for costs above the initial coverage limit under paragraph (3) and below the out-of-pocket threshold) for the negotiated price (as defined in section 1860D-14A(g)(6)) of covered part D drugs that are applicable drugs under section 1860D-14A(g)(2) that is—

(I) equal to the difference between the applicable gap percentage (specified in clause (ii) for the year) and the discount percentage specified in section 1860D-14A(g)(4)(A) for such applicable drugs; or

(II) actuarially equivalent (using processes and methods established under section 1860D-11(c)) to an average expected payment of such percentage of such costs, for covered part D drugs that are applicable drugs under section 1860D-14A(g)(2).

(ii) Applicable Gap Percentage.——The applicable gap percentage specified in this clause for—

(I) 2013 and 2014 is 97.5 percent;

(II) 2015 and 2016 is 95 percent;

(III) 2017 is 90 percent;

(IV) 2018 is 85 percent;

(V) 2019 is 80 percent; and

(VI) 2020 and each subsequent year is 75 percent.

(3) Initial Coverage Limit.—

(A) In General.—Except as provided in paragraphs (2)(C), (2)(D), and (4) and (7), the coverage has an initial coverage limit on the maximum costs that may be recognized for payment purposes (including the annual deductible)—

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(4) ***

(B) ***
(i) IN GENERAL.—For purposes of this part, the ‘annual out-of-pocket threshold’ specified in this subparagraph—

(I) for 2006, is equal to $3,600;

(II) for each of years 2007 through 2013, is equal to the amount specified in this subparagraph for the previous year, increased by the annual percentage increase described in paragraph (6) for the year involved;

(III) for 2014 and 2015, is equal to the amount specified in this subparagraph for the previous year, increased by the annual percentage increase described in paragraph (6) for the year involved, minus 0.25 percentage point;

(IV) for each of years 2016 through 2019, is equal to the amount specified in this subparagraph for the previous year, increased by the lesser of—

(aa) the annual percentage increase described in paragraph (7) for the year involved, plus 2 percentage points; or

(bb) the annual percentage increase described in paragraph (6) for the year;

(V) for 2020, is equal to the amount that would have been applied under this subparagraph for 2020 if the amendments made by section 1101(d)(1) of the Health Care and Education Reconciliation Act of 2010 had not been enacted; or

(VI) for a subsequent year, is equal to the amount specified in this subparagraph for the previous year, increased by the annual percentage increase described in paragraph (6) for the year involved.

(ii) ROUNDING.—Any amount determined under clause (i)(II) that is not a multiple of $50 shall be rounded to the nearest multiple of $50.

(C) APPLICATION.—Except as provided in subparagraph (E), in applying subparagraph (A)—

(i) incurred costs shall only include costs incurred with respect to covered part D drugs for the annual deductible described in paragraph (1), for cost-sharing described in paragraph (2), and for amounts for which benefits are not provided because of the application of the initial coverage limit described in paragraph (3), but does not include any costs incurred for covered part D drugs which are not included (or treated as being included) in the plan’s formulary;

(ii) subject to clause (iii), such costs shall be treated as incurred only if they are paid by the part D eligible individual (or by another person, such as a family member, on behalf of the individual) and the part D eligible individual (or other person) is not reimbursed through insurance or otherwise, a group health plan, or other third-party payment arrangement (other than under such section or such a Program) for such costs; and

(iii) such costs shall be treated as incurred and shall not be considered to be reimbursed under clause (ii) if such costs are borne or paid—

(I) under section 1860D-14;

(II) under a State Pharmaceutical Assistance Program;

(III) by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act); or

(IV) under an AIDS Drug Assistance Program under part B of title XXVI of the Public Health Service Act.

(E) INCLUSION OF COSTS OF APPLICABLE DRUGS UNDER MEDICARE COVERAGE GAP DISCOUNT PROGRAM.—In applying subparagraph (A), incurred costs shall include the negotiated price (as defined in paragraph (6) of section 1860D-14A(g)) of an applicable drug (as defined in paragraph (2) of such section) of a manufacturer that is furnished to an applicable beneficiary (as defined in paragraph (1) of such section) under the Medicare coverage gap discount program under section 1860D-14A, regardless of whether part of such costs were paid by a manufacturer under such program, except that incurred costs shall not include the portion of the negotiated price that represents the reduction in coinsurance resulting from the application of paragraph (2)(D).
(7) ADDITIONAL ANNUAL PERCENTAGE INCREASE.—

The annual percentage increase specified in this paragraph for a year is equal to the annual percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending in July of the previous year.

...
(iii) IMPLEMENTATION.—The Secretary shall establish the criteria under clause (ii)(II) and any exceptions under clause (i)(II) through the promulgation of a regulation which includes a public notice and comment period.

(iv) REQUIREMENT FOR CERTAIN CATEGORIES AND CLASSES UNTIL CRITERIA ESTABLISHED.—Until such time as the Secretary establishes the criteria under clause (ii)(II) the following categories and classes of drugs shall be identified under clause (ii)(I):

(I) Anticonvulsants.

(II) Antidepressants.

(III) Antineoplastics.

(IV) Antipsychotics.

(V) Antiretrovirals.

(VI) Immunosuppressants for the treatment of transplant rejection.

(H) USE OF SINGLE, UNIFORM EXCEPTIONS AND APPEALS PROCESS.—Notwithstanding any other provision of this part, each PDP sponsor of a prescription drug plan shall—

(i) use a single, uniform exceptions and appeals process (including, to the extent the Secretary determines feasible, a single, uniform model form for use under such process) with respect to the determination of prescription drug coverage for an enrollee under the plan; and

(ii) provide instant access to such process by enrollees through a toll-free telephone number and an Internet website.

(c) ***

(2) ***

(C) REQUIRED INTERVENTIONS.—For plan years beginning on or after the date that is 2 years after the date of the enactment of the Patient Protection and Affordable Care Act, prescription drug plan sponsors shall offer medication therapy management services to targeted beneficiaries described in subparagraph (A)(ii) that include, at a minimum, the following to increase adherence to prescription medications or other goals deemed necessary by the Secretary:

(i) An annual comprehensive medication review furnished person-to-person or using telehealth technologies (as defined by the Secretary) by a licensed pharmacist or other qualified provider. The comprehensive medication review—

(I) shall include a review of the individual’s medications and may result in the creation of a recommended medication action plan or other actions in consultation with the individual and with input from the prescriber to the extent necessary and practicable; and

(II) shall include providing the individual with a written or printed summary of the results of the review.

The Secretary, in consultation with relevant stakeholders, shall develop a standardized format for the action plan under subclause (I) and the summary under subclause (II).

(ii) Follow-up interventions as warranted based on the findings of the annual medication review or the targeted medication enrollment and which may be provided person-to-person or using telehealth technologies (as defined by the Secretary).

(D) ASSESSMENT.—The prescription drug plan sponsor shall have in place a process to assess, at least on a quarterly basis, the medication use of individuals who are at risk but not enrolled in the medication therapy management program, including individuals who have experienced a transition in care, if the prescription drug plan sponsor has access to that information.

Caution: Sec. 10328(a) of the Patient Protection and Affordable Care Act (PubL No 111-148) redesignated 1860D-4(c)(2)(C) as 1860D-4(c)(2)(E) and added new subparagraph 1860D-4(c)(2)(E). Both versions of subparagraph (E) appear below.

(E) AUTOMATIC ENROLLMENT WITH ABILITY TO OPT-OUT.—The prescription drug plan sponsor shall have in place a process to—

¶15,481 §1860D-4(b)(3)(G)(iii)
(i) subject to clause (ii), automatically enroll targeted beneficiaries described in subparagraph (A)(ii), including beneficiaries identified under subparagraph (D), in the medication therapy management program required under this subsection; and

(ii) permit such beneficiaries to opt-out of enrollment in such program.

(E) DEVELOPMENT OF PROGRAM IN COOPERATION WITH LICENSED PHARMACISTS.—Such program shall be developed in cooperation with licensed and practicing pharmacists and physicians.

(F) COORDINATION WITH CARE MANAGEMENT PLANS.—The Secretary shall establish guidelines for the coordination of any medication therapy management program under this paragraph with respect to a targeted beneficiary with any care management plan established with respect to such beneficiary under a chronic care improvement program under section 1807.

(G) CONSIDERATIONS IN PHARMACY FEES.—The PDP sponsor of a prescription drug plan shall take into account, in establishing fees for pharmacists and others providing services under such plan, the resources used, and time required to, implement the medication therapy management program under this paragraph. Each such sponsor shall disclose to the Secretary upon request the amount of any such management or dispensing fees. The provisions of section 1927(b)(3)(D) apply to information disclosed under this subparagraph.

(3) REDUCING WASTEFUL DISPENSING OF OUTPATIENT PRESCRIPTION DRUGS IN LONG-TERM CARE FACILITIES.—The Secretary shall require PDP sponsors of prescription drug plans to utilize specific, uniform dispensing techniques, as determined by the Secretary, in consultation with relevant stakeholders (including representatives of nursing facilities, residents of nursing facilities, pharmacists, the pharmacy industry (including retail and long-term care pharmacy), prescription drug plans, MA-PD plans, and any other stakeholders the Secretary determines appropriate), such as weekly, daily, or automated dose dispensing, when dispensing covered part D drugs to enrollees who reside in a long-term care facility in order to reduce waste associated with 30-day fills.

***

[Explanation at ¶ 1210, ¶ 1255, ¶ 1260 and ¶ 1270.]

2010 Amendments:

Sec. 3307(a) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective for plan year 2011 and subsequent plan years, amended sec. 1860D-4(b)(3)(G), to read as follows, by striking original paragraph (G) and inserting a new paragraph (G). Prior to amendment, Act Sec. 1860D-4(b)(3)(G) read as follows:

“(G) REQUIRED INCLUSION OF DRUGS IN CERTAIN CATEGORIES AND CLASSES.—

“(i) IDENTIFICATION OF DRUGS IN CERTAIN CATEGORIES AND CLASSES.—Beginning with plan year 2010, the Secretary shall identify, as appropriate, categories and classes of drugs for which both of the following criteria are met:

“(I) Restricted access to drugs in the category or class would have major or life threatening clinical consequences for individuals who have a disease or disorder treated by the drugs in such category or class.

“(II) There is significant clinical need for such individuals to have access to multiple drugs within a category or class due to unique chemical actions and pharmacological effects of the drugs within the category or class, such as drugs used in the treatment of cancer.

“(ii) Formulary requirements.—Subject to clause (iii), PDP sponsors offering prescription drug plans shall be required to include all covered part D drugs in the categories and classes identified by the Secretary under clause (i).

“(iii) EXCEPTIONS.—The Secretary may establish exceptions that permits a PDP sponsor of a prescription drug plan to exclude from its formulary a particular covered part D drug in a category or class that is otherwise required to be included in the formulary under clause (i) (or to otherwise limit access to such a drug, including through prior authorization or utilization management). Any exceptions established under the preceding sentence shall be provided under a process that—

“(I) ensures that any exception to such requirement is based upon scientific evidence and medical standards of practice (and, in the case of antiretroviral medications, is consistent with the Department of Health and Human Services Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents); and

“(II) includes a public notice and comment period.

Sec. 3310(a) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective for plan years beginning on or after Jan. 1, 2012, amended sec. 1860D-4(c)(3), by adding at the end the new paragraph (3).

Sec. 3312(a) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective for exceptions and appeals on or after Jan. 1, 2012, amended sec. 1860D-4(b)(3), by adding at the end the new subparagraph (H)

Sec. 10328(a) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1860D-4(c)(2), by redesignating subparagraphs (C), (D), and (E) as subparagraphs (E), (F), and (G), respectively and by inserting after subparagraph (B) the new subparagraphs (C), (D) and (E).

§1860D-4(c)(3) ¶15,481
Sec. 1860D-11. PDP Regions; Submission of Bids; Plan Approval

[42 U.S.C. §1395w-111]

(d)

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(3) REJECTION OF BIDS.—Paragraph (5)(C) of section 1854(a) shall apply with respect to bids submitted by a PDP sponsor under subsection (b) in the same manner as such paragraph applies to bids submitted by an MA organization under such section 1854(a).

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Explanation at ¶ 1180.

2010 Amendments:

Sec. 3209(b) of the "Patient Protection and Affordable Care Act" (PubLNo 111-148), effective for bids submitted for contract years beginning on or after Jan. 1, 2011, amended sec. 1860D-11(d), by adding at the end new paragraph (3).

Sec. 1860D-13. Premiums; Late Enrollment Penalty

[42 U.S.C. §1395w-113]

(a)(1)

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(F) INCREASE BASED ON INCOME.—The monthly beneficiary premium shall be increased pursuant to paragraph (7).

(G) UNIFORM PREMIUM.—Except as provided in subparagraphs (D), (E), and (F) the monthly beneficiary premium for a prescription drug plan in a PDP region is the same for all part D eligible individuals enrolled in the plan.

***

(7) INCREASE IN BASE BENEFICIARY PREMIUM BASED ON INCOME.—

(A) IN GENERAL.—In the case of an individual whose modified adjusted gross income exceeds the threshold amount applicable under paragraph (2) of section 1839(i) (including application of paragraph (5) of such section) for the calendar year, the monthly amount of the beneficiary premium applicable under this section for a month after December 2010 shall be increased by the monthly adjustment amount specified in subparagraph (B).

(B) MONTHLY ADJUSTMENT AMOUNT.—The monthly adjustment amount specified in this subparagraph for an individual for a month in a year is equal to the product of—

(i) the quotient obtained by dividing—

(I) the applicable percentage determined under paragraph (3)(C) of section 1839(i) (including application of paragraph (5) of such section) for the individual for the calendar year reduced by 25.5 percent; by

(II) 25.5 percent; and

(ii) the base beneficiary premium (as computed under paragraph (2)).

(C) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this paragraph, the term ‘modified adjusted gross income’ has the meaning given such term in subparagraph (A) of section 1839(i)(4), determined for the taxable year applicable under subparagraphs (B) and (C) of such section.

(D) DETERMINATION BY COMMISSIONER OF SOCIAL SECURITY.—The Commissioner of Social Security shall make any determination necessary to carry out the income-related increase in the base beneficiary premium under this paragraph.
(E) PROCEDURES TO ASSURE CORRECT INCOME-RELATED INCREASE IN BASE BENEFICIARY PREMIUM.—

(i) DISCLOSURE OF BASE BENEFICIARY PREMIUM.—Not later than September 15 of each year beginning with 2010, the Secretary shall disclose to the Commissioner of Social Security the amount of the base beneficiary premium (as computed under paragraph (2)) for the purpose of carrying out the income-related increase in the base beneficiary premium under this paragraph with respect to the following year.

(ii) ADDITIONAL DISCLOSURE.—Not later than October 15 of each year beginning with 2010, the Secretary shall disclose to the Commissioner of Social Security the following information for the purpose of carrying out the income-related increase in the base beneficiary premium under this paragraph with respect to the following year:

(I) The modified adjusted gross income threshold applicable under paragraph (2) of section 1839(i) (including application of paragraph (5) of such section).

(II) The applicable percentage determined under paragraph (3)(C) of section 1839(i) (including application of paragraph (5) of such section).

(III) The monthly adjustment amount specified in subparagraph (B).

(IV) Any other information the Commissioner of Social Security determines necessary to carry out the income-related increase in the base beneficiary premium under this paragraph.

(F) RULE OF CONSTRUCTION.—The formula used to determine the monthly adjustment amount specified under subparagraph (B) shall only be used for the purpose of determining such monthly adjustment amount under such subparagraph.

(c)(1) IN GENERAL.—Subject to paragraphs (2), (3), and (4), the provisions of section 1854(d) shall apply to PDP sponsors and premiums (and any late enrollment penalty) under this part in the same manner as they apply to MA organizations and beneficiary premiums under part C, except that any reference to a Trust Fund is deemed for this purpose a reference to the Medicare Prescription Drug Account.

(4) COLLECTION OF MONTHLY ADJUSTMENT AMOUNT.—

(A) IN GENERAL.—Notwithstanding any provision of this subsection or section 1854(d)(2), subject to subparagraph (B), the amount of the income-related increase in the base beneficiary premium for an individual for a month (as determined under subsection (a)(7)) shall be paid through withholding from benefit payments in the manner provided under section 1840.

(B) AGREEMENTS.—In the case where the monthly benefit payments of an individual that are withheld under subparagraph (A) are insufficient to pay the amount described in such subparagraph, the Commissioner of Social Security shall enter into agreements with the Secretary, the Director of the Office of Personnel Management, and the Railroad Retirement Board as necessary in order to allow other agencies to collect the amount described in subparagraph (A) that was not withheld under such subparagraph.

[Explanation at ¶1245.]

2010 Amendments:

Sec. 3308(h)(1) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1860D-13(a), by adding at the end new paragraph (7).

Sec. 3308(a)(2) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1860D-13(c), in paragraph (1), by striking “(2) and (3)” and inserting “(2), (3), and (4)” and by adding at the end new paragraph (4).
Sec. 1860D-14. Premium and Cost-sharing Subsidies for Low-Income Individuals

[42 U.S.C. §1395w-114]

(a)(1)

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(D)(i) INSTITUTIONALIZED INDIVIDUALS.—In the case of an individual who is a full-benefit dual eligible individual and who is an institutionalized individual or couple (as defined in section 1902(q)(1)(B)) or, effective on a date specified by the Secretary (but in no case earlier than January 1, 2012), who would be such an institutionalized individual or couple, if the full-benefit dual eligible individual were not receiving services under a home and community-based waiver authorized for a State under section 1115 or subsection (c) or (d) of section 1915 or under a State plan amendment under subsection (t) of such section or services provided through enrollment in a Medicaid managed care organization with a contract under section 1903(m) or under section 1932, the elimination of any beneficiary coinsurance described in section 1860D-2(b)(2) (for all amounts through the total amount of expenditures at which benefits are available under section 1860D-2(b)(4)).

***

(3)

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(B)

***

(vi) SPECIAL RULE FOR WIDOWS AND WIDOWERS.—Notwithstanding the preceding provisions of this subparagraph, in the case of an individual whose spouse dies during the effective period for a determination or redetermination that has been made under this subparagraph, such effective period shall be extended through the date that is 1 year after the date on which the determination or redetermination would (but for the application of this clause) otherwise cease to be effective.

***

(5) WAIVER OF DE MINIMIS PREMIUMS.—The Secretary shall, under procedures established by the Secretary, permit a prescription drug plan or an MA-PD plan to waive the monthly beneficiary premium for a subsidy eligible individual if the amount of such premium is de minimis. If such premium is waived under the plan, the Secretary shall not reassign subsidy eligible individuals enrolled in the plan to other plans based on the fact that the monthly beneficiary premium under the plan was greater than the low-income benchmark premium amount.

(b)

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(2)

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(B)

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(iii) an MA-PD plan, the portion of the MA monthly prescription drug beneficiary premium that is attributable to basic prescription drug benefits (described in section 1852(a)(6)(B)(ii)) and determined before the application of the monthly rebate computed under section 1854(b)(1)(C)(i) for that plan and year involved and, in the case of a qualifying plan, before the application of the increase under section 1853(o) for that plan and year involved.

***

(d) FACILITATION OF REASSIGNMENTS.—Beginning not later than January 1, 2011, the Secretary shall, in the case of a subsidy eligible individual who is enrolled in one prescription drug plan and is subsequently
reassigned by the Secretary to a new prescription drug plan, provide the individual, within 30 days of such reassignment, with—

(1) information on formulary differences between the individual’s former plan and the plan to which the individual is reassigned with respect to the individual’s drug regimens; and

(2) a description of the individual’s right to request a coverage determination, exception, or reconsideration under section 1860D-4(g), bring an appeal under section 1860D-4(h), or resolve a grievance under section 1860D-4(f).

(e) RELATION TO MEDICAID PROGRAM.—For special provisions under the medicaid program relating to medicare prescription drug benefits, see section 1935.

[Explanation at ¶ 1205, ¶ 1215, ¶ 1220, ¶ 1225, ¶ 1230, ¶ 1235 and ¶ 1250.]

2010 Amendments:

Sec. 3302(a) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective for premiums for months beginning on or after Jan. 1, 2011, amended sec. 1860D-14(b)(2)(B)(iii), by inserting “, determined without regard to any reduction in such premium as a result of any beneficiary rebate under section 1854(b)(1)(C) or bonus payment under section 1853(n)” before the period at the end.

Sec. 3303(a) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective for premiums for months, and enrollment for plan years, beginning on or after Jan. 1, 2011, amended sec. 1860D-14(a), by adding at the end the new paragraph (5).

Sec. 3304(a) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective Jan. 1, 2011, amended sec. 1860D-14(a)(3)(B), by adding at the end the new clause (vi).

Sec. 3305 of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), by redesignating subsection (d) as subsection (e), and by inserting after subsection (c) the new subsection (d).

§ 1860D-14A Medicare Coverage Gap Discount Program

(a) ESTABLISHMENT.—The Secretary shall establish a Medicare coverage gap discount program (in this section referred to as the ‘program’) by not later than January 1, 2011. Under the program, the Secretary shall enter into agreements described in subsection (b) with manufacturers and provide for the performance of the duties described in subsection (c)(1). The Secretary shall establish a model agreement for use under the program by not later than 180 days after the date of the enactment of this section, in consultation with manufacturers, and allow for comment on such model agreement.

(b) TERMS OF AGREEMENT.—

(1) IN GENERAL.—

(A) AGREEMENT.—An agreement under this section shall require the manufacturer to provide applicable beneficiaries access to discounted prices for applicable drugs of the manufacturer.

(B) PROVISION OF DISCOUNTED PRICES AT THE POINT-OF-SALE.—Except as provided in subsection (c)(1)(A)(iii), such discounted prices shall be provided to the applicable beneficiary at the pharmacy or by the mail order service at the point-of-sale of an applicable drug.

(C) TIMING OF AGREEMENT.—

(i) SPECIAL RULE FOR 2011.—In order for an agreement with a manufacturer to be in effect under this section with respect to the period beginning on January 1, 2011, and ending on December 31, 2011, the manufacturer shall enter into such agreement not later than not later than 30 days after the date of the establishment of a model agreement under subsection (a).

(ii) 2012 AND SUBSEQUENT YEARS.—In order for an agreement with a manufacturer to be in effect under this section with respect to plan year 2012 or a subsequent plan year, the
manufacturer shall enter into such agreement (or such agreement shall be renewed under paragraph (4)(A)) not later than January 30 of the preceding year.

(2) Provision of appropriate data.—Each manufacturer with an agreement in effect under this section shall collect and have available appropriate data, as determined by the Secretary, to ensure that it can demonstrate to the Secretary compliance with the requirements under the program.

(3) Compliance with requirements for administration of program.—Each manufacturer with an agreement in effect under this section shall comply with requirements imposed by the Secretary or a third party with a contract under subsection (d)(3), as applicable, for purposes of administering the program, including any determination under clause (i) of subsection (c)(1)(A) or procedures established under such subsection (c)(1)(A).

(4) Length of agreement.—

(A) In general.—An agreement under this section shall be effective for an initial period of not less than 18 months and shall be automatically renewed for a period of not less than 1 year unless terminated under subparagraph (B).

(B) Termination.—

(i) By the Secretary.—The Secretary may provide for termination of an agreement under this section for a knowing and willful violation of the requirements of the agreement or other good cause shown. Such termination shall not be effective earlier than 30 days after the date of notice to the manufacturer of such termination. The Secretary shall provide, upon request, a manufacturer with a hearing concerning such a termination, and such hearing shall take place prior to the effective date of the termination with sufficient time for such effective date to be repealed if the Secretary determines appropriate.

(ii) By a manufacturer.—A manufacturer may terminate an agreement under this section for any reason. Any such termination shall be effective, with respect to a plan year—

(I) if the termination occurs before January 30 of a plan year, as of the day after the end of the plan year; and

(II) if the termination occurs on or after January 30 of a plan year, as of the day after the end of the succeeding plan year.

(iii) Effectiveness of termination.—Any termination under this subparagraph shall not affect discounts for applicable drugs of the manufacturer that are due under the agreement before the effective date of its termination.

(iv) Notice to third party.—The Secretary shall provide notice of such termination to a third party with a contract under subsection (d)(3) within not less than 30 days before the effective date of such termination.

(c) Duties described and special rule for supplemental benefits.—

(1) Duties described.—The duties described in this subsection are the following:

(A) Administration of program.—Administering the program, including—

(i) the determination of the amount of the discounted price of an applicable drug of a manufacturer;

(ii) except as provided in clause (iii), the establishment of procedures under which discounted prices are provided to applicable beneficiaries at pharmacies or by mail order service at the point-of-sale of an applicable drug;

(iii) in the case where, during the period beginning on January 1, 2011, and ending on December 31, 2011, it is not practicable to provide such discounted prices at the point-of-sale (as described in clause (ii)), the establishment of procedures to provide such discounted prices as soon as practicable after the point-of-sale;

(iv) the establishment of procedures to ensure that, not later than the applicable number of calendar days after the dispensing of an applicable drug by a pharmacy or mail order service, the pharmacy or mail order service is reimbursed for an amount equal to the difference between—
(I) the negotiated price of the applicable drug; and
(II) the discounted price of the applicable drug;

(v) the establishment of procedures to ensure that the discounted price for an applicable drug under this section is applied before any coverage or financial assistance under other health benefit plans or programs that provide coverage or financial assistance for the purchase or provision of prescription drug coverage on behalf of applicable beneficiaries as the Secretary may specify;

(vi) the establishment of procedures to implement the special rule for supplemental benefits under paragraph (2); and

(vii) providing a reasonable dispute resolution mechanism to resolve disagreements between manufacturers, applicable beneficiaries, and the third party with a contract under subsection (d)(3).

(B) MONITORING COMPLIANCE.—

(i) IN GENERAL.—The Secretary shall monitor compliance by a manufacturer with the terms of an agreement under this section.

(ii) NOTIFICATION.—If a third party with a contract under subsection (d)(3) determines that the manufacturer is not in compliance with such agreement, the third party shall notify the Secretary of such noncompliance for appropriate enforcement under subsection (e).

(C) COLLECTION OF DATA FROM PRESCRIPTION DRUG PLANS AND MA-PD PLANS.—The Secretary may collect appropriate data from prescription drug plans and MA-PD plans in a timeframe that allows for discounted prices to be provided for applicable drugs under this section.

(2) SPECIAL RULE FOR SUPPLEMENTAL BENEFITS.—For plan year 2011 and each subsequent plan year, in the case where an applicable beneficiary has supplemental benefits with respect to applicable drugs under the prescription drug plan or MA-PD plan that the applicable beneficiary is enrolled in, the applicable beneficiary shall not be provided a discounted price for an applicable drug under this section until after such supplemental benefits have been applied with respect to the applicable drug.

(d) ADMINISTRATION.—

(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall provide for the implementation of this section, including the performance of the duties described in subsection (c)(1).

(2) LIMITATION.—

(A) IN GENERAL.—Subject to subparagraph (B), in providing for such implementation, the Secretary shall not receive or distribute any funds of a manufacturer under the program.

(B) EXCEPTION.—The limitation under subparagraph (A) shall not apply to the Secretary with respect to drugs dispensed during the period beginning on January 1, 2011, and ending on December 31, 2011, but only if the Secretary determines that the exception to such limitation under this subparagraph is necessary in order for the Secretary to begin implementation of this section and provide applicable beneficiaries timely access to discounted prices during such period.

(3) CONTRACT WITH THIRD PARTIES.—The Secretary shall enter into a contract with 1 or more third parties to administer the requirements established by the Secretary in order to carry out this section. At a minimum, the contract with a third party under the preceding sentence shall require that the third party—

(A) receive and transmit information between the Secretary, manufacturers, and other individuals or entities the Secretary determines appropriate;

(B) receive, distribute, or facilitate the distribution of funds of manufacturers to appropriate individuals or entities in order to meet the obligations of manufacturers under agreements under this section;

(C) provide adequate and timely information to manufacturers, consistent with the agreement with the manufacturer under this section, as necessary for the manufacturer to fulfill its obligations under this section; and
(D) permit manufacturers to conduct periodic audits, directly or through contracts, of the data
and information used by the third party to determine discounts for applicable drugs of the manufac-
turer under the program.

(4) PERFORMANCE REQUIREMENTS.—The Secretary shall establish performance requirements for a third
party with a contract under paragraph (3) and safeguards to protect the independence and integrity of the
activities carried out by the third party under the program under this section.

(5) IMPLEMENTATION.—The Secretary may implement the program under this section by program
instruction or otherwise.

(6) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the program
under this section.

(e) ENFORCEMENT.—

(1) AUDITS.—Each manufacturer with an agreement in effect under this section shall be subject to
periodic audit by the Secretary.

(2) CIVIL MONEY PENALTY.—

(A) IN GENERAL.—The Secretary shall impose a civil money penalty on a manufacturer that fails
to provide applicable beneficiaries discounts for applicable drugs of the manufacturer in accordance
with such agreement for each such failure in an amount the Secretary determines is commensurate
with the sum of—

(i) the amount that the manufacturer would have paid with respect to such discounts under
the agreement, which will then be used to pay the discounts which the manufacturer had failed to
provide; and

(ii) 25 percent of such amount.

(B) APPLICATION.—The provisions of section 1128A (other than subsections (a) and (b)) shall
apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a
penalty or proceeding under section 1128A(a).

(f) CLARIFICATION REGARDING AVAILABILITY OF OTHER COVERED PART D DRUGS.—Nothing in this section
shall prevent an applicable beneficiary from purchasing a covered part D drug that is not an applicable drug
(including a generic drug or a drug that is not on the formulary of the prescription drug plan or MA-PD plan
that the applicable beneficiary is enrolled in).

(g) DEFINITIONS.—In this section:

(1) APPLICABLE BENEFICIARY.—The term ‘applicable beneficiary’ means an individual who, on the date
of dispensing a covered part D drug—

(A) is enrolled in a prescription drug plan or an MA-PD plan;

(B) is not enrolled in a qualified retiree prescription drug plan;

(C) is not entitled to an income-related subsidy under section 1860D-14(a); and

(D) who—

(i) has reached or exceeded the initial coverage limit under section 1860D-2(b)(3) during
the year; and

(ii) has not incurred costs for covered part D drugs in the year equal to the annual out-of-
pocket threshold specified in section 1860D-2(b)(4)(B).

(2) APPLICABLE DRUG.—The term ‘applicable drug’ means, with respect to an applicable beneficiary, a
covered part D drug—

(A) approved under a new drug application under section 505(b) of the Federal Food, Drug, and
Cosmetic Act or, in the case of a biologic product, licensed under section 351 of the Public Health
Service Act (other than a product licensed under subsection (k) of such section 351); and

(B)(i) if the PDP sponsor of the prescription drug plan or the MA organization offering the
MA-PD plan uses a formulary, which is on the formulary of the prescription drug plan or MA-PD
plan that the applicable beneficiary is enrolled in;
(ii) if the PDP sponsor of the prescription drug plan or the MA organization offering the MA-PD plan does not use a formulary, for which benefits are available under the prescription drug plan or MA-PD plan that the applicable beneficiary is enrolled in; or
(iii) is provided through an exception or appeal.

(3) **APPLICABLE NUMBER OF CALENDAR DAYS.** — The term ‘applicable number of calendar days’ means—
(A) with respect to claims for reimbursement submitted electronically, 14 days; and
(B) with respect to claims for reimbursement submitted otherwise, 30 days.

(4) **DISCOUNTED PRICE.** —
(A) **IN GENERAL.** — The term ‘discounted price’ means 50 percent of the negotiated price of the applicable drug of a manufacturer.
(B) **CLARIFICATION.** — Nothing in this section shall be construed as affecting the responsibility of an applicable beneficiary for payment of a dispensing fee for an applicable drug.
(C) **SPECIAL CASE FOR CERTAIN CLAIMS.** — In the case where the entire amount of the negotiated price of an individual claim for an applicable drug with respect to an applicable beneficiary does not fall at or above the initial coverage limit under section 1860D-2(b)(3) and below the annual out-of-pocket threshold specified in section 1860D-2(b)(4)(B) for the year, the manufacturer of the applicable drug shall provide the discounted price under this section on only the portion of the negotiated price of the applicable drug that falls at or above such initial coverage limit and below such annual out-of-pocket threshold.

(5) **MANUFACTURER.** — The term ‘manufacturer’ means any entity which is engaged in the production, preparation, propagation, compounding, conversion, or processing of prescription drug products, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis. Such term does not include a wholesale distributor of drugs or a retail pharmacy licensed under State law.

(6) **NEGOTIATED PRICE.** — The term ‘negotiated price’ has the meaning given such term in section 423.100 of title 42, Code of Federal Regulations (as in effect on the date of enactment of this section), except that such negotiated price shall not include any dispensing fee for the applicable drug.

(7) **QUALIFIED RETIREE PRESCRIPTION DRUG PLAN.** — The term ‘qualified retiree prescription drug plan’ has the meaning given such term in section 1860D-22(a)(2).

[Explanation at ¶ 1205 and ¶ 1215.]

2010 Amendments: Sec. 3301(b) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, added new section 1860D-14A.
Sec. 1101(b)(2) of the “Health Care and Education Reconciliation Act of 2010” (PubLNo 111-152), effective March 30, 2010, amended sec. 1860D-14A in subsection (a) by striking “July 1, 2010” and inserting “January 1, 2011”; by striking “April 1, 2010” and inserting “180 days after the date of the enactment of this section”; in subsection (b)(1)(C) in the heading, by striking “2010 AND”; by striking “July 1, 2010” and inserting “January 1, 2011”; by striking “May 1, 2010” and inserting “not later than 30 days after the date of the establishment of a model agreement under subsection (a)”; in subsection (c)(1)(A)(i)(i), by striking “July 1, 2010, and ending on December 31, 2011” and inserting “January 1, 2011, and ending on December 31, 2011”; in paragraph (2), by striking “2010” and inserting “2011”; in subsection (d)(2)(B), by striking “July 1, 2010, and ending on December 31, 2010” and inserting “January 1, 2011, and ending on December 31, 2011”; in subsection (g)(1) in the matter before subparagraph (A), by striking “an applicable drug” and inserting “a covered Part D drug”;
by adding “and” at the end of subparagraph (C); by striking subparagraph (D); and by redesignating subparagraph (E) as subparagraph (D).

Prior to being struck, subparagraph (D) read as follows: “(D) is not subject to a reduction in premium subsidy under section 1839(i); and”.

¶ 15,521 Sec. 1860D-15. Subsidies for Part D Eligible Individuals for Qualified Prescription Drug Coverage

[42 U.S.C. § 1395w-115]

**§ 1860D-15(f)** ¶15,521
(2) RESTRICTION ON USE OF INFORMATION.—Information disclosed or obtained pursuant to the provisions of this section may be used—

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

(i) carrying out this section; and

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

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

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[Explanation at ¶ 1811.]

2010 Amendments:

Sec. 6402(b)(1) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1860D-15(f)(2), by striking “may be used by” and all that follows through the period at the end and inserting “may be used” and subsection (A) and (B).

¶15,525 Sec. 1860D-22. Special Rules for Employer-Sponsored Programs

[42 U.S.C. §1395w-132]

(a) SUBSIDY PAYMENT.—

***

(2) ***

(A) ATTESTATION OF ACTUARIAL EQUIVALENCE TO STANDARD COVERAGE.—The sponsor of the plan provides the Secretary, annually or at such other time as the Secretary may require, with an attestation that the actuarial value of prescription drug coverage under the plan (as determined using the processes and methods described in section 1860D-11(c)) is at least equal to the actuarial value of standard prescription drug coverage, not taking into account the value of any discount or coverage provided during the gap in prescription drug coverage that occurs between the initial coverage limit under section 1860D-2(b)(3) during the year and the out-of-pocket threshold specified in section 1860D-2(b)(4)(B).

2010 Amendments:

Section 1101(b)(4) of the “Health Care and Education Reconciliation Act of 2010” (PubLNo 111-152), effective March 30, 2010, amended sec. 1860D-22(a)(2)(A) by inserting before the period at the end the following: “, not taking into account the value of any discount or coverage provided during the gap in prescription drug coverage that occurs between the initial coverage limit under section 1860D-2(b)(3) during the year and the out-of-pocket threshold specified in section 1860D-2(b)(4)(B)”.

¶15,529 Sec. 1860D-42. Miscellaneous Provisions

[42 U.S.C. §1395w-152]

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(c) COVERAGE GAP REBATE FOR 2010.—(1) IN GENERAL.—In the case of an individual described in subparagraphs (A) through (D) of section 1860D-14A(g)(1) who as of the last day of a calendar quarter in 2010 has incurred costs for covered part D drugs so that the individual has exceeded the initial coverage limit under section 1860D-2(b)(3) for 2010, the Secretary shall provide for payment from the Medicare Prescription Drug Account of $250 to the individual by not later than the 15th day of the third month following the end of such quarter.

(2) LIMITATION.—The Secretary shall provide only 1 payment under this subsection with respect to any individual.
SEC. 1860D-43. CONDITION FOR COVERAGE OF DRUGS UNDER THIS PART

(a) IN GENERAL.—In order for coverage to be available under this part for covered part D drugs (as defined in section 1860D-2(c)) of a manufacturer, the manufacturer must—

(1) participate in the Medicare coverage gap discount program under section 1860D-14A;

(2) have entered into and have in effect an agreement described in subsection (b) of such section with the Secretary; and

(3) have entered into and have in effect, under terms and conditions specified by the Secretary, a contract with a third party that the Secretary has entered into a contract with under subsection (d)(3) of such section.

(b) EFFECTIVE DATE.—Subsection (a) shall apply to covered part D drugs dispensed under this part on or after January 1, 2011.

(c) AUTHORIZING COVERAGE FOR DRUGS NOT COVERED UNDER AGREEMENTS.—Subsection (a) shall not apply to the dispensing of a covered part D drug if—

(1) the Secretary has made a determination that the availability of the drug is essential to the health of beneficiaries under this part; or

(2) the Secretary determines that in the period beginning on January 1, 2011, and December 31, 2011, there were extenuating circumstances.

(d) DEFINITION OF MANUFACTURER.—In this section, the term ‘manufacturer’ has the meaning given such term in section 1860D-14A(g)(5).

[Explanation at ¶ 1205.]

2010 Amendments:

Sec. 1101(b)(1) of the “Health Care and Education Reconciliation Act of 2010” (PubL No 111-152), effective March 30, 2010, added new section 1860D-43.


[¶ 15,541] Sec. 1861. Definitions of Services, Institutions, Etc.

[42 U.S.C. §1395x]

***

(o) ***

(7) ***

(C) for a year in the period described in subparagraph (A) in an amount that is equal to the lesser of $50,000 or 10 percent of the aggregate amount of payments to the agency under this title and title XIX for that year, as estimated by the Secretary that the Secretary determines is commensurate with the volume of the billing of the home health agency; and

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(s) ***

(2) ***

§1861(s)(2) ¶15,541
(K)(i) services which would be physicians’ services and services described in subsections (ww)(1) and (hhh) if furnished by a physician (as defined in subsection (r)(1) of this section) and which are performed by a physician assistant (as defined in subsection (aa)(5) of this section) under the supervision of a physician (as so defined) and which the physician assistant is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as incident to such services as would be covered under subparagraph (A) if furnished incident to a physician’s professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services,

(ii) services which would be physicians’ services and services described in subsections (ww)(1) and (hhh) if furnished by a nurse practitioner or clinical nurse specialist (as defined in subsection (aa)(5)) working in collaboration (as defined in subsection (aa)(6)) with a physician (as defined in subsection (r)(1)) which the nurse practitioner or clinical nurse specialist is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as an incident to such services as would be covered under subparagraph (A) if furnished incident to a physician’s professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services;

(DD) items and services furnished under an intensive cardiac rehabilitation program (as defined in subsection (eee)(4));

(EE) kidney disease education services (as defined in subsection (ggg)); and

(FF) personalized prevention plan services (as defined in subsection (hhh));

(3) (A) services of the type described in subparagraphs (A) through (C) of paragraph (1) and preventive services (as defined in section 1861(ddd)(3)); and

(ff) A program described in this paragraph is a program which is furnished by a hospital to its outpatients or by a community mental health center (as defined in subparagraph (B)), and which is a distinct and organized intensive ambulatory treatment service offering less than 24-hour-daily care other than in an individual’s home or in an inpatient or residential setting.

(B) For purposes of subparagraph (A), the term “community mental health center” means an entity that—

(ii) meets applicable licensing or certification requirements for community mental health centers in the State in which it is located;

(iii) provides at least 40 percent of its services to individuals who are not eligible for benefits under this title; and

(iv) meets such additional conditions as the Secretary shall specify to ensure (I) the health and safety of individuals being furnished such services, (II) the effective and efficient furnishing of such services, and (III) the compliance of such entity with the criteria described in section 1931(c)(1) of the Public Health Service Act.
(ddd) Additional Preventive Services; Preventive Services

(1) The term "additional preventive services" means services not described in subparagraph (A) or (C) of paragraph (3) that identify medical conditions or risk factors and that the Secretary determines are—

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(3) The term "preventive services" means the following:

(A) The screening and preventive services described in subsection (ww)(2) (other than the service described in subparagraph (M) of such subsection).

(B) An initial preventive physical examination (as defined in subsection (ww)).

(C) Personalized prevention plan services (as defined in subsection (hhh)(1)).

***

(hhh) Annual Wellness Visit

(1) The term "personalized prevention plan services" means the creation of a plan for an individual—

(A) that includes a health risk assessment (that meets the guidelines established by the Secretary under paragraph (4)(A)) of the individual that is completed prior to or as part of the same visit with a health professional described in paragraph (3); and

(B) that—

(i) takes into account the results of the health risk assessment; and

(ii) may contain the elements described in paragraph (2).

(2) Subject to paragraph (4)(H), the elements described in this paragraph are the following:

(A) The establishment of, or an update to, the individual’s medical and family history.

(B) A list of current providers and suppliers that are regularly involved in providing medical care to the individual (including a list of all prescribed medications).

(C) A measurement of height, weight, body mass index (or waist circumference, if appropriate), blood pressure, and other routine measurements.

(D) Detection of any cognitive impairment.

(E) The establishment of, or an update to, the following:

(i) A screening schedule for the next 5 to 10 years, as appropriate, based on recommendations of the United States Preventive Services Task Force and the Advisory Committee on Immunization Practices, and the individual’s health status, screening history, and age-appropriate preventive services covered under this title.

(ii) A list of risk factors and conditions for which primary, secondary, or tertiary prevention interventions are recommended or are underway, including any mental health conditions or any such risk factors or conditions that have been identified through an initial preventive physical examination (as described under subsection (ww)(1)), and a list of treatment options and their associated risks and benefits.

(F) The furnishing of personalized health advice and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management, or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition.

(G) Any other element determined appropriate by the Secretary.

(3) A health professional described in this paragraph is—

(A) a physician;

(B) a practitioner described in clause (i) of section 1842(b)(18)(C); or

(C) a medical professional (including a health educator, registered dietitian, or nutrition professional) or a team of medical professionals, as determined appropriate by the Secretary, under the supervision of a physician.
(4)(A) For purposes of paragraph (1)(A), the Secretary, not later than 1 year after the date of enactment of this subsection, shall establish publicly available guidelines for health risk assessments. Such guidelines shall be developed in consultation with relevant groups and entities and shall provide that a health risk assessment—

(i) identify chronic diseases, injury risks, modifiable risk factors, and urgent health needs of the individual; and

(ii) may be furnished—

(I) through an interactive telephonic or web-based program that meets the standards established under subparagraph (B);

(II) during an encounter with a health care professional;

(III) through community-based prevention programs; or

(IV) through any other means the Secretary determines appropriate to maximize accessibility and ease of use by beneficiaries, while ensuring the privacy of such beneficiaries.

(B) Not later than 1 year after the date of enactment of this subsection, the Secretary shall establish standards for interactive telephonic or web-based programs used to furnish health risk assessments under subparagraph (A)(ii)(I). The Secretary may utilize any health risk assessment developed under section 4004(f) of the Patient Protection and Affordable Care Act as part of the requirement to develop a personalized prevention plan to comply with this subparagraph.

(C)(i) Not later than 18 months after the date of enactment of this subsection, the Secretary shall develop and make available to the public a health risk assessment model. Such model shall meet the guidelines under subparagraph (A) and may be used to meet the requirement under paragraph (1)(A).

(ii) Any health risk assessment that meets the guidelines under subparagraph (A) and is approved by the Secretary may be used to meet the requirement under paragraph (1)(A).

(D) The Secretary may coordinate with community-based entities (including State Health Insurance Programs, Area Agencies on Aging, Aging and Disability Resource Centers, and the Administration on Aging) to—

(i) ensure that health risk assessments are accessible to beneficiaries; and

(ii) provide appropriate support for the completion of health risk assessments by beneficiaries.

(E) The Secretary shall establish procedures to make beneficiaries and providers aware of the requirement that a beneficiary complete a health risk assessment prior to or at the same time as receiving personalized prevention plan services.

(F) To the extent practicable, the Secretary shall encourage the use of, integration with, and coordination of health information technology (including use of technology that is compatible with electronic medical records and personal health records) and may experiment with the use of personalized technology to aid in the development of self-management skills and management of and adherence to provider recommendations in order to improve the health status of beneficiaries.

(G) A beneficiary shall be eligible to receive only an initial preventive physical examination (as defined under subsection (ww)(1)) during the 12-month period after the date that the beneficiary’s coverage begins under part B and shall be eligible to receive personalized prevention plan services under this subsection each year thereafter provided that the beneficiary has not received either an initial preventive physical examination or personalized prevention plan services within the preceding 12-month period.

(H) The Secretary shall issue guidance that—

(i) identifies elements under paragraph (2) that are required to be provided to a beneficiary as part of their first visit for personalized prevention plan services; and

(ii) establishes a yearly schedule for appropriate provision of such elements thereafter.
Sec. 1862 EXCLUSIONS FROM COVERAGE AND MEDICARE AS SECONDARY PAYER

(a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

(1) ***

(N) in the case of ultrasound screening for abdominal aortic aneurysm which is performed more frequently than is provided for under section 1861(s)(2)(AA),

(O) in the case of kidney disease education services (as defined in paragraph (1) of section 1861(ggg)), which are furnished in excess of the number of sessions covered under paragraph (4) of such section, and

(P) in the case of personalized prevention plan services (as defined in section 1861(hhh)(1)), which are performed more frequently than is covered under such section;***

(7) where such expenses are for routine physical checkups, eyeglasses (other than eyewear described in section 1861(s)(8)) or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, procedures performed (during the course of any eye examination) to determine the refractive state of the eyes, hearing aids or examinations therefor, or immunizations (except as otherwise allowed under section 1861(s)(10) and subparagraph (A) of paragraph (C) of section 1861(hhh)(1)),

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(23) which are the technical component of advanced diagnostic imaging services described in section 1834(e)(1)(B) for which payment is made under the fee schedule established under section 1848(b) and that are furnished by a supplier (as defined in section 1861(d)), if such supplier is not accredited by an accreditation organization designated by the Secretary under section 1834(e)(2)(B);

(24) where such expenses are for renal dialysis services (as defined in subparagraph (B) of section 1881(b)(14)) for which payment is made under such section unless such payment is made under such section to a provider of services or a renal dialysis facility for such services; or

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(25) not later than January 1, 2014, for which the payment is other than by electronic funds transfer (EFT) or an electronic remittance in a form as specified in ASC X12 835 Health Care Payment and Remittance Advice or subsequent standard.

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

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

(2) PROVIDER OF SERVICES OR SUPPLIER DESCRIBED.—A provider of services or supplier described in this paragraph is a provider of services or supplier the Secretary determines appropriate based on the level of risk involved with respect to the provider of services or supplier, and consistent with the surety bond requirements under sections 1834(a)(16)(B) and 1861(o)(7)(C).

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

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

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

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

[Explanation at ¶ 145, ¶ 1417, ¶ 1817 and ¶ 1821.]

2010 Amendments:

Sec. 1103(d) of the “Patient Protection and Affordable Care Act” (Pub.L. No 111-148), effective March 23, 2010, amended sec. 1862(a) by striking “or,” at the end of the paragraph (25), striking the period and inserting “; or,” at the end of the paragraph (25) and by inserting after paragraph (24) new paragraph (25).

Sec. 4103(d)(1) of the “Patient Protection and Affordable Care Act” (Pub.L. No 111-148), effective for services furnished on or after Jan. 1, 2011, amended sec. 1862(a)(1) by striking “and” at the end of subparagraph (N), striking the semicolon at the end of subparagraph (O) and inserting “; and” and by adding at the end new subparagraph (P).

Sec. 4103(d)(2) of the “Patient Protection and Affordable Care Act” (Pub.L. No 111-148), effective for services furnished on or after Jan. 1, 2011, amended sec. 1862(a)(7) by striking “or (K)” and inserting “(K), or (P)”.

Sec. 6402(g)(5) of the “Patient Protection and Affordable Care Act” (Pub.L. No 111-148), effective March 23, 2010, amended sec. 1862 by adding at the end new subsection (n).

Sec. 6402(h)(1) of the “Patient Protection and Affordable Care Act” (Pub.L. No 111-148), effective March 23, 2010, amended sec. 1862 by adding at the end new subsection (o).

[¶ 15,561] Sec. 1866. Agreements with Providers of Services; Enrollment Processes

[42 U.S.C. §1395cc]

(a)(1) ***

(U) in the case of hospitals which furnish inpatient hospital services for which payment may be made under this title, to be a participating provider of medical care both—

(i) under the contract health services program funded by the Indian Health Service and operated by the Indian Health Service, an Indian tribe, or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), with respect to items and services that are covered under such program and furnished to an individual eligible for such items and services under such program; and

¶ 15,561 §1862(a)(25)
(ii) under any program funded by the Indian Health Service and operated by an urban Indian organization with respect to the purchase of items and services for an eligible urban Indian (as those terms are defined in such section 4), in accordance with regulations promulgated by the Secretary regarding admission practices, payment methodology, and rates of payment (including the acceptance of no more than such payment rate as payment in full for such items and services, (V) in the case of hospitals that are not otherwise subject to the Occupational Safety and Health Act of 1970 (or a State occupational safety and health plan that is approved under 18(b) of such Act), to comply with the Bloodborne Pathogens standard under section 1910.1030 of title 29 of the Code of Federal Regulations (or as subsequently redesignated); and

Caution: Sec. 1866(a)(1)(W), below, was added by secs. 3005 and 6406(b) of the Patient Protection and Affordable Care Act (PubL No 111-148). Both new subparagraphs (W) are added below.

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

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

(j) ENROLLMENT PROCESS FOR PROVIDERS OF SERVICES AND SUPPLIERS.—

(1)

(A) IN GENERAL.—The Secretary shall establish by regulation a process for the enrollment of providers of services and suppliers under this title. Such process shall include screening of providers and suppliers in accordance with paragraph (2), a provisional period of enhanced oversight in accordance with paragraph (3), disclosure requirements in accordance with paragraph (4), the imposition of temporary enrollment moratoria in accordance with paragraph (5), and the establishment of compliance programs in accordance with paragraph (6).

(2) PROVIDER SCREENING.

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

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

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

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

(I) a criminal background check;

(II) fingerprinting;

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

(IV) database checks (including such checks across States); and
such other screening as the Secretary determines appropriate.

(C) **APPLICATION FEES.—**

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

(I) for 2010, $500; and

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

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

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

(D) **APPLICATION AND ENFORCEMENT.—**

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

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

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

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

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

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

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

(B) **IMPLEMENTATION**.— The Secretary may establish by program instruction or otherwise the procedures under this paragraph.
(4) 90-DAY PERIOD OF ENHANCED OVERSIGHT FOR INITIAL CLAIMS OF DME SUPPLIERS.—

For periods beginning after January 1, 2011, if the Secretary determines that there is a significant risk of fraudulent activity among suppliers of durable medical equipment, in the case of a supplier of durable medical equipment who is within a category or geographic area under title XVIII identified pursuant to such determination and who is initially enrolling under such title, the Secretary shall, notwithstanding sections 1816(c), 1842(c), and 1869(a)(2), withhold payment under such title with respect to durable medical equipment furnished by such supplier during the 90-day period beginning on the date of the first submission of a claim under such title for durable medical equipment furnished by such supplier.

(5) INCREASED DISCLOSURE REQUIREMENTS.—

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

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

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

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

(B) DEFINITIONS.—In this paragraph:

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

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

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

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

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

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

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

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

HEARING RIGHTS IN CASES OF DENIAL OR NONRENEWAL.—A provider of services or supplier whose application to enroll (or, if applicable, to renew enrollment) under this title is denied may have a hearing and judicial review of such denial under the procedures that apply under subsection (h)(1)(A) to a provider of services that is dissatisfied with a determination by the Secretary.

QUALITY REPORTING BY CANCER HOSPITALS.—

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

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

(3) QUALITY MEASURES.—

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

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

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

(4) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under paragraph (4) available to the public. Such procedures shall ensure that a hospital described in section 1886(d)(1)(B)(v) has the opportunity to review the data that is to be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality measures of process, structure, outcome, patients’ perspective on care, efficiency, and costs of care that relate to services furnished in such hospitals on the Internet website of the Centers for Medicare & Medicaid Services.
Sec. 1866C. Health Care Quality Demonstration Program

[42 U.S.C. §1395cc-3]

(b) Demonstration Projects.—The Secretary shall establish a demonstration program under which the Secretary shall approve demonstration projects that examine health delivery factors that encourage the delivery of improved quality in patient care, including—

(1) the provision of incentives to improve the safety of care provided to beneficiaries;
(2) the appropriate use of best practice guidelines by providers and services by beneficiaries;
(3) reduced scientific uncertainty in the delivery of care through the examination of variations in the utilization and allocation of services, and outcomes measurement and research;
(4) encourage shared decision making between providers and patients;
(5) the provision of incentives for improving the quality and safety of care and achieving the efficient allocation of resources;
(6) the appropriate use of culturally and ethnically sensitive health care delivery; and
(7) the financial effects on the health care marketplace of altering the incentives for care delivery and changing the allocation of resources.

(f) Budget Neutrality.—With respect to the period of the demonstration program under subsection (b), the aggregate expenditures under this title for such period shall not exceed the aggregate expenditures that would have been expended under this title if the program established under this section had not been implemented.

Prior to amendment, sec. 1866(f) read as follows: “Budget Neutrality.—With respect to the 5-year period of the demonstration program under subsection (b), the aggregate expenditures under this title for such period shall not exceed the aggregate expenditures that would have been expended under this title if the program established under this section had not been implemented.”
[¶ 15,581] Sec. 1866D. National Pilot Program on Payment Bundling

[42 U.S.C. §1395cc-4]

(a) **IMPLEMENTATION.**—

(1) **IN GENERAL.**—The Secretary shall establish a pilot program for integrated care during an episode of care provided to an applicable beneficiary around a hospitalization in order to improve the coordination, quality, and efficiency of health care services under this title.

(2) **DEFINITIONS.**—In this section:

(A) **APPLICABLE BENEFICIARY.**—The term ‘applicable beneficiary’ means an individual who—

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

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

(B) **APPLICABLE CONDITION.**—The term ‘applicable condition’ means 1 or more of 10 conditions selected by the Secretary. In selecting conditions under the preceding sentence, the Secretary shall take into consideration the following factors:

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

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

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

(iv) Whether a condition has significant variation in—

(I) the number of readmissions; and

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

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

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

(C) **APPLICABLE SERVICES.**—The term ‘applicable services’ means the following:

(i) Acute care inpatient services.

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

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

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

(v) Other services the Secretary determines appropriate.

(D) **EPISODE OF CARE.**—

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

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

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

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

(ii) **ESTABLISHMENT OF PERIOD BY THE SECRETARY.**—The Secretary, as appropriate, may establish a period (other than the period described in clause (i)) for an episode of care under the pilot program.
(E) **Physicians’ Services.**—The term ‘physicians’ services’ has the meaning given such term in section 1861(q).

(F) **Pilot Program.**—The term ‘pilot program’ means the pilot program under this section.

(G) **Provider of Services.**—The term ‘provider of services’ has the meaning given such term in section 1861(a).

(H) **Readmission.**—The term ‘readmission’ has the meaning given such term in section 1886(q)(5)(E).

(I) **Supplier.**—The term ‘supplier’ has the meaning given such term in section 1861(d).

(3) **Deadline for Implementation.**—The Secretary shall establish the pilot program not later than January 1, 2013.

(b) **Developmental Phase.**—

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

(2) **Development of Quality Measures for an Episode of Care and for Post-Acute Care.**—

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

(i) for episodes of care; and

(ii) for post-acute care.

(B) **Site-Neutral Post-Acute Care Quality Measures.**—Any quality measures developed under subparagraph (A)(ii) shall be site-neutral.

(C) **Coordination with Quality Measure Development and Endorsement Procedures.**—The Secretary shall ensure that the development of quality measures under subparagraph (A) is done in a manner that is consistent with the measures developed and endorsed under section 1890 and 1890A that are applicable to all post-acute care settings.

(c) **Details.**—

(1) **Duration.**—

(A) **In General.**—Subject to subparagraph (B), the pilot program shall be conducted for a period of 5 years.

(B) **Expansion.**—The Secretary may, at any point after January 1, 2016, expand the duration and scope of the pilot program, to the extent determined appropriate by the Secretary, if—

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

(I) reduce spending under title XVIII of the Social Security Act without reducing the quality of care; or

(II) improve the quality of care and reduce spending;

(ii) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce program spending under such title XVIII; and

(iii) the Secretary determines that such expansion would not deny or limit the coverage or provision of benefits under this title for individuals.”’; and

(2) **Participating Providers of Services and Suppliers.**—

(A) **In General.**—An entity comprised of providers of services and suppliers, including a hospital, a physician group, a skilled nursing facility, and a home health agency, who are otherwise
participating under this title, may submit an application to the Secretary to provide applicable services to applicable individuals under this section.

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

(3) PAYMENT METHODOLOGY.—

(A) IN GENERAL.—

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

(ii) NO ADDITIONAL PROGRAM EXPENDITURES.—Payments under this section for applicable items and services under this title (including payment for services described in subparagraph (B)) for applicable beneficiaries for a year shall be established in a manner that does not result in spending more for such entity for such beneficiaries than would otherwise be expended for such entity for such beneficiaries for such year if the pilot program were not implemented, as estimated by the Secretary.

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

(C) BUNDLED PAYMENTS.—

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

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

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

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

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

(4) QUALITY MEASURES.—

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

(i) Functional status improvement.

(ii) Reducing rates of avoidable hospital readmissions.

(iii) Rates of discharge to the community.

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

(v) Incidence of health care acquired infections.

(vi) Efficiency measures.

(vii) Measures of patient-centeredness of care.

(viii) Measures of patient perception of care.
(ix) Other measures, including measures of patient outcomes, determined appropriate by the Secretary.

(B) REPORTING ON QUALITY MEASURES.—

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

(ii) SUBMISSION OF DATA THROUGH ELECTRONIC HEALTH RECORD.—To the extent practicable, the Secretary shall specify that data on measures be submitted under clause (i) through the use of an qualified electronic health record (as defined in section 3000(13) of the Public Health Service Act (42 U.S.C. 300jj(13)) [CCH note: 300jj-11(13) in the text of the Patient Protection and Affordable Care Act (P.L. 111-148).] in a manner specified by the Secretary.

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

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

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

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

(B) improved health outcomes;

(C) improved applicable beneficiary access to care; and

(D) reduced spending under this title.

(2) REPORTS.—

(A) INTERIM REPORT.—Not later than 2 years after the implementation of the pilot program, the Secretary shall submit to Congress a report on the initial results of the independent evaluation conducted under paragraph (1).

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

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

(g) APPLICATION OF PILOT PROGRAM TO CONTINUING CARE HOSPITALS.—

(1) IN GENERAL.—In conducting the pilot program, the Secretary shall apply the provisions of the program so as to separately pilot test the continuing care hospital model.

(2) SPECIAL RULES.—In pilot testing the continuing care hospital model under paragraph (1), the following rules shall apply:

(A) Such model shall be tested without the limitation to the conditions selected under subsection (a)(2)(B).

(B) Notwithstanding subsection (a)(2)(D), an episode of care shall be defined as the full period that a patient stays in the continuing care hospital plus the first 30 days following discharge from such hospital.

(3) CONTINUING CARE HOSPITAL DEFINED.—In this subsection, the term ‘continuing care hospital’ means an entity that has demonstrated the ability to meet patient care and patient safety standards and that provides under common management the medical and rehabilitation services provided in inpatient rehabilitation hospitals and units (as defined in section 1886(d)(1)(B)(ii)), long term care hospitals (as defined in section 1886(d)(1)(B)(iv)(I)), and skilled nursing facilities (as defined in section 1819(a)) that are located in a hospital described in section 1886(d).
(b) Administration.—Chapter 35 of title 44, United States Code, shall not apply to the selection, testing, and evaluation of models or the expansion of such models under this section.

[Explanation at ¶ 745 and ¶ 747.]

2010 Amendments:
Sec. 3023 of the “Patient Protection and Affordable Care Act” (Pub.L. No. 111-148), effective March 23, 2010, added new sec. 1866D.
Sec. 10308(a)(1) of the “Patient Protection and Affordable Care Act” (Pub.L. No. 111-148), effective March 23, 2010, amended sec. 1866D(g), as added by Act Sec. 3023, by striking subsection (c)(1)(B) and inserting new subsection (B).
Sec. 10308(a)(2) of the “Patient Protection and Affordable Care Act” (Pub.L. No. 111-148), effective March 23, 2010, amended sec. 1866D(g), as added by Act Sec. 3023, by striking subsection (g) and inserting new subsection (g).

¶15,591 Sec. 1866E. Independence at Home Medical Practice Demonstration Program

[42 U.S.C. §1395cc-5]

(a) Establishment.—

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

(2) Requirement.—The demonstration program shall test whether a model described in paragraph (1), which is accountable for providing comprehensive, coordinated, continuous, and accessible care to high-need populations at home and coordinating health care across all treatment settings, results in—

(A) reducing preventable hospitalizations;
(B) preventing hospital readmissions;
(C) reducing emergency room visits;
(D) improving health outcomes commensurate with the beneficiaries’ stage of chronic illness;
(E) improving the efficiency of care, such as by reducing duplicative diagnostic and laboratory tests;
(F) reducing the cost of health care services covered under this title; and
(G) achieving beneficiary and family caregiver satisfaction.

(b) Independence at Home Medical Practice.—

(1) Independence at Home Medical Practice Defined.—In this section:

(A) In General.—The term ‘independence at home medical practice’ means a legal entity that—

(i) is comprised of an individual physician or nurse practitioner or group of physicians and nurse practitioners that provides care as part of a team that includes physicians, nurses, physician assistants, pharmacists, and other health and social services staff as appropriate who have experience providing home-based primary care to applicable beneficiaries, make in-home visits, and are available 24 hours per day, 7 days per week to carry out plans of care that are tailored to the individual beneficiary’s chronic conditions and designed to achieve the results in subsection (a);

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

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

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

(v) has entered into an agreement with the Secretary;
(vi) uses electronic health information systems, remote monitoring, and mobile diagnostic technology; and

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

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

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

(2) PARTICIPATION OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.—Nothing in this section shall be construed to prevent a nurse practitioner or physician assistant from participating in, or leading, a home-based primary care team as part of an independence at home medical practice if—

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

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

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

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

(4) QUALITY AND PERFORMANCE STANDARDS.—The Secretary shall develop quality performance standards for independence at home medical practices participating in the demonstration program.

(c) PAYMENT METHODOLOGY.—

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

(2) INCENTIVE PAYMENTS.—Subject to performance on quality measures, a qualifying independence at home medical practice is eligible to receive an incentive payment under this section if actual expenditures for a year for the applicable beneficiaries it enrolls are less than the estimated spending target established under paragraph (1) for such year. An incentive payment for such year shall be equal to a portion (as determined by the Secretary) of the amount by which actual expenditures (including incentive payments under this paragraph) for applicable beneficiaries under parts A and B for such year are estimated to be less than 5 percent less than the estimated spending target for such year, as determined under paragraph (1).

(d) APPLICABLE BENEFICIARIES.—

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

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

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

(C) has 2 or more chronic illnesses, such as congestive heart failure, diabetes, other dementias designated by the Secretary, chronic obstructive pulmonary disease, ischemic heart disease, stroke,
Alzheimer’s Disease and neurodegenerative diseases, and other diseases and conditions designated by
the Secretary which result in high costs under this title;
(D) within the past 12 months has had a nonelective hospital admission;
(E) within the past 12 months has received acute or subacute rehabilitation services;
(F) has 2 or more functional dependencies requiring the assistance of another person (such as
bathing, dressing, toileting, walking, or feeding); and
(G) meets such other criteria as the Secretary determines appropriate.

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

(3) BENEFICIARY ACCESS TO SERVICES.—Nothing in this section shall be construed as encouraging
physicians or nurse practitioners to limit applicable beneficiary access to services covered under this title
and applicable beneficiaries shall not be required to relinquish access to any benefit under this title as a
condition of receiving services from an independence at home medical practice.

(e) IMPLEMENTATION.—

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

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

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

(4) PREFERENCE.—In approving an independence at home medical practice, the Secretary shall give
preference to practices that are—
(A) located in high-cost areas of the country;
(B) have experience in furnishing health care services to applicable beneficiaries in the home; and
(C) use electronic medical records, health information technology, and individualized plans of
care.

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

(6) WAIVER.—The Secretary may waive such provisions of this title and title XI as the Secretary
determines necessary in order to implement the demonstration program.

(7) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to this section.

(f) EVALUATION AND MONITORING.—

(1) IN GENERAL.—The Secretary shall evaluate each independence at home medical practice under the
demonstration program to assess whether the practice achieved the results described in subsection (a).

(2) MONITORING APPLICABLE BENEFICIARIES.—The Secretary may monitor data on expenditures and
quality of services under this title after an applicable beneficiary discontinues receiving services under this
title through a qualifying independence at home medical practice.

(g) REPORTS TO CONGRESS.—The Secretary shall conduct an independent evaluation of the demonstration
program and submit to Congress a final report, including best practices under the demonstration program.
Such report shall include an analysis of the demonstration program on coordination of care, expenditures under
this title, applicable beneficiary access to services, and the quality of health care services provided to applicable
beneficiaries.
(h) FUNDING.—For purposes of administering and carrying out the demonstration program, other than for payments for items and services furnished under this title and incentive payments under subsection (c), in addition to funds otherwise appropriated, there shall be transferred to the Secretary for the Center for Medicare & Medicaid Services Program Management Account from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841 (in proportions determined appropriate by the Secretary) $5,000,000 for each of fiscal years 2010 through 2015. Amounts transferred under this subsection for a fiscal year shall be available until expended.

(i) TERMINATION.—

(1) MANDATORY TERMINATION.—The Secretary shall terminate an agreement with an independence at home medical practice if—

(A) the Secretary estimates or determines that such practice will not receive an incentive payment for the second of 2 consecutive years under the demonstration program; or

(B) such practice fails to meet quality standards during any year of the demonstration program.

(2) PERMISSIVE TERMINATION.—The Secretary may terminate an agreement with an independence at home medical practice for such other reasons determined appropriate by the Secretary.

[Explanation at ¶ 747.]

2010 Amendments:

Sec. 10308(b)(2) of the “Patient Protection and Affordable Care Act” (Pub.L. No. 111-148), effective March 23, 2010, amended sec. 1866D, as added by section 3024, as section 1866E.

[¶15,601] Sec. 1868. Practicing Physicians Advisory Council; Council for Technology and Innovation

[42 U.S.C. § 1395ee]

(a) [Repealed.]

* * *

[Explanation at ¶ 1020.]

2010 Amendments:

Sec. 3134(h)(2) of the “Patient Protection and Affordable Care Act” (Pub.L. No. 111-148), effective March 23, 2010, repealed sec. 1868(a). Prior to being repealed, sec. 1868(a) read as follows:

“(a) PRACTICING PHYSICIANS ADVISORY COUNCIL.—

“(1) The Secretary shall appoint, based upon nominations submitted by medical organizations representing physicians, a Practicing Physicians Advisory Council (in this subsection referred to as the “Council”) to be composed of 15 physicians, each of whom has submitted at least 250 claims for physicians’ services under this title in the previous year. At least 11 of the members of the Council shall be physicians described in section 1861(r)(1) and the members of the Council shall include both participating and nonparticipating physicians and physicians practicing in rural areas and underserved urban areas.

“(2) The Council shall meet once during each calendar quarter to discuss certain proposed changes in regulations and carrier manual instructions related to physician services identified by the Secretary. To the extent feasible and consistent with statutory deadlines, such consultation shall occur before the publication of such proposed changes.

“(3) Members of the Council shall be entitled to receive reimbursement of expenses and per diem in lieu of subsistence in the same manner as other members of advisory councils appointed by the Secretary are provided such reimbursement and per diem under this title.

[¶15,621] Sec. 1874. ADMINISTRATION

[42 U.S.C. § 1395kk]

(e) AVAILABILITY OF MEDICARE DATA.—

(1) IN GENERAL.—Subject to paragraph (4), the Secretary shall make available to qualified entities (as defined in paragraph (2)) data described in paragraph (3) for the evaluation of the performance of providers of services and suppliers.

(2) QUALIFIED ENTITIES.—For purposes of this subsection, the term ‘qualified entity’ means a public or private entity that—

§1874(e)(2) ¶15,621
(A) is qualified (as determined by the Secretary) to use claims data to evaluate the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use; and

(B) agrees to meet the requirements described in paragraph (4) and meets such other requirements as the Secretary may specify, such as ensuring security of data.

(3) DATA DESCRIBED.—The data described in this paragraph are standardized extracts (as determined by the Secretary) of claims data under parts A, B, and D for items and services furnished under such parts for one or more specified geographic areas and time periods requested by a qualified entity. The Secretary shall take such actions as the Secretary deems necessary to protect the identity of individuals entitled to or enrolled for benefits under such parts.

(4) REQUIREMENTS.—

(A) FEE.—Data described in paragraph (3) shall be made available to a qualified entity under this subsection at a fee equal to the cost of making such data available. Any fee collected pursuant to the preceding sentence shall be deposited into the Federal Supplementary Medical Insurance Trust Fund under section 1841.

(B) SPECIFICATION OF USES AND METHODOLOGIES.—A qualified entity requesting data under this subsection shall—

(i) submit to the Secretary a description of the methodologies that such qualified entity will use to evaluate the performance of providers of services and suppliers using such data;

(ii)(I) except as provided in subclause (II), if available, use standard measures, such as measures endorsed by the entity with a contract under section 1890(a) and measures developed pursuant to section 931 of the Public Health Service Act; or

(II) use alternative measures if the Secretary, in consultation with appropriate stakeholders, determines that use of such alternative measures would be more valid, reliable, responsive to consumer preferences, cost-effective, or relevant to dimensions of quality and resource use not addressed by such standard measures;

(iii) include data made available under this subsection with claims data from sources other than claims data under this title in the evaluation of performance of providers of services and suppliers;

(iv) only include information on the evaluation of performance of providers and suppliers in reports described in subparagraph (C);

(v) make available to providers of services and suppliers, upon their request, data made available under this subsection; and

(vi) prior to their release, submit to the Secretary the format of reports under subparagraph (C).

(C) REPORTS.—Any report by a qualified entity evaluating the performance of providers of services and suppliers using data made available under this subsection shall—

(i) include an understandable description of the measures, which shall include quality measures and the rationale for use of other measures described in subparagraph (B)(ii)(II), risk adjustment methods, physician attribution methods, other applicable methods, data specifications and limitations, and the sponsors, so that consumers, providers of services and suppliers, health plans, researchers, and other stakeholders can assess such reports;

(ii) be made available confidentially, to any provider of services or supplier to be identified in such report, prior to the public release of such report, and provide an opportunity to appeal and correct errors;

(iii) only include information on a provider of services or supplier in an aggregate form as determined appropriate by the Secretary; and

(iv) except as described in clause (ii), be made available to the public.

(D) APPROVAL AND LIMITATION OF USES.—The Secretary shall not make data described in paragraph (3) available to a qualified entity unless the qualified entity agrees to release the information on the evaluation of performance of providers of services and suppliers. Such entity shall
only use such data, and information derived from such evaluation, for the reports under subparagraph (C). Data released to a qualified entity under this subsection shall not be subject to discovery or admission as evidence in judicial or administrative proceedings without consent of the applicable provider of services or supplier.

[Explanation at ¶ 737 and ¶ 1673.]

2010 Amendments:
Sec. 10332(a) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective Jan. 1, 2012, amended sec. 1874 by adding at the end new subsection (e).

¶ 15,625 Sec. 1874A. Contracts with Medicare Administrative Contractors

[42 U.S.C. §1395kk-1]

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[Explanation at ¶ 1673.]

2010 Amendments:
Sec. 1302 of the “Health Care and Education Reconciliation Act of 2010” (PubLNo 111-152), effective March 30, 2010, repealed sec. 1874A(h). Prior to being repealed, sec. 1874A(h) read as follows:

"(B) CONDUCT OF PREPAYMENT REVIEW"

"(I) CONDUCT OF RANDOM PREPAYMENT REVIEW"

"(A) IN GENERAL A medicare administrative contractor may conduct random prepayment review only to develop a contractor-wide or program-wide claims payment error rates or under such additional circumstances as may be provided under regulations, developed in consultation with providers of services and suppliers."

"(B) USE OF STANDARD PROTOCOLS WHEN CONDUCTING PREPAYMENT REVIEWS When a medicare administrative contractor conducts a random prepayment review, the contractor may conduct such review only in accordance with a standard protocol for random prepayment audits developed by the Secretary."

"(C) CONSTRUCTION Nothing in this paragraph shall be construed as preventing the denial of payments for claims actually reviewed under a random prepayment review."

¶ 15,631 Sec. 1876. Payments to Health Maintenance Organizations and Competitive Medical Plans

[42 U.S.C. §1395mm]

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(h)

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(5)

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(C)

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(ii) For any period beginning on or after January 1, 2013, a reasonable cost reimbursement contract under this subsection may not be extended or renewed for a service area insofar as such area during the entire previous year was within the service area of—

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Sec. 1877. Limitation on Certain Physician Referrals

[42 U.S.C. §1395nn]

(b) ***

(2) ***

if the ownership or investment interest in such services meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse. Such requirements shall, with respect to magnetic resonance imaging, computed tomography, positron emission tomography, and any other designated health services specified under subsection (h)(6)(D) that the Secretary determines appropriate, include a requirement that the referring physician inform the individual in writing at the time of the referral that the individual may obtain the services for which the individual is being referred from a person other than a person described in subparagraph (A)(i) and provide such individual with a written list of suppliers (as defined in section 1861(d)) who furnish such services in the area in which such individual resides.

(d) ***

(2) RURAL PROVIDERS.—In the case of designated health services furnished in a rural area (as defined in section 1886(d)(2)(D)) by an entity, if—

(A) substantially all of the designated health services furnished by the entity are furnished to individuals residing in such a rural area;

(B) effective for the 18-month period beginning on November 18, 2003, the entity is not a specialty hospital (as defined in subsection (h)(7)); and

(C) in the case where the entity is a hospital, the hospital meets the requirements of paragraph (3)(D).

(3) HOSPITAL OWNERSHIP.—In the case of designated health services provided by a hospital (other than a hospital described in paragraph (1)) if—

(B) effective for the 18-month period beginning on November 18, 2003, the hospital is not a specialty hospital (as defined in subsection (h)(7));

(C) the ownership or investment interest is in the hospital itself (and not merely in a subdivision of the hospital); and

(D) the hospital meets the requirements described in subsection (i)(1) not later than 18 months after the date of the enactment of this subparagraph; and
(i) REQUIREMENTS FOR HOSPITALS TO QUALIFY FOR RURAL PROVIDER AND HOSPITAL EXCEPTION TO OWNERSHIP OR INVESTMENT PROHIBITION.—

(1) REQUIREMENTS DESCRIBED.—For purposes of subsection (d)(3)(D), the requirements described in this paragraph for a hospital are as follows:

(A) PROVIDER AGREEMENT.—The hospital had—

(i) physician ownership or investment on December 31, 2010; and

(ii) a provider agreement under section 1866 in effect on such date.

(B) LIMITATION ON EXPANSION OF FACILITY CAPACITY.—Except as provided in paragraph (3), the number of operating rooms, procedure rooms, and beds for which the hospital is licensed at any time on or after the date of the enactment of this subsection is no greater than the number of operating rooms, procedure rooms, and beds for which the hospital is licensed as of such date.

(C) PREVENTING CONFLICTS OF INTEREST.—

(i) The hospital submits to the Secretary an annual report containing a detailed description of—

(I) the identity of each physician owner or investor and any other owners or investors of the hospital; and

(II) the nature and extent of all ownership and investment interests in the hospital.

(ii) The hospital has procedures in place to require that any referring physician owner or investor discloses to the patient being referred, by a time that permits the patient to make a meaningful decision regarding the receipt of care, as determined by the Secretary—

(I) the ownership or investment interest, as applicable, of such referring physician in the hospital; and

(II) if applicable, any such ownership or investment interest of the treating physician.

(iii) The hospital does not condition any physician ownership or investment interests either directly or indirectly on the physician owner or investor making or influencing referrals to the hospital or otherwise generating business for the hospital.

(iv) The hospital discloses the fact that the hospital is partially owned or invested in by physicians—

(I) on any public website for the hospital; and

(II) in any public advertising for the hospital.

(D) ENSURING BONA FIDE INVESTMENT.—

(i) The percentage of the total value of the ownership or investment interests held in the hospital, or in an entity whose assets include the hospital, by physician owners or investors in the aggregate does not exceed such percentage as of the date of enactment of this subsection.

(ii) Any ownership or investment interests that the hospital offers to a physician owner or investor are not offered on more favorable terms than the terms offered to a person who is not a physician owner or investor.

(iii) The hospital (or any owner or investor in the hospital) does not directly or indirectly provide loans or financing for any investment in the hospital by a physician owner or investor.

(iv) The hospital (or any owner or investor in the hospital) does not directly or indirectly guarantee a loan, make a payment toward a loan, or otherwise subsidize a loan, for any individual physician owner or investor or group of physician owners or investors that is related to acquiring any ownership or investment interest in the hospital.

(v) Ownership or investment returns are distributed to each owner or investor in the hospital in an amount that is directly proportional to the ownership or investment interest of such owner or investor in the hospital.

(vi) Physician owners and investors do not receive, directly or indirectly, any guaranteed receipt of or right to purchase other business interests related to the hospital, including the purchase or lease of any property under the control of other owners or investors in the hospital or located near the premises of the hospital.
(vii) The hospital does not offer a physician owner or investor the opportunity to purchase or lease any property under the control of the hospital or any other owner or investor in the hospital on more favorable terms than the terms offered to an individual who is not a physician owner or investor.

(E) PATIENT SAFETY.—

(i) Insofar as the hospital admits a patient and does not have any physician available on the premises to provide services during all hours in which the hospital is providing services to such patient, before admitting the patient—

(I) the hospital discloses such fact to a patient; and

(II) following such disclosure, the hospital receives from the patient a signed acknowledgment that the patient understands such fact.

(ii) The hospital has the capacity to—

(I) provide assessment and initial treatment for patients; and

(II) refer and transfer patients to hospitals with the capability to treat the needs of the patient involved.

(F) LIMITATION ON APPLICATION TO CERTAIN CONVERTED FACILITIES.—The hospital was not converted from an ambulatory surgical center to a hospital on or after the date of enactment of this subsection.

(2) PUBLICATION OF INFORMATION REPORTED.—The Secretary shall publish, and update on an annual basis, the information submitted by hospitals under paragraph (1)(C)(i) on the public Internet website of the Centers for Medicare & Medicaid Services.

(3) EXCEPTION TO PROHIBITION ON EXPANSION OF FACILITY CAPACITY.—

(A) PROCESS.—

(i) ESTABLISHMENT.—The Secretary shall establish and implement a process under which a hospital that is an applicable hospital (as defined in subparagraph (E)) or is a high Medicaid facility described in subparagraph (F) may apply for an exception from the requirement under paragraph (1)(B).

(ii) OPPORTUNITY FOR COMMUNITY INPUT.—The process under clause (i) shall provide individuals and entities in the community in which the applicable hospital applying for an exception is located with the opportunity to provide input with respect to the application.

(iii) TIMING FOR IMPLEMENTATION.—The Secretary shall implement the process under clause (i) on February 1, 2012.

(iv) REGULATIONS.—Not later than January 1, 2012, the Secretary shall promulgate regulations to carry out the process under clause (i).

(B) FREQUENCY.—The process described in subparagraph (A) shall permit an applicable hospital to apply for an exception up to once every 2 years.

(C) PERMITTED INCREASE.—

(i) IN GENERAL.—Subject to clause (ii) and subparagraph (D), an applicable hospital granted an exception under the process described in subparagraph (A) may increase the number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed above the baseline number of operating rooms, procedure rooms, and beds of the applicable hospital (or, if the applicable hospital has been granted a previous exception under this paragraph, above the number of operating rooms, procedure rooms, and beds for which the hospital is licensed after the application of the most recent increase under such an exception).

(ii) 100 PERCENT INCREASE LIMITATION.—The Secretary shall not permit an increase in the number of operating rooms, procedure rooms, and beds for which an applicable hospital is licensed under clause (i) to the extent such increase would result in the number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed exceeding 200
percent of the baseline number of operating rooms, procedure rooms, and beds of the applicable hospital.

(iii) **Baseline Number of Operating Rooms, Procedure Rooms, and Beds.**—In this paragraph, the term ‘baseline number of operating rooms, procedure rooms, and beds’ means the number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed as of the date of enactment of this subsection (or, in the case of a hospital that did not have a provider agreement in effect as of such date but does have such an agreement in effect on December 31, 2010, the effective date of such provider agreement).

(D) **Increase Limited to Facilities on the Main Campus of the Hospital.**—Any increase in the number of operating rooms, procedure rooms, and beds for which an applicable hospital is licensed pursuant to this paragraph may only occur in facilities on the main campus of the applicable hospital.

(E) **Applicable Hospital.**—In this paragraph, the term ‘applicable hospital’ means a hospital—

(i) that is located in a county in which the percentage increase in the population during the most recent 5-year period (as of the date of the application under subparagraph (A)) is at least 150 percent of the percentage increase in the population growth of the State in which the hospital is located during that period, as estimated by Bureau of the Census;

(ii) whose annual percent of total inpatient admissions that represent inpatient admissions under the program under title XIX is equal to or greater than the average percent with respect to such admissions for all hospitals located in the county in which the hospital is located;

(iii) that does not discriminate against beneficiaries of Federal health care programs and does not permit physicians practicing at the hospital to discriminate against such beneficiaries;

(iv) that is located in a State in which the average bed capacity in the State is less than the national average bed capacity; and

(v) that has an average bed occupancy rate that is greater than the average bed occupancy rate in the State in which the hospital is located.

(F) **High Medicaid Facility Described.**—A high Medicaid facility described in this subparagraph is a hospital that—

(i) is not the sole hospital in a county;

(ii) with respect to each of the 3 most recent years for which data are available, has an annual percent of total inpatient admissions that represent inpatient admissions under title XIX that is estimated to be greater than such percent with respect to such admissions for any other hospital located in the county in which the hospital is located; and

(iii) meets the conditions described in subparagraph (E)(iii).

(G) **Procedure Rooms.**—In this subsection, the term ‘procedure rooms’ includes rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed, except such term shall not include emergency rooms or departments (exclusive of rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed).

(H) **Publication of Final Decisions.**—Not later than 60 days after receiving a complete application under this paragraph, the Secretary shall publish in the Federal Register the final decision with respect to such application.

(I) **Limitation on Review.**—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the process under this paragraph (including the establishment of such process).

(4) **Collection of Ownership and Investment Information.**—For purposes of subparagraphs (A)(i) and (D)(i) of paragraph (1), the Secretary shall collect physician ownership and investment information for each hospital.

(5) **Physician Owner or Investor Defined.**—For purposes of this subsection, the term ‘physician owner or investor’ means a physician (or an immediate family member of such physician) with a direct or an indirect ownership or investment interest in the hospital.
(6) CLARIFICATION.—Nothing in this subsection shall be construed as preventing the Secretary from revoking a hospital's provider agreement if not in compliance with regulations implementing section 1866.

[Explanation at ¶ 1605 and ¶ 1615.]

2010 Amendments:
Sec. 6001(a)(1) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1877(d)(2) in subparagraph (A), by striking “and” at the end; in subparagraph (B), by striking the period at the end and inserting “; and”; and by adding at the end the new subparagraph (C).

Sec. 6001(a)(2) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1877(d)(3) in subparagraph (B), by striking “and” at the end; in subparagraph (C), by striking the period at the end and inserting “; and”; and by adding at the end the new subparagraph (D).

Sec. 6001(a)(3) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1877 by adding at the end the new subsection (i).

Sec. 6003(a) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1877 by adding at the end the new subsection (i).

Sec. 1880. Indian Health Services Facilities
[42 U.S.C. §1395qq]

(e)(1)(A) Notwithstanding section 1835(d), subject to subparagraph (B), the Secretary shall make payment under part B to a hospital or an ambulatory care clinic (whether provider-based or freestanding) that is operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined for purposes of subsection (a)) for services described in paragraph (2) and for items and services furnished on or before January 1, 2010, amended sec. 1877(i)(6) by striking “February 1, 2010” and inserting “August 1, 2010”; in paragraph (3)(A)(iii), by striking “August 1, 2011” and inserting “February 1, 2012”; and in clause (iv), by striking “July 1, 2011” and inserting “January 1, 2012”.

Sec. 1106 of the “Health Care Reconciliation Act of 2010” (PubLNo 111-152) amended sec. 1877(i)—

in paragraph (1)(A)(1) by striking “August 1, 2010” and inserting “December 31, 2010”;

in paragraph (3)(A)(i), by striking “an applicable hospital (as defined in subparagraph (E))” and inserting “a hospital that is an applicable hospital (as defined in subparagraph (E)) or is a high Medicaid facility described in subparagraph (F)”;

in subparagraph (C)(iii), by inserting after “date of enactment” the following: “or, in the case of a hospital that did not have a provider agreement in effect as of such date but does have such an agreement in effect on December 31, 2010, the effective date of such provider agreement”;

by redesignating subparagraphs (F) through (H) as subparagraphs (G) through (I), respectively;

by inserting after subparagraph (E) a new subparagraph (F).

¶15,651 Sec. 1881. Medicare Coverage for End Stage Renal Disease Patients
[42 U.S.C. §1395rr]

(b)

¶15,651 §1877(i)(6)
(F)(i) Subject to subclause (II) and clause (ii), beginning in 2012, the Secretary shall annually increase payment amounts established under this paragraph by an ESRD market basket percentage increase factor for a bundled payment system for renal dialysis services that reflects changes over time in the prices of an appropriate mix of goods and services included in renal dialysis services.

(II) For 2012 and each subsequent year, after determining the increase factor described in subclause (I), the Secretary shall reduce such increase factor by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II). The application of the preceding sentence may result in such increase factor being less than 0.0 for a year, and may result in payment rates under the payment system under this paragraph for a year being less than such payment rates for the preceding year.

(ii)

(II) Subject to clause (i)(II), the Secretary shall annually increase such composite rate by the ESRD market basket percentage increase factor described in clause (i)(I).

[Explanation at ¶ 770, ¶ 845 and ¶ 1340.]

2010 Amendments:

Sec. 3401(h) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1881B(b)(14)(F) in clause (i) by inserting “(I)” after “(F)(i)”, in subclause (I), as inserted by subparagraph (A) by striking “clause (ii)” and inserting “subclause (ii)” and clause (ii); and by striking “minus 1.0 percentage point” and by adding at the end the new subclause (II), in clause (ii)(II) by striking “The” and inserting “Subject to clause (i)(II), the” and by striking “clause (i) minus 1.0 percentage point” and inserting “clause (i)(I)”.

¶15,671 Sec. 1881A. MEDICARE COVERAGE FOR INDIVIDUALS EXPOSED TO ENVIRONMENTAL HEALTH HAZARDS

(a) Deeming of Individuals as Eligible for Medicare Benefits.—

(1) In general.—For purposes of eligibility for benefits under this title, an individual determined under subsection (c) to be an environmental exposure affected individual described in subsection (e)(2) shall be deemed to meet the conditions specified in section 226(a).

(2) Discretionary deeming.—For purposes of eligibility for benefits under this title, the Secretary may deem an individual determined under subsection (c) to be an environmental exposure affected individual described in subsection (e)(3) to meet the conditions specified in section 226(a).

(3) Effective date of coverage.—An individual who is deemed eligible for benefits under this title under paragraph (1) or (2) shall be—

(A) entitled to benefits under the program under Part A as of the date of such deeming; and

(B) eligible to enroll in the program under Part B beginning with the month in which such deeming occurs.

(b) Pilot Program for Care of Certain Individuals Residing in Emergency Declaration Areas.—

(1) Program; purpose.—

(A) Primary pilot program.—The Secretary shall establish a pilot program in accordance with this subsection to provide innovative approaches to furnishing comprehensive, coordinated, and cost-effective care under this title to individuals described in paragraph (2)(A).

(B) Optional pilot programs.—The Secretary may establish a separate pilot program, in accordance with this subsection, with respect to each geographic area subject to an emergency declaration (other than the declaration of June 17, 2009), in order to furnish such comprehensive,
coordinated and cost-effective care to individuals described in subparagraph (2)(B) who reside in each such area.

(2) INDIVIDUAL DESCRIBED.—For purposes of paragraph (1), an individual described in this paragraph is an individual who enrolls in part B, submits to the Secretary an application to participate in the applicable pilot program under this subsection, and—

(A) is an environmental exposure affected individual described in subsection (e)(2) who resides in or around the geographic area subject to an emergency declaration made as of June 17, 2009; or

(B) is an environmental exposure affected individual described in subsection (e)(3) who—

(i) is deemed under subsection (a)(2); and

(ii) meets such other criteria or conditions for participation in a pilot program under paragraph (1)(B) as the Secretary specifies.

(3) FLEXIBLE BENEFITS AND SERVICES.—A pilot program under this subsection may provide for the furnishing of benefits, items, or services not otherwise covered or authorized under this title, if the Secretary determines that furnishing such benefits, items, or services will further the purposes of such pilot program (as described in paragraph (1)).

(4) INNOVATIVE REIMBURSEMENT METHODOLOGIES.—For purposes of the pilot program under this subsection, the Secretary—

(A) shall develop and implement appropriate methodologies to reimburse providers for furnishing benefits, items, or services for which payment is not otherwise covered or authorized under this title, if such benefits, items, or services are furnished pursuant to paragraph (3); and

(B) may develop and implement innovative approaches to reimbursing providers for any benefits, items, or services furnished under this subsection.

(5) LIMITATION.—Consistent with section 1862(b), no payment shall be made under the pilot program under this subsection with respect to benefits, items, or services furnished to an environmental exposure affected individual (as defined in subsection (e)) to the extent that such individual is eligible to receive such benefits, items, or services through any other public or private benefits plan or legal agreement.

(6) WAIVER AUTHORITY.—The Secretary may waive such provisions of this title and title XI as are necessary to carry out pilot programs under this subsection.

(7) FUNDING.—For purposes of carrying out pilot programs under this subsection, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841, in such proportion as the Secretary determines appropriate, of such sums as the Secretary determines necessary, to the Centers for Medicare & Medicaid Services Program Management Account.

(8) WAIVER OF BUDGET NEUTRALITY.—The Secretary shall not require that pilot programs under this subsection be budget neutral with respect to expenditures under this title.

(c) DETERMINATIONS.—

(1) BY THE COMMISSIONER OF SOCIAL SECURITY.—For purposes of this section, the Commissioner of Social Security, in consultation with the Secretary, and using the cost allocation method prescribed in section 201(g), shall determine whether individuals are environmental exposure affected individuals.

(2) BY THE SECRETARY.—The Secretary shall determine eligibility for pilot programs under subsection (b).

(d) EMERGENCY DECLARATION DEFINED.—For purposes of this section, the term 'emergency declaration' means a declaration of a public health emergency under section 104(a) of the Comprehensive Environmental Response, Compensation, and Liability Act of 1980.

(e) ENVIRONMENTAL EXPOSURE AFFECTED INDIVIDUAL DEFINED.—

(1) IN GENERAL.—For purposes of this section, the term 'environmental exposure affected individual' means—

(A) an individual described in paragraph (2); and
(B) an individual described in paragraph (3).

(2) INDIVIDUAL DESCRIBED.—

(A) IN GENERAL.—An individual described in this paragraph is any individual who—

(i) is diagnosed with 1 or more conditions described in subparagraph (B);

(ii) as demonstrated in such manner as the Secretary determines appropriate, has been present for an aggregate total of 6 months in the geographic area subject to an emergency declaration specified in subsection (b)(2)(A), during a period ending—

(I) not less than 10 years prior to such diagnosis; and

(II) prior to the implementation of all the remedial and removal actions specified in the Record of Decision for Operating Unit 4 and the Record of Decision for Operating Unit 7;

(iii) files an application for benefits under this title (or has an application filed on behalf of the individual), including pursuant to this section; and

(iv) is determined under this section to meet the criteria in this subparagraph.

(B) CONDITIONS DESCRIBED.—For purposes of subparagraph (A), the following conditions are described in this subparagraph:

(i) Asbestosis, pleural thickening, or pleural plaques as established by—

(I) interpretation by a ‘B Reader’ qualified physician of a plain chest x-ray or interpretation of a computed tomographic radiograph of the chest by a qualified physician, as determined by the Secretary; or

(II) such other diagnostic standards as the Secretary specifies, except that this clause shall not apply to pleural thickening or pleural plaques unless there are symptoms or conditions requiring medical treatment as a result of these diagnoses.

(ii) Mesothelioma, or malignancies of the lung, colon, rectum, larynx, stomach, esophagus, pharynx, or ovary, as established by—

(I) pathologic examination of biopsy tissue;

(II) cytology from bronchioalveolar lavage; or

(III) such other diagnostic standards as the Secretary specifies.

(iii) Any other diagnosis which the Secretary, in consultation with the Commissioner of Social Security, determines is an asbestos-related medical condition, as established by such diagnostic standards as the Secretary specifies.

(3) OTHER INDIVIDUAL DESCRIBED.—An individual described in this paragraph is any individual who—

(A) is not an individual described in paragraph (2);

(B) is diagnosed with a medical condition caused by the exposure of the individual to a public health hazard to which an emergency declaration applies, based on such medical conditions, diagnostic standards, and other criteria as the Secretary specifies;

(C) as demonstrated in such manner as the Secretary determines appropriate, has been present for an aggregate total of 6 months in the geographic area subject to the emergency declaration involved, during a period determined appropriate by the Secretary;

(D) files an application for benefits under this title (or has an application filed on behalf of the individual), including pursuant to this section; and

(E) is determined under this section to meet the criteria in this paragraph.
Sec. 1882. Development of New Standards for Certain Medicare Supplemental Policies

[42 U.S.C. §1395ss(y)]

(o) 

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(1) Each medicare supplemental policy shall provide for coverage of a group of benefits consistent with subsections (p), (v), (w), and (y).

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(y) DEVELOPMENT OF NEW STANDARDS FOR CERTAIN MEDIGAP PLANS.—

(1) IN GENERAL.—The Secretary shall request the National Association of Insurance Commissioners to review and revise the standards for benefit packages described in paragraph (2) under subsection (p)(1), to otherwise update standards to include requirements for nominal cost sharing to encourage the use of appropriate physicians’ services under part B. Such revisions shall be based on evidence published in peer-reviewed journals or current examples used by integrated delivery systems and made consistent with the rules applicable under subsection (p)(1)(E) with the reference to the ‘1991 NAIC Model Regulation’ deemed a reference to the NAIC Model Regulation as published in the Federal Register on December 4, 1998, and as subsequently updated by the National Association of Insurance Commissioners to reflect previous changes in law and the reference to ‘date of enactment of this subsection’ deemed a reference to the date of enactment of the Patient Protection and Affordable Care Act. To the extent practicable, such revision shall provide for the implementation of revised standards for benefit packages as of January 1, 2015.

(2) BENEFIT PACKAGES DESCRIBED.—The benefit packages described in this paragraph are benefit packages classified as ‘C’ and ‘F’.

Sec. 3210(b) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1882 by adding the new subsection (y).

Sec. 3210(a) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1882(o)(1) by striking “,” and (w)” and inserting “(w), and (y)”.

Sec. 1882(o)(1) by striking “,” and (w)” and inserting “(w), and (y)”.

(3) ***

(B)(i) ***

(XX) for each subsequent fiscal year, subject to clauses (viii), (ix), (xi), and (xii), the market basket percentage increase for hospitals in all areas.

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(viii)(I) For purposes of clause (i) for fiscal year 2007 and each subsequent fiscal year, in the case of a subsection (d) hospital that does not submit, to the Secretary in accordance with this clause, data required to be submitted on measures selected under this clause with respect to such a fiscal year, the applicable percentage increase under clause (i) for such fiscal year shall be reduced by 2.0 percentage points (or, beginning with fiscal year 2015, by one-quarter of such applicable percentage increase (determined without regard to clause (ix), (xi), or (xii))). Such reduction shall apply only with respect to...
the fiscal year involved and the Secretary shall not take into account such reduction in computing the applicable percentage increase under clause (i) for a subsequent fiscal year, and the Secretary and the Medicare Payment Advisory Commission shall carry out the requirements under section 5001(b) of the Deficit Reduction Act of 2005.

(II) Each subsection (d) hospital shall submit data on measures selected under this clause to the Secretary in a form and manner, and at a time, specified by the Secretary for purposes of this clause. The Secretary may require hospitals to submit data on measures that are not used for the determination of value-based incentive payments under subsection (o).

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(V) Effective for payments for fiscal years 2008 through 2012, the Secretary shall add other measures that reflect consensus among affected parties and, to the extent feasible and practicable, shall include measures set forth by one or more national consensus building entities.

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(VII) The Secretary shall establish procedures for making information regarding measures submitted under this clause available to the public. Such procedures shall ensure that a hospital has the opportunity to review the data that are to be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality measures of process, structure, outcome, patients’ perspectives on care, efficiency, and costs of care that relate to services furnished in inpatient settings in hospitals on the Internet website of the Centers for Medicare & Medicaid Services.

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

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

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

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

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

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

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

***

(ix)(I) For purposes of clause (i) for fiscal year 2015 and each subsequent fiscal year, in the case of an eligible hospital (as defined in subsection (n)(6)(A)) that is not a meaningful EHR user (as defined in subsection (n)(3)) for an EHR reporting period for such fiscal year, three-quarters of the applicable percentage increase otherwise applicable under clause (i) (determined without regard to clause (viii), (xi), or (xii)) for such fiscal year shall be reduced by 33 1/3 percent for fiscal year 2015, 66 2/3 percent for fiscal year 2016, and 100 percent for fiscal year 2017 and each subsequent fiscal year. Such
reduction shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the applicable percentage increase under clause (i) for a subsequent fiscal year.

***

(x)(I) The Secretary shall develop standard Internet website reports tailored to meet the needs of various stakeholders such as hospitals, patients, researchers, and policymakers. The Secretary shall seek input from such stakeholders in determining the type of information that is useful and the formats that best facilitate the use of the information.

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

(xii)(I) For 2012 and each subsequent fiscal year, after determining the applicable percentage increase described in clause (i) and after application of clauses (viii) and (ix), such percentage increase shall be reduced by the productivity adjustment described in subclause (II).

(II) The productivity adjustment described in this subclause, with respect to a percentage, factor, or update for a fiscal year, year, cost reporting period, or other annual period, is a productivity adjustment equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, year, cost reporting period, or other annual period).

(III) The application of subclause (I) may result in the applicable percentage increase described in clause (i) being less than 0.0 for a fiscal year, and may result in payment rates under this section for a fiscal year being less than such payment rates for the preceding fiscal year.

(xiii) After determining the applicable percentage increase described in clause (i), and after application of clauses (viii), (ix), and (xii), the Secretary shall reduce such applicable percentage increase—

(I) for each of fiscal years 2010 and 2011, by 0.25 percentage point;

(II) for each of fiscal years 2012 and 2013, by 0.1 percentage point;

(III) for fiscal year 2014, by 0.3 percentage point;

(IV) for each of fiscal years 2015 and 2016, by 0.2 percentage point; and

(V) for each of fiscal years 2017, 2018, and 2019, by 0.75 percentage point.

***

(D) For cost reporting periods ending on or before September 30, 1994, and for discharges occurring on or after October 1, 1997, and before October 1, 2012, in the case of a hospital that is a medicare-dependent, small rural hospital (as defined in subsection (d)(5)(G)), subject to subparagraph (K), the term “target amount” means—

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(iv) with respect to discharges occurring during fiscal year 1998 through fiscal year 2012, the target amount for the preceding year increased by the applicable percentage increase under subparagraph (B)(iv).
(i) IN GENERAL.—Except as provided in clause (ii) or (iii), the Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals’ costs which are attributable to wages and wage-related costs, of the DRG prospective payment rates computed under subparagraph (D) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level. Not later than October 1, 1990, and October 1, 1993 (and at least every 12 months thereafter), the Secretary shall update the factor under the preceding sentence on the basis of a survey conducted by the Secretary (and updated as appropriate) of the wages and wage-related costs of subsection (d) hospitals in the United States. Not less often than once every 3 years the Secretary (through such survey or otherwise) shall measure the earnings and paid hours of employment by occupational category and shall exclude data with respect to the wages and wage-related costs incurred in furnishing skilled nursing facility services. Any adjustments or updates made under this subparagraph for a fiscal year (beginning with fiscal year 1991) shall be made in a manner that assures that the aggregate payments under this subsection in the fiscal year are not greater or less than those that would have been made in the year without such adjustment. The Secretary shall apply the previous sentence for any period as if the amendments made by section 403(a)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and the amendments made by section 10324(a)(1) of the Patient Protection and Affordable Care Act had not been enacted.

(iii) FLOOR ON AREA WAGE INDEX FOR HOSPITALS IN FRONTIER STATES.—

(I) IN GENERAL.—Subject to subclause (IV), for discharges occurring on or after October 1, 2010, the area wage index applicable under this subparagraph to any hospital which is located in a frontier State (as defined in subclause (II)) may not be less than 1.00.

(II) FRONTIER STATE DEFINED.—In this clause, the term ‘frontier State’ means a State in which at least 50 percent of the counties in the State are frontier counties.

(III) FRONTIER COUNTY DEFINED.—In this clause, the term ‘frontier county’ means a county in which the population per square mile is less than 6.

(IV) LIMITATION.—This clause shall not apply to any hospital located in a State that receives a non-labor related share adjustment under paragraph (5)(H).

(v) In determining the adjustment with respect to a hospital for discharges occurring on or after October 1, 1997, the total number of full-time equivalent interns and...
residents in the fields of allopathic and osteopathic medicine in either a hospital or nonhospital setting may not exceed the number (or, 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent interns and residents in the hospital with respect to the hospital’s most recent cost reporting period ending on or before December 31, 1996. Rules similar to the rules of subsection (h)(4)(F)(ii) shall apply for purposes of this clause. The provisions of subsections (h)(4)(H)(vi), (h)(7), and (h)(8) shall apply with respect to the first sentence of this clause in the same manner as they apply with respect to subsection (h)(4)(F)(i).

***

Caution: Section 1886(d)(5)(B)(x)(III) of the Social Security Act, as added by sec. 5505(b) of the Patient Protection and Affordable Care Act (Pub.L. No. 111-148), shall apply to cost reporting periods beginning on or after October 1, 2001. Such section, as so added, shall not give rise to any inference as to how the law in effect prior to such date should be interpreted.

(x) For discharges occurring on or after July 1, 2011, insofar as an additional payment amount under this subparagraph is attributable to resident positions distributed to a hospital under subsection (h)(8)(B), the indirect teaching adjustment factor shall be computed in the same manner as provided under clause (ii) with respect to such resident positions.

***

Caution: The previous sec. 1886(d)(5)(B)(x) was added by sec. 5503(b)(2) of the Patient Protection and Affordable Care Act (P.L. 111-148). The next section, also 1886(d)(5)(B)(x), was added by sec. 5505(b) of that Act.

(x)(I) The provisions of subparagraph (K) of subsection (h)(4) shall apply under this subparagraph in the same manner as they apply under such subsection.

(II) In determining the hospital’s number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in non-patient care activities, such as didactic conferences and seminars, as such time and activities are defined by the Secretary, that occurs in the hospital shall be counted toward the determination of full-time equivalency if the hospital—

(aa) is recognized as a subsection (d) hospital;

(bb) is recognized as a subsection (d) Puerto Rico hospital;

(cc) is reimbursed under a reimbursement system authorized under section 1814(b)(3); or

(dd) is a provider-based hospital outpatient department.

(III) In determining the hospital’s number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in research activities that are not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall not be counted toward the determination of full-time equivalency.

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(F)(i) Subject to subsection (r), for discharges occurring on or after May 1, 1986, the Secretary shall provide, in accordance with this subparagraph, for an additional payment amount for each subsection (d) hospital which—

***

(G)(i) For any cost reporting period or for discharges in the fiscal year beginning on or after April 1, 1990, and before October 1, 1994, or discharges occurring on or after October 1, 1997, and before October 1, 2012, in the case of a subsection (d) hospital which is a medicare-dependent, small rural hospital, payment under paragraph (1)(A) shall be equal to the sum of the amount determined under clause (ii) and the amount determined under paragraph (1)(A)(iii).

***

(ii)
(II) for discharges occurring during any subsequent cost reporting period (or portion thereof) and before October 1, 1994, or discharges occurring on or after October 1, 1997, and before October 1, 2006, 50 percent (or 75 percent in the case of discharges occurring on or after October 1, 2006) of the amount by which the hospital’s target amount for the cost reporting period (as defined in subsection (b)(3)(D)) exceeds the amount determined under paragraph (1)(A)(iii).

***

(A) IN GENERAL.—In addition to any payments calculated under this section for a subsection (d) hospital, for discharges occurring during a fiscal year (beginning with fiscal year 2005), the Secretary shall provide for an additional payment amount to each low-volume hospital (as defined in subparagraph (C)(i)) for discharges occurring during that fiscal year that is equal to the applicable percentage increase (determined under subparagraph (B) or (D) for the hospital involved) in the amount paid to such hospital under this section for such discharges (determined without regard to this paragraph).

(B) APPLICABLE PERCENTAGE INCREASE.—For discharges occurring in fiscal years 2005 through 2010 and for discharges occurring in fiscal year 2013 and subsequent fiscal years, the Secretary shall determine an applicable percentage increase for purposes of subparagraph (A) as follows:

***

(C)(i) LOW-VOLUME HOSPITAL.—For purposes of this paragraph, the term “low-volume hospital” means, for a fiscal year, a subsection (d) hospital (as defined in paragraph (1)(B)) that the Secretary determines is located more than 25 road miles (or, with respect to fiscal years 2011 and 2012, 15 road miles) from another subsection (d) hospital and has less than 800 discharges (or, with respect to fiscal years 2011 and 2012, 1,600 discharges of individuals entitled to, or enrolled for, benefits under part A) during the fiscal year.

***

(D) TEMPORARY APPLICABLE PERCENTAGE INCREASE.—For discharges occurring in fiscal years 2011 and 2012, the Secretary shall determine an applicable percentage increase for purposes of subparagraph (A) using a continuous linear sliding scale ranging from 25 percent for low-volume hospitals with 200 or fewer discharges of individuals entitled to, or enrolled for, benefits under part A in the fiscal year to 0 percent for low-volume hospitals with greater than 1,600 discharges of such individuals in the fiscal year.

(h)

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(4)

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(E) COUNTING TIME SPENT IN OUTPATIENT SETTINGS.—Subject to subparagraphs (f) and (k), such rules shall provide that only time spent in activities relating to patient care shall be counted and that—

(i) effective for cost reporting periods beginning before July 1, 2010, all the time; so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting; and

(ii) effective for cost reporting periods beginning on or after July 1, 2010, all the time so spent by a resident shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if a hospital incurs the costs of the stipends and fringe benefits of the resident during the time the resident spends in that setting, and if more than one hospital incurs these costs, either directly or through a third party, such hospitals shall count a proportional share of the time, as determined by written agreement between the hospitals, that a resident spends training in that setting.
Any hospital claiming under this subparagraph for time spent in a nonprovider setting shall maintain and make available to the Secretary records regarding the amount of such time and such amount in comparison with amounts of such time in such base year as the Secretary shall specify.

(F)(i) IN GENERAL.—Such rules shall provide that for purposes of a cost reporting period beginning on or after October 1, 1997, subject to paragraphs (7) and (8), the total number of full-time equivalent residents before application of weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic medicine and osteopathic medicine may not exceed the number (or, 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.

(H)(i) NEW FACILITIES.—The Secretary shall, consistent with the principles of subparagraphs (F) and (G) and subject to paragraphs (7) and (8), prescribe rules for the application of such subparagraphs in the case of medical residency training programs established on or after January 1, 1995. In promulgating such rules for purposes of subparagraph (F), the Secretary shall give special consideration to facilities that meet the needs of underserved rural areas.

(iv) NONRURAL HOSPITALS OPERATING TRAINING PROGRAMS IN RURAL AREAS.—In the case of a hospital that is not located in a rural area but establishes separately accredited approved medical residency training programs (or rural tracks) in an rural area or has an accredited training program with an integrated rural track, the Secretary shall adjust the limitation under subparagraph (F) in an appropriate manner in order to encourage the training of physicians in rural areas.

(vi) REDISTRIBUTION OF RESIDENCY SLOTS AFTER A HOSPITAL CLOSES.—(I) IN GENERAL.—Subject to the succeeding provisions of this clause, the Secretary shall, by regulation, establish a process under which, in the case where a hospital (other than a hospital described in clause (v)) with an approved medical residency program closes on or after a date that is 2 years before the date of enactment of this clause, the Secretary shall increase the otherwise applicable resident limit under this paragraph for other hospitals in accordance with this clause.

(II) PRIORITY FOR HOSPITALS IN CERTAIN AREAS.—Subject to the succeeding provisions of this clause, in determining for which hospitals the increase in the otherwise applicable resident limit is provided under such process, the Secretary shall distribute the increase to hospitals in the following priority order (with preference given within each category to hospitals that are members of the same affiliated group (as defined by the Secretary under clause (ii)) as the closed hospital):

(aa) First, to hospitals located in the same core-based statistical area as, or a core-based statistical area contiguous to, the hospital that closed.

(bb) Second, to hospitals located in the same State as the hospital that closed.

(cc) Third, to hospitals located in the same region of the country as the hospital that closed.

(dd) Fourth, only if the Secretary is not able to distribute the increase to hospitals described in item (cc), to qualifying hospitals in accordance with the provisions of paragraph (8).

(III) REQUIREMENT HOSPITAL LIKELY TO FILL POSITION WITHIN CERTAIN TIME PERIOD.—The Secretary may only increase the otherwise applicable resident limit of a hospital under such process if the Secretary determines the hospital has demonstrated a likelihood of filling the positions made available under this clause within 3 years.
(IV) LIMITATION.—The aggregate number of increases in the otherwise applicable resident limits for hospitals under this clause shall be equal to the number of resident positions in the approved medical residency programs that closed on or after the date described in subclause (I).

(V) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the implementation of this clause.

Caution: Sec. 5505(a)(1)(B) of the Patient Protection and Affordable Care Act (P.L. 111-148) amended this sec. 1886(h)(4) in such a way that the subsections jump from (H) to (J).

(J) TREATMENT OF CERTAIN NONPROVIDER AND DIDACTIC ACTIVITIES.—Such rules shall provide that all time spent by an intern or resident in an approved medical residency training program in a nonprovider setting that is primarily engaged in furnishing patient care (as defined in paragraph (5)(K)) in non-patient care activities, such as didactic conferences and seminars, but not including research not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall be counted toward the determination of full-time equivalency.

(K) TREATMENT OF CERTAIN OTHER ACTIVITIES.—In determining the hospital’s number of full-time equivalent residents for purposes of this subsection, all the time that is spent by an intern or resident in an approved medical residency training program on vacation, sick leave, or other approved leave, as such time is defined by the Secretary, and that does not prolong the total time the resident is participating in the approved program beyond the normal duration of the program shall be counted toward the determination of full-time equivalency.

(5) ***

(K) NONPROVIDER SETTING THAT IS PRIMARILY ENGAGED IN FURNISHING PATIENT CARE.—The term ‘nonprovider setting that is primarily engaged in furnishing patient care’ means a nonprovider setting in which the primary activity is the care and treatment of patients, as defined by the Secretary.

***

(7) ***

(E) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, with respect to determinations made under this paragraph, paragraph (8), or paragraph (4)(H)(v).

(8) DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS.—

(A) REDUCTIONS IN LIMIT BASED ON UNUSED POSITIONS.—

(i) IN GENERAL.—Except as provided in clause (ii), if a hospital’s reference resident level (as defined in subparagraph (H)(i)) is less than the otherwise applicable resident limit (as defined in subparagraph (H)(iii)), effective for portions of cost reporting periods occurring on or after July 1, 2011, the otherwise applicable resident limit shall be reduced by 65 percent of the difference between such otherwise applicable resident limit and such reference resident level.

(ii) EXCEPTIONS.—This subparagraph shall not apply to—

(I) a hospital located in a rural area (as defined in subsection (d)(2)(D)(ii)) with fewer than 250 acute care inpatient beds;

(II) a hospital that was part of a qualifying entity which had a voluntary residency reduction plan approved under paragraph (6)(B) or under the authority of section 402 of Public Law 90-248, if the hospital demonstrates to the Secretary that it has a specified plan in place for filling the unused positions by not later than 2 years after the date of enactment of this paragraph; or

(III) a hospital described in paragraph (4)(H)(v).
(B) DISTRIBUTION.—

(i) IN GENERAL.—The Secretary shall increase the otherwise applicable resident limit for each qualifying hospital that submits an application under this subparagraph by such number as the Secretary may approve for portions of cost reporting periods occurring on or after July 1, 2011. The aggregate number of increases in the otherwise applicable resident limit under this subparagraph shall be equal to the aggregate reduction in such limits attributable to subparagraph (A) (as estimated by the Secretary).

(ii) REQUIREMENTS.—Subject to clause (iii), a hospital that receives an increase in the otherwise applicable resident limit under this subparagraph shall ensure, during the 5-year period beginning on the date of such increase, that—

(I) the number of full-time equivalent primary care residents, as defined in paragraph (5)(H) (as determined by the Secretary), excluding any additional positions under subclause (II), is not less than the average number of full-time equivalent primary care residents (as so determined) during the 3 most recent cost reporting periods ending prior to the date of enactment of this paragraph; and

(II) not less than 75 percent of the positions attributable to such increase are in a primary care or general surgery residency (as determined by the Secretary).

The Secretary may determine whether a hospital has met the requirements under this clause during such 5-year period in such manner and at such time as the Secretary determines appropriate, including at the end of such 5-year period.

(iii) REDISTRIBUTION OF POSITIONS IF HOSPITAL NO LONGER MEETS CERTAIN REQUIREMENTS.—In the case where the Secretary determines that a hospital described in clause (ii) does not meet either of the requirements under subclause (I) or (II) of such clause, the Secretary shall—

(I) reduce the otherwise applicable resident limit of the hospital by the amount by which such limit was increased under this paragraph; and

(II) provide for the distribution of positions attributable to such reduction in accordance with the requirements of this paragraph.

(C) CONSIDERATIONS IN REDISTRIBUTION.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subparagraph (B), the Secretary shall take into account—

(i) the demonstration likelihood of the hospital filling the positions made available under this paragraph within the first 3 cost reporting periods beginning on or after July 1, 2011, as determined by the Secretary; and

(ii) whether the hospital has an accredited rural training track (as described in paragraph (4)(H)(iv)).

(D) PRIORITY FOR CERTAIN AREAS.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subparagraph (B), subject to subparagraph (E), the Secretary shall distribute the increase to hospitals based on the following factors:

(i) Whether the hospital is located in a State with a resident-to-population ratio in the lowest quartile (as determined by the Secretary).

(ii) Whether the hospital is located in a State, a territory of the United States, or the District of Columbia that is among the top 10 States, territories, or Districts in terms of the ratio of—

(I) the total population of the State, territory, or District living in an area designated (under such section 332(a)(1)(A)) as a health professional shortage area (as of the date of enactment of this paragraph); to

(II) the total population of the State, territory, or District (as determined by the Secretary based on the most recent available population data published by the Bureau of the Census);

(iii) Whether the hospital is located in a rural area (as defined in subsection (d)(2)(D)(ii)).
(E) RESERVATION OF POSITIONS FOR CERTAIN HOSPITALS.—

(i) IN GENERAL.—Subject to clause (ii), the Secretary shall reserve the positions available for distribution under this paragraph as follows:

(I) 70 percent of such positions for distribution to hospitals described in clause (i) of subparagraph (D).

(II) 30 percent of such positions for distribution to hospitals described in clause (ii) and (iii) of such subparagraph.

(ii) EXCEPTION IF POSITIONS NOT REDISTRIBUTED BY JULY 1, 2011.—In the case where the Secretary does not distribute positions to hospitals in accordance with clause (i) by July 1, 2011, the Secretary shall distribute such positions to other hospitals in accordance with the considerations described in subparagraph (C) and the priority described in subparagraph (D).

(F) LIMITATION.—A hospital may not receive more than 75 full-time equivalent additional residency positions under this paragraph.

(G) APPLICATION OF PER RESIDENT AMOUNTS FOR PRIMARY CARE AND NONPRIMARY CARE.—With respect to additional residency positions in a hospital attributable to the increase provided under this paragraph, the approved FTE per resident amounts are deemed to be equal to the hospital per resident amounts for primary care and nonprimary care computed under paragraph (2)(D) for that hospital.

(H) DEFINITIONS.—In this paragraph:

(i) REFERENCE RESIDENT LEVEL.—The term ‘reference resident level’ means, with respect to a hospital, the highest resident level for any of the 3 most recent cost reporting periods (ending before the date of the enactment of this paragraph) of the hospital for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary.

(ii) RESIDENT LEVEL.—The term ‘resident level’ has the meaning given such term in paragraph (7)(C)(i).

(iii) OTHERWISE APPLICABLE RESIDENT LIMIT.—The term ‘otherwise applicable resident limit’ means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) of paragraph (4) on the resident level for the hospital determined without regard to this paragraph but taking into account paragraph (7)(A).

** *(j)* **

**(3)** **

(C) INCREASE FACTOR.—(i) IN GENERAL.—For purposes of this subsection for payment units in each fiscal year (beginning with fiscal year 2001), the Secretary shall establish an increase factor. Such factor shall be based on an appropriate percentage increase in a market basket of goods and services comprising services for which payment is made under this subsection, which may be the market basket percentage increase described in subsection (b)(3)(B)(iii). The increase factor to be applied under this subparagraph for each of fiscal years 2008 and 2009 shall be 0 percent subject to clause (ii).

(ii) PRODUCTIVITY AND OTHER ADJUSTMENT.—After establishing the increase factor described in clause (i) for a fiscal year, the Secretary shall reduce such increase factor—

(I) for fiscal year 2012 and each subsequent fiscal year, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

(II) for each of fiscal years 2010 through 2019, by the other adjustment described in subparagraph (D).

The application of this clause may result in the increase factor under this subparagraph being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.
(D) **Other Adjustment.**—

For purposes of subparagraph (C)(ii)(II), the other adjustment described in this subparagraph is—

(i) for each of fiscal years 2010 and 2011, 0.25 percentage point;

(ii) for each of fiscal years 2012 and 2013, 0.1 percentage point;

(iii) for fiscal year 2014, 0.3 percentage point;

(iv) for each of fiscal years 2015 and 2016, 0.2 percentage point; and

(v) for each of fiscal years 2017, 2018, and 2019, 0.75 percentage point.

***

(6) **Area Wage Adjustment.**—The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of rehabilitation facilities’ costs which are attributable to wages and wage-related costs, of the prospective payment rates computed under paragraph (3) for area differences in wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for such facilities. Not later than October 1, 2001 (and at least every 36 months thereafter), the Secretary shall update the factor under the preceding sentence on the basis of information available to the Secretary (and updated as appropriate) of the wages and wage-related costs incurred in furnishing rehabilitation services. Any adjustments or updates made under this paragraph for a fiscal year shall be made in a manner that assures that the aggregated payments under this subsection in the fiscal year are not greater or less than those that would have been made in the year without such adjustment.

(7) **Quality Reporting.**—

(A) **Reduction in Update for Failure to Report.**—

(i) **In General.**—For purposes of fiscal year 2014 and each subsequent fiscal year, in the case of a rehabilitation facility that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a fiscal year, after determining the increase factor described in paragraph (3)(C), and after application of paragraph (3)(D), the Secretary shall reduce such increase factor for payments for discharges occurring during such fiscal year by 2 percentage points.

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

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

(C) **Submission of Quality Data.**—For fiscal year 2014 and each subsequent rate year, each rehabilitation facility shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

(D) **Quality Measures.**—

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

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

(iii) **Time Frame.**—Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to fiscal year 2014.
(E) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under subparagraph (C) available to the public. Such procedures shall ensure that the Rehabilitation Facility has the opportunity to review the data that is to be made public with respect to the facility prior to such data being made public. The Secretary shall report quality measures that relate to services furnished in inpatient settings in rehabilitation facilities on the Internet website of the Centers for Medicare & Medicaid Services.

(8) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of the establishment of—

(A) case mix groups, of the methodology for the classification of patients within such groups, and of the appropriate weighting factors thereof under paragraph (2),

(B) the prospective payment rates under paragraph (3),

(C) outlier and special payments under paragraph (4), and

(D) area wage adjustments under paragraph (6).

* * *

(m)

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Caution: Sec. 3401(p) of the Patient Protection and Affordable Care Act (PubLNo 111-148) provides that sec. 1886(m)(3) is not effective for discharges occurring before April 1, 2010.

(3) IMPLEMENTATION FOR RATE YEAR 2010 AND SUBSEQUENT YEARS.—

(A) In general.—In implementing the system described in paragraph (1) for rate year 2010 and each subsequent rate year, any annual update to a standard Federal rate for discharges for the hospital during the rate year, shall be reduced—

(i) for rate year 2012 and each subsequent rate year, by the productivity adjustment described in section 1886(b)(3)(B)(xii)(II); and

(ii) for each of rate years 2010 through 2019, by the other adjustment described in paragraph (4).

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

Caution: Not effective for discharges occurring before April 1, 2010.

(4) OTHER ADJUSTMENT.—For purposes of paragraph (3)(A)(ii), the other adjustment described in this paragraph is—

(A) for rate year 2010, 0.25 percentage point;

(B) for rate year 2011, 0.50 percentage point;

(C) for each of the rate years beginning in 2012 and 2013, 0.1 percentage point;

(D) for rate year 2014, 0.3 percentage point;

(E) for each of rate years 2015 and 2016, 0.2 percentage point; and

(F) for each of rate years 2017, 2018, and 2019, 0.75 percentage point.

(5) QUALITY REPORTING.—

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

(i) In general.—Under the system described in paragraph (1), for rate year 2014 and each subsequent rate year, in the case of a long-term care hospital that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a rate year, any annual update to a standard Federal rate for discharges for the hospital during the rate year, and after application of paragraph (3), shall be reduced by 2 percentage points.
(ii) **Special Rule.**—The application of this subparagraph may result in such annual update being less than 0.0 for a rate year, and may result in payment rates under the system described in paragraph (1) for a rate year being less than such payment rates for the preceding rate year.

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

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

(D) **Quality Measures.**—

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

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

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

(E) **Public Availability of Data Submitted.**—The Secretary shall establish procedures for making data submitted under subparagraph (C) available to the public. Such procedures shall ensure that a long-term care hospital has the opportunity to review the data that is to be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality measures that relate to services furnished in inpatient settings in long-term care hospitals on the Internet website of the Centers for Medicare & Medicaid Services.

**Hospital Value-Based Purchasing Program.**

(1) **Establishment.**—

(A) **In General.**—Subject to the succeeding provisions of this subsection, the Secretary shall establish a hospital value-based purchasing program (in this subsection referred to as the 'Program') under which value-based incentive payments are made in a fiscal year to hospitals that meet the performance standards under paragraph (3) for the performance period for such fiscal year (as established under paragraph (4)).

(B) **Program to Begin in Fiscal Year 2013.**—The Program shall apply to payments for discharges occurring on or after October 1, 2012.

(C) **Applicability of Program to Hospitals.**—

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

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

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

(II) for which, during the performance period for such fiscal year, the Secretary has cited deficiencies that pose immediate jeopardy to the health or safety of patients;

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

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

(iv) EXEMPTION.—In the case of a hospital that is paid under section 1814(b)(3), the Secretary may exempt such hospital from the application of this subsection if the State which is paid under such section submits an annual report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under this subsection.

(2) MEASURES.—

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

(B) REQUIREMENTS.—

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

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

(aa) Acute myocardial infarction (AMI).

(bb) Heart failure.

(cc) Pneumonia.

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

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

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

(ii) INCLUSION OF EFFICIENCY MEASURES.—For value-based incentive payments made with respect to discharges occurring during fiscal year 2014 or a subsequent fiscal year, the Secretary shall ensure that measures selected under subparagraph (A) include efficiency measures, including measures of ‘Medicare spending per beneficiary’. Such measures shall be adjusted for factors such as age, sex, race, severity of illness, and other factors that the Secretary determines appropriate.

(C) LIMITATIONS.—

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

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

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

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

(B) Achievement and Improvement.—The performance standards established under subparagraph (A) shall include levels of achievement and improvement.

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

(D) Considerations in Establishing Standards.—In establishing performance standards with respect to measures under this paragraph, the Secretary shall take into account appropriate factors, such as—

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

(ii) historical performance standards;

(iii) improvement rates; and

(iv) the opportunity for continued improvement.

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

(5) Hospital Performance Score.—

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

(B) Application.—

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

(ii) Higher of Achievement or Improvement.—The methodology developed under subparagraph (A) shall provide that the hospital performance score is determined using the higher of its achievement or improvement score for each measure.

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

(iv) No Minimum Performance Standard.—The Secretary shall not set a minimum performance standard in determining the hospital performance score for any hospital.

(v) Reflection of Measures Applicable to the Hospital.—The hospital performance score for a hospital shall reflect the measures that apply to the hospital.

(6) Calculation of Value-Based Incentive Payments.—

(A) In General.—In the case of a hospital that the Secretary determines meets (or exceeds) the performance standards under paragraph (3) for the performance period for a fiscal year (as established under paragraph (4)), the Secretary shall increase the base operating DRG payment amount (as defined in paragraph (7)(D)), as determined after application of paragraph (7)(B)(i), for a hospital for each discharge occurring in such fiscal year by the value-based incentive payment amount.
(B) VALUE-BASED INCENTIVE PAYMENT AMOUNT.—The value-based incentive payment amount for each discharge of a hospital in a fiscal year shall be equal to the product of—

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

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

(C) VALUE-BASED INCENTIVE PAYMENT PERCENTAGE.—

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

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

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

(II) the total amount of value-based incentive payments under this paragraph to all hospitals in such fiscal year is equal to the total amount available for value-based incentive payments for such fiscal year under paragraph (7)(A), as estimated by the Secretary.

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

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

(B) ADJUSTMENT TO PAYMENTS.—

(i) IN GENERAL.—The Secretary shall reduce the base operating DRG payment amount (as defined in subparagraph (D)) for a hospital for each discharge in a fiscal year (beginning with fiscal year 2013) by an amount equal to the applicable percent (as defined in subparagraph (C)) of the base operating DRG payment amount for the discharge for the hospital for such fiscal year. The Secretary shall make such reductions for all hospitals in the fiscal year involved, regardless of whether or not the hospital has been determined by the Secretary to have earned a value-based incentive payment under paragraph (6) for such fiscal year.

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

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

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

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

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

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

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

(D) BASE OPERATING DRG PAYMENT AMOUNT DEFINED.—

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

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

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

(aa) payments under paragraphs (5)(A), (5)(B), (5)(F), and (12) of subsection (d); and
(bb) such other payments under subsection (d) determined appropriate by the Secretary.

(ii) Special rules for certain hospitals.—

(I) Sole community hospitals and Medicare-dependent, small rural hospitals.—In the case of a Medicare-dependent, small rural hospital (with respect to discharges occurring during fiscal year 2012 and 2013) or a sole community hospital, in applying subparagraph (A)(i), the payment amount that would otherwise be made under subsection (d) shall be determined without regard to subparagraphs (I) and (L) of subsection (b)(3) and subparagraphs (D) and (G) of subsection (d)(5).

(II) Hospitals paid under section 1814.—In the case of a hospital that is paid under section 1814(b)(3), the term ‘base operating DRG payment amount’ means the payment amount under such section.

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

(9) No effect in subsequent fiscal years.—The value-based incentive payment under paragraph (6) and the payment reduction under paragraph (7)(B)(i) shall each apply only with respect to the fiscal year involved, and the Secretary shall not take into account such value-based incentive payment or payment reduction in making payments to a hospital under this section in a subsequent fiscal year.

(10) Public reporting.—

(A) Hospital specific information.—

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

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

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

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

(ii) Opportunity to review and submit corrections.—The Secretary shall ensure that a hospital has the opportunity to review, and submit corrections for, the information to be made public with respect to the hospital under clause (i) prior to such information being made public.

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

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

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

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

(11) Implementation.—

(A) Appeals.—The Secretary shall establish a process by which hospitals may appeal the calculation of a hospital’s performance assessment with respect to the performance standards established under paragraph (3)(A) and the hospital performance score under paragraph (5). The Secretary shall ensure that such process provides for resolution of such appeals in a timely manner.

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

(i) The methodology used to determine the amount of the value-based incentive payment under paragraph (6) and the determination of such amount.
(ii) The determination of the amount of funding available for such value-based incentive payments under paragraph (7)(A) and the payment reduction under paragraph (7)(B)(i).

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

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

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


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

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

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

(1) IN GENERAL.—In order to provide an incentive for applicable hospitals to reduce hospital acquired conditions under this title, with respect to discharges from an applicable hospital occurring during fiscal year 2015 or a subsequent fiscal year, the amount of payment under this section or section 1814(b)(3), as applicable, for such discharges during the fiscal year shall be equal to 99 percent of the amount of payment that would otherwise apply to such discharges under this section or section 1814(b)(3) (determined after the application of subsections (o) and (q) and section 1814(l)(4) but without regard to this subsection).

(2) APPLICABLE HOSPITALS.—

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

(B) CRITERIA DESCRIBED.—

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

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

(C) EXEMPTION.—In the case of a hospital that is paid under section 1814(b)(3), the Secretary may exempt such hospital from the application of this subsection if the State which is paid under such section submits an annual report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under this subsection.

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

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

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

(A) **In General.**—The Secretary shall make information available to the public regarding hospital acquired conditions of each applicable hospital.

(B) **Opportunity to Review and Submit Corrections.**—The Secretary shall ensure that an applicable hospital has the opportunity to review, and submit corrections for, the information to be made public with respect to the hospital under subparagraph (A) prior to such information being made public.

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

(7) **Limitations on Review.**—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

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

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

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

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

(q) **Hospital Readmissions Reduction Program.**—

(1) **In General.**—With respect to payment for discharges from an applicable hospital (as defined in paragraph (5)(C)) occurring during a fiscal year beginning on or after October 1, 2012, in order to account for excess readmissions in the hospital, the Secretary shall make payments (in addition to the payments described in paragraph (2)(A)(ii)) for such a discharge to such hospital under subsection (d) (or section 1814(b)(3), as the case may be) in an amount equal to the product of—

(A) the base operating DRG payment amount (as defined in paragraph (2)) for the discharge; and

(B) the adjustment factor (described in paragraph (3)(A)) for the hospital for the fiscal year.

(2) **Base Operating DRG Payment Amount Defined.**—

(A) **In General.**—Except as provided in subparagraph (B), in this subsection, the term ‘base operating DRG payment amount’ means, with respect to a hospital for a fiscal year—

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

(ii) any portion of such payment amount that is attributable to payments under paragraphs (5)(A), (5)(B), (5)(F), and (12) of subsection (d).

(B) **Special Rules for Certain Hospitals.**—

(i) **sole Community Hospitals and Medicare-Dependent, Small Rural Hospitals.**—In the case of a medicare-dependent, small rural hospital (with respect to discharges occurring during fiscal years 2012 and 2013) or a sole community hospital, in applying subparagraph (A)(i), the payment amount that would otherwise be made under subsection (d) shall be determined without regard to subparagraphs (I) and (L) of subsection (b)(3) and subparagraphs (D) and (G) of subsection (d)/(5).

(ii) **Hospitals Paid Under Section 1814.**—In the case of a hospital that is paid under section 1814(b)(3), the Secretary may exempt such hospitals provided that States paid under such section submit an annual report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established herein with respect to this section.

(3) **Adjustment Factor.**—

(A) **In General.**—For purposes of paragraph (1), the adjustment factor under this paragraph for an applicable hospital for a fiscal year is equal to the greater of—
(i) the ratio described in subparagraph (B) for the hospital for the applicable period (as defined in paragraph (5)(D)) for such fiscal year; or
(ii) the floor adjustment factor specified in subparagraph (C).

(B) RATIO.—The ratio described in this subparagraph for a hospital for an applicable period is equal to 1 minus the ratio of—
(i) the aggregate payments for excess readmissions (as defined in paragraph (4)(A)) with respect to an applicable hospital for the applicable period; and
(ii) the aggregate payments for all discharges (as defined in paragraph (4)(B)) with respect to such applicable hospital for such applicable period.

(C) FLOOR ADJUSTMENT FACTOR.—For purposes of subparagraph (A), the floor adjustment factor specified in this subparagraph for—
(i) fiscal year 2013 is 0.99;
(ii) fiscal year 2014 is 0.98; or
(iii) fiscal year 2015 and subsequent fiscal years is 0.97.

(4) AGGREGATE PAYMENTS, EXCESS READMISSION RATIO DEFINED.—For purposes of this subsection:

(A) AGGREGATE PAYMENTS FOR EXCESS READMISSIONS.—The term 'aggregate payments for excess readmissions' means, for a hospital for an applicable period, the sum, for applicable conditions (as defined in paragraph (5)(A)), of the product, for each applicable condition, of—
(i) the base operating DRG payment amount for such hospital for such applicable period for such condition;
(ii) the number of admissions for such condition for such hospital for such applicable period; and
(iii) the excess readmissions ratio (as defined in subparagraph (C)) for such hospital for such applicable period minus 1.

(B) AGGREGATE PAYMENTS FOR ALL DISCHARGES.—The term 'aggregate payments for all discharges' means, for a hospital for an applicable period, the sum of the base operating DRG payment amounts for all discharges for all conditions from such hospital for such applicable period.

(C) EXCESS READMISSION RATIO.—
(i) IN GENERAL.—Subject to clause (ii), the term 'excess readmissions ratio' means, with respect to an applicable condition for a hospital for an applicable period, the ratio (but not less than 1.0) of—
(I) the risk adjusted readmissions based on actual readmissions, as determined consistent with a readmission measure methodology that has been endorsed under paragraph (5)(A)(ii)(I), for an applicable hospital for such condition with respect to such applicable period; to
(II) the risk adjusted expected readmissions (as determined consistent with such a methodology) for such hospital for such condition with respect to such applicable period.
(ii) EXCLUSION OF CERTAIN READMISSIONS.—For purposes of clause (i), with respect to a hospital, excess readmissions shall not include readmissions for an applicable condition for which there are fewer than a minimum number (as determined by the Secretary) of discharges for such applicable condition for the applicable period and such hospital.

(5) DEFINITIONS.—For purposes of this subsection:

(A) APPLICABLE CONDITION.—The term 'applicable condition' means, subject to subparagraph (B), a condition or procedure selected by the Secretary among conditions and procedures for which—
(i) readmissions (as defined in subparagraph (E)) that represent conditions or procedures that are high volume or high expenditures under this title (or other criteria specified by the Secretary); and
(ii) measures of such readmissions—
(I) have been endorsed by the entity with a contract under section 1890(a); and

(II) such endorsed measures have exclusions for readmissions that are unrelated to the prior discharge (such as a planned readmission or transfer to another applicable hospital).

(B) EXPANSION OF APPLICABLE CONDITIONS.—Beginning with fiscal year 2015, the Secretary shall, to the extent practicable, expand the applicable conditions beyond the 3 conditions for which measures have been endorsed as described in subparagraph (A)(ii)(I) as of the date of the enactment of this subsection to the additional 4 conditions that have been identified by the Medicare Payment Advisory Commission in its report to Congress in June 2007 and to other conditions and procedures as determined appropriate by the Secretary. In expanding such applicable conditions, the Secretary shall seek the endorsement described in subparagraph (A)(ii)(I) but may apply such measures without such an endorsement in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a) as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

(C) APPLICABLE HOSPITAL.—The term ‘applicable hospital’ means a subsection (d) hospital or a hospital that is paid under section 1814(b)(3), as the case may be.

(D) APPLICABLE PERIOD.—The term ‘applicable period’ means, with respect to a fiscal year, such period as the Secretary shall specify.

(E) READMISSION.—The term ‘readmission’ means, in the case of an individual who is discharged from an applicable hospital, the admission of the individual to the same or another applicable hospital within a time period specified by the Secretary from the date of such discharge. Insofar as the discharge relates to an applicable condition for which there is an endorsed measure described in subparagraph (A)(ii)(I), such time period (such as 30 days) shall be consistent with the time period specified for such measure.

(6) REPORTING HOSPITAL SPECIFIC INFORMATION.—

(A) IN GENERAL.—The Secretary shall make information available to the public regarding readmission rates of each subsection (d) hospital under the program.

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

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

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

(A) The determination of base operating DRG payment amounts.

(B) The methodology for determining the adjustment factor under paragraph (3), including excess readmissions ratio under paragraph (4)(C), aggregate payments for excess readmissions under paragraph (4)(A), and aggregate payments for all discharges under paragraph (4)(B), and applicable periods and applicable conditions under paragraph (5).

(C) The measures of readmissions as described in paragraph (5)(A)(ii).

(8) READMISSION RATES FOR ALL PATIENTS.—

(A) CALCULATION OF READMISSION.—The Secretary shall calculate readmission rates for all patients (as defined in subparagraph (D)) for a specified hospital (as defined in subparagraph (D)(ii)) for an applicable condition (as defined in paragraph (5)(B)) and other conditions deemed appropriate by the Secretary for an applicable period (as defined in paragraph (5)(D)) in the same manner as used to calculate such readmission rates for hospitals with respect to this title and posted on the CMS Hospital Compare website.

(B) POSTING OF HOSPITAL SPECIFIC ALL PATIENT READMISSION RATES.—The Secretary shall make information on all patient readmission rates calculated under subparagraph (A) available on the CMS Hospital Compare website.
Hospital Compare website in a form and manner determined appropriate by the Secretary. The Secretary may also make other information determined appropriate by the Secretary available on such website.

(C) Hospital Submission of All Patient Data.—

(i) Except as provided for in clause (ii), each specified hospital (as defined in subparagraph (D)(ii)) shall submit to the Secretary, in a form, manner and time specified by the Secretary, data and information determined necessary by the Secretary for the Secretary to calculate the all patient readmission rates described in subparagraph (A).

(ii) Instead of a specified hospital submitting to the Secretary the data and information described in clause (i), such data and information may be submitted to the Secretary, on behalf of such a specified hospital, by a state or an entity determined appropriate by the Secretary.

(D) Definitions.—For purposes of this paragraph:

(i) The term ‘all patients’ means patients who are treated on an inpatient basis and discharged from a specified hospital (as defined in clause (ii)).

(ii) The term ‘specified hospital’ means a subsection (d) hospital, hospitals described in clauses (i) through (v) of subsection (d)(1)(B) and, as determined feasible and appropriate by the Secretary, other hospitals not otherwise described in this subparagraph.

(r) Adjustments to Medicare DSH Payments.—

(1) Empirically Justified DSH Payments.—For fiscal year 2014 and each subsequent fiscal year, instead of the amount of disproportionate share hospital payment that would otherwise be made under subsection (d)(5)(F) to a subsection (d) hospital for the fiscal year, the Secretary shall pay to the subsection (d) hospital 25 percent of such amount (which represents the empirically justified amount for such payment, as determined by the Medicare Payment Advisory Commission in its March 2007 Report to the Congress).

(2) Additional Payment.—In addition to the payment made to a subsection (d) hospital under paragraph (1), for fiscal year 2014 and each subsequent fiscal year, the Secretary shall pay to such subsection (d) hospitals an additional amount equal to the product of the following factors:

(A) Factor One.—A factor equal to the difference between—

(i) the aggregate amount of payments that would be made to subsection (d) hospitals under subsection (d)(5)(F) if this subsection did not apply for such fiscal year (as estimated by the Secretary); and

(ii) the aggregate amount of payments that are made to subsection (d) hospitals under paragraph (1) for such fiscal year (as so estimated).

(B) Factor Two.—

(i) Fiscal Years 2014, 2015, 2016, and 2017.—For each of fiscal years 2014, 2015, 2016, and 2017, a factor equal to 1 minus the percent change in the percent of individuals under the age of 65 who are uninsured, as determined by comparing the percent of such individuals—

(I) who are uninsured in 2013, the last year before coverage expansion under the Patient Protection and Affordable Care Act (as calculated by the Secretary based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Health Care and Education Reconciliation Act of 2010 that, if determined in the affirmative, would clear such Act for enrollment); and

(II) who are uninsured in the most recent period for which data is available (as so calculated), minus 0.1 percentage points for fiscal year 2014 and minus 0.2 percentage points for each of fiscal years 2015, 2016, and 2017.

(ii) 2018 and Subsequent Years.—For fiscal year 2018 and each subsequent fiscal year, a factor equal to 1 minus the percent change in the percent of individuals who are uninsured, as determined by comparing the percent of individuals—
(I) who are uninsured in 2013 (as estimated by the Secretary, based on data from the Census Bureau or other sources the Secretary determines appropriate, and certified by the Chief Actuary of the Centers for Medicare & Medicaid Services); and

(II) who are uninsured in the most recent period for which data is available (as so estimated and certified),

minus 0.2 percentage points for each of fiscal years 2018 and 2019.

(C) FACTOR THREE.—A factor equal to the percent, for each subsection (d) hospital, that represents the quotient of—

(i) the amount of uncompensated care for such hospital for a period selected by the Secretary (as estimated by the Secretary, based on appropriate data (including, in the case where the Secretary determines that alternative data is available which is a better proxy for the costs of subsection (d) hospitals for treating the uninsured, the use of such alternative data)); and

(ii) the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment under this subsection for such period (as so estimated, based on such data).

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

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).

(B) Any period selected by the Secretary for such purposes.

(s) PROSPECTIVE PAYMENT FOR PSYCHIATRIC HOSPITALS.—

(1) REFERENCE TO ESTABLISHMENT AND IMPLEMENTATION OF SYSTEM.—For provisions related to the establishment and implementation of a prospective payment system for payments under this title for inpatient hospital services furnished by psychiatric hospitals (as described in clause (i) of subsection (d)(1)(B)) and psychiatric units (as described in the matter following clause (v) of such subsection), see section 124 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999.

(2) IMPLEMENTATION FOR RATE YEAR BEGINNING IN 2010 AND SUBSEQUENT RATE YEARS.—

(A) IN GENERAL.—In implementing the system described in paragraph (1) for the rate year beginning in 2010 and any subsequent rate year, any update to a base rate for days during the rate year for a psychiatric hospital or unit, respectively, shall be reduced—

(i) for the rate year beginning in 2012 and each subsequent rate year, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

(ii) for each of the rate years beginning in 2010 through 2019, by the other adjustment described in paragraph (3).

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

(3) OTHER ADJUSTMENT.—

For purposes of paragraph (2)(A)(ii), the other adjustment described in this paragraph is—

(A) for each of the rate years beginning in 2010 and 2011, 0.25 percentage point;

(B) for each of the rate years beginning in 2012 and 2013, 0.1 percentage point;

(C) for the rate year beginning in 2014, 0.3 percentage point;

(D) for each of the rate years beginning in 2015 and 2016, 0.2 percentage point; and

(E) for each of the rate years beginning in 2017, 2018, and 2019, 0.75 percentage point.

(4) QUALITY REPORTING.—

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

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

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

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

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

(D) QUALITY MEASURES.—

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

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

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

(E) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under subparagraph (C) available to the public. Such procedures shall ensure that a psychiatric hospital and a psychiatric unit has the opportunity to review the data that is to be made public with respect to the hospital or unit prior to such data being made public. The Secretary shall report quality measures that relate to services furnished in inpatient settings in psychiatric hospitals and psychiatric units on the Internet website of the Centers for Medicare & Medicaid Services.
inserting “For discharges occurring in fiscal years 2005 through 2010 and for discharges occurring in fiscal year 2013 and subsequent fiscal years, the Secretary” in subparagraph (C)(i), by striking “1,500 discharges” and inserting “1,600 discharges” and in subparagraph (D), by striking “1,500 discharges” and inserting “1,600 discharges”.

Sec. 10324a(1) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1886(d)(12) in subparagraph (C)(i), by striking “1,500 discharges” and inserting “1,600 discharges”; and in subparagraph (D), by striking “1,500 discharges” and inserting “1,600 discharges”.

Sec. 10324a(2) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1886(d)(3)(E) by inserting “and the amendments made by section 10324 of the Patient Protection and Affordable Care Act” after “2005”.

Sec. 5504(b)(1) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1886(d)(5)(G) in clause (i) by striking “October 1, 2011” and inserting “October 1, 2012” and in clause (ii)(II) by striking “October 1, 2011” and inserting “October 1, 2012”.

Sec. 5504(b)(2) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1886(d)(5)(E) by inserting “and the amendments made by section 10324 of the Patient Protection and Affordable Care Act” after “2005”.

Sec. 5503(b)(1) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1886(d)(5)(B)(iv) by inserting “(iv) Effective for discharges occurring on or after October 1, 1997” and inserting “(iv) Effective for discharges occurring on or after October 1, 1997, and before July 1, 2010”.

Sec. 5504(b)(2) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1886(d)(5)(B)(iv) by striking “subsection (h)(7)” and inserting “subsections (h)(7) and (h)(8)” and by striking “it applies” and inserting “they apply”.

Sec. 5504(b) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1886(d)(5)(B)(iv) by inserting “subsections (h)(7) and (h)(8)” and inserting “subsections (h)(4)(F)(vi), (h)(7), and (h)(8)”.

Sec. 5503(b)(2) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1886(d)(5)(B)(iv) by adding at the end the new clause (s).

Sec. 5505(b) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1886(d)(5)(B) by adding at the end the new subclause (s).

Sec. 5503(3) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1886(d)(5)(F)(i) by striking “For” and inserting “Subject to subsection (i), for”.

Sec. 5503(a) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1886(h) in paragraph 4(F)(i), by striking “paragraph (7)” and inserting “paragraphs (7) and (8)” in paragraph (4)(F)(i), by striking “paragraph (7)” and inserting “paragraphs (7) and (8)” in paragraph (7)(E), by inserting “or paragraph (8)” before the period at the end; and by adding at the end the new paragraph (8).

Sec. 5504(a)(4) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1886(h)(4)(E) by adding at the end a new flush sentence.

Sec. 5505(a)(1)(A) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective the Secretary of Health and Human Services shall implement the amendments made by this section in a manner so as to apply to cost reporting periods beginning on or after January 1, 1983, amended sec. 1886(h)(4)(E) by striking “Such rules” and inserting “Subject to subparagraphs (I) and (K), such rules”.

Sec. 5504a(1) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1886(h)(4)(E) by striking “shall be counted and that all the time” and inserting “shall be counted and that—” and then inserting new clause (i).

Sec. 5504(a)(2) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1886(h)(4)(E) by striking the period at the end and inserting “; and”.

Sec. 5504(a)(3) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1886(h)(4)(E) by inserting after clause (i), as so inserted, new clause (ii).

Sec. 5506(a) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1886(h)(4)(F)(ii) by adding at the end new clause (vi).

Sec. 5505(a)(1)(B) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1886(h)(4)(F)(ii) by adding at the end new subparagraphs (I) and (K).

Sec. 5505(a)(2) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective the Secretary of Health and Human Services shall implement the amendments made by this section in a manner so as to apply to cost reporting periods beginning on or after January 1, 1983, amended sec. 1886(h)(5)(K) by adding at the end new subparagraph (K).

Sec. 5506(e) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1886(h)(7)(E) by striking “paragraph or paragraph (8)” and inserting “this paragraph, paragraph (8), or paragraph (4)(F)(vi)”.

Sec. 3004(b) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1886(g) by redesignating paragraph (7) as paragraph (8), and by inserting after paragraph (6) the new paragraph (7).

Sec. 3401(d) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1886(j)(5)(D)(i) in subparagraph (C) by striking “FACTOR—for purposes” and inserting “FACTOR—For purposes” and then inserting new clause (i); by inserting “subject to clause (ii)” before the period at the end of the first sentence of clause (i), as added by paragraph (1), by adding at the end new clause (ii), and by adding at the end new subparagraph (D).

Sec. 10319(c) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1886(h)(4)(E) in subclause (5), by striking “and” at the end; redesignating subclause (II) as subclause (III), inserting after subclause (II) new subclause (II); and in subclause (III), as redesignated by paragraph (2), by striking “2012” and inserting “2014”.

¶15,691 §1886(s)(4)(E)
Sec. 3401(c) of the "Patient Protection and Affordable Care Act" (Pub.L. No. 111-148), effective March 23, 2010, amended sec. 1886(m) by adding at the end new paragraphs (3) and (4).

Sec. 10319(b) of the "Patient Protection and Affordable Care Act" (Pub.L. No. 111-148), effective March 23, 2010, amended sec. 1886m(4) in subparagraph (A), in clause (i), by striking "each of rate years 2010 and 2011,", and inserting "rate year 2010", by striking "and" at the end, by redesignating clause (ii) as clause (iv), and by inserting after clause (i) new clauses (ii) and (iii); in clause (iv), as redesignated by subparagraph (B), by striking "2012" and inserting "2014", in subparagraph (B), by striking "(A)(ii)" and inserting "(A)(iii)".

Sec. 3004(a) of the "Patient Protection and Affordable Care Act" (Pub.L. No. 111-148), effective March 23, 2010, amended sec. 1886m by adding at the end new paragraph (5).

Sec. 3001(a)(1) of the "Patient Protection and Affordable Care Act" (Pub.L. No. 111-148), effective March 23, 2010, amended sec. 1886 by adding at the end new subsection (o).

Sec. 10335 of the "Patient Protection and Affordable Care Act" (Pub.L. No. 111-148), effective March 23, 2010, amended sec. 1886(o)(2)(A) by inserting ", other than measures of readmissions,", after "shall select measures".

Sec. 3008(a) of the "Patient Protection and Affordable Care Act" (Pub.L. No. 111-148), effective March 23, 2010, amended sec. 1886 by adding at the end new subsection (p).

Sec. 3025(a) of the "Patient Protection and Affordable Care Act" (Pub.L. No. 111-148), effective March 23, 2010, amended sec. 1886 by adding at the end new subsection (q).

Sec. 10309 of the "Patient Protection and Affordable Care Act" (Pub.L. No. 111-148), effective March 23, 2010, amended sec. 1886(g)(1) by striking "the Secretary shall reduce the payments" and all that follows through "the product of", and inserting "the Secretary shall make payments in addition to the payments described in paragraph (2)(A)(ii) for such a discharge to such hospital under subsection (d) (or section 1814(b)(3), as the case may be) in an amount equal to the product of".

Sec. 31332 of the "Patient Protection and Affordable Care Act" (Pub.L. No. 111-148), effective March 23, 2010, amended sec. 1886 by adding at the end new subsection (s).

Sec. 10316 of the "Patient Protection and Affordable Care Act" (Pub.L. No. 111-148), effective March 23, 2010, amended sec. 1886(t)(2)(B) by inserting in clause (i) in an amount equal to the product of section 1814(b)(3), as the case may be) in an amount equal to the product of 

Sec. 3401(f) of the "Patient Protection and Affordable Care Act" (Pub.L. No. 111-148), effective March 23, 2010, amended sec. 1886 by adding at the end new subsection (s).

Sec. 10319(e) of the "Patient Protection and Affordable Care Act" (Pub.L. No. 111-148), effective March 23, 2010, amended sec. 1886(e)(3)(A) in clause (i), by striking "and" at the end, by redesignating clause (ii) as clause (iii), and by inserting after clause (i) new clause (ii); and in clause (iii), as redesignated by paragraph (2), by striking "2012" and inserting "2014."

Sec. 10322(a) of the "Patient Protection and Affordable Care Act" (Pub.L. No. 111-148), effective March 23, 2010, amended sec. 1886(e) by adding at the end new paragraph (4).

Sec. 1104 of the "Health Care and Education Reconciliation Act" (Pub.L. No. 111-152), effective March 30, 2010, amended sec. 1886(r) in paragraph (1), by striking "2015" and inserting "2014", in paragraph (2) in the matter preceding subparagraph (A), by striking "2015" and inserting "2014", and in subparagraph (B)(ii) in the heading, by inserting "2014", after "YEARS", in the matter preceding subclause (I), by inserting "2014", after "each of fiscal years", in subclause (I), by striking "on such Act" and inserting "on the Health Care and Education Reconciliation Act of 2010", and in the matter following subclause (II), by striking "minus 1.5 percentage points" and inserting "minus 0.1 percentage points for each fiscal year 2014 and minus 0.2 percentage points for each of fiscal years 2015, 2016, and 2017", and in subparagraph (B)(ii), in the matter following subclause (II), by striking "and, for each of 2018 and 2019, minus 1.5 percentage points" and inserting "minus 0.2 percentage points for each of fiscal years 2018 and 2019".

Sec. 1105(a) of the "Health Care and Education Reconciliation Act of 2010" (Pub.L. No. 111-152), effective March 30, 2010, amended sec. 1886(b)(3)(B) in clause (xii) by striking "and" at the end of subclause (II), by striking subclause (III) and inserting new subclauses (II), (IV), and (V), and by striking clause (xiii). Prior to removal the original subclause (III) read as follows: "(III) subject to clause (xii), for each of fiscal years 2014 through 2019, by 0.2 percentage point." and clause (xiii) read as follows:

"(xiii) Clause (xii) shall be applied with respect to any of fiscal years 2014 through 2019 by substituting "0.0 percentage points for 0.2 percentage point", if for such fiscal year"

"(f) the excess (if any) of"

"(a) the total percentage of the non-elderly insured population for the preceding fiscal year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House of the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over"

"(bb) the total percentage of the non-elderly insured population for such preceding fiscal year (as estimated by the Secretary); exceeds"

"(II) 5 percentage points."
Sec. 1105(d) of the "Health Care and Education Reconciliation Act of 2010" (Pub.L. No. 111-152), effective March 30, 2010, amended sec. 1886(e)(3)(D) in clause (i) by striking "(ii) 5 percentage points." and clause (ii) read: 

"(ii) Reduction of other adjustment--Subparagraph (A)(ii) shall be applied with respect to any fiscal years 2014 through 2019 by substituting '0.0 percentage points' for '0.2 percentage point', if for such fiscal year—

"(I) the excess (if any) of—

"(aa) the total percentage of the non-elderly insured population for the preceding fiscal year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

"(bb) the total percentage of the non-elderly insured population for such preceding fiscal year (as estimated by the Secretary); exceeds

"(II) 5 percentage points."

Sec. 1888. Payment to Skilled Nursing Facilities for Routine Service Costs

[42 U.S.C. §1395yy]

(e) ***

(5) ***

(B) SKILLED NURSING FACILITY MARKET BASKET PERCENTAGE.—

(i) IN GENERAL.—Subject to clause (ii), the term "skilled nursing facility market basket percentage" means, for a fiscal year or other annual period and as calculated by the Secretary, the percentage change in the skilled nursing facility market basket index (established under subparagraph (A)) from the midpoint of the prior fiscal year (or period) to the midpoint of the fiscal year (or other period) involved.

(ii) ADJUSTMENT.—For fiscal year 2012 and each subsequent fiscal year, after determining the percentage described in clause (i), the Secretary shall reduce such percentage by the productivity adjustment described in section 1886(b)(3)(B)(ii)(I). The application of the preceding sentence may result in such percentage being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.

(f) REPORTING OF DIRECT CARE EXPENDITURES.—

(1) IN GENERAL.—For cost reports submitted under this title for cost reporting periods beginning on or after the date that is 2 years after the date of the enactment of this subsection, skilled nursing facilities shall separately report expenditures for wages and benefits for direct care staff (breaking out (at a minimum) registered nurses, licensed professional nurses, certified nurse assistants, and other medical and therapy staff).
(2) Modification of Form.—The Secretary, in consultation with private sector accountants experienced with Medicare and Medicaid nursing facility home cost reports, shall redesign such reports to meet the requirement of paragraph (1) not later than 1 year after the date of the enactment of this subsection.

(3) Categorization by Functional Accounts.—Not later than 30 months after the date of the enactment of this subsection, the Secretary, working in consultation with the Medicare Payment Advisory Commission, the Medicaid and CHIP Payment and Access Commission, the Inspector General of the Department of Health and Human Services, and other expert parties the Secretary determines appropriate, shall take the expenditures listed on cost reports, as modified under paragraph (1), submitted by skilled nursing facilities and categorize such expenditures, regardless of any source of payment for such expenditures, for each skilled nursing facility into the following functional accounts on an annual basis:

(A) Spending on direct care services (including nursing, therapy, and medical services).
(B) Spending on indirect care (including housekeeping and dietary services).
(C) Capital assets (including building and land costs).
(D) Administrative services costs.

(4) Availability of Information Submitted.—The Secretary shall establish procedures to make information on expenditures submitted under this subsection readily available to interested parties upon request, subject to such requirements as the Secretary may specify under the procedures established under this paragraph.

[Explanation at ¶ 1310 and ¶ 1645.]

2010 Amendments: [Sec. 6104 of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended Sec. 1888 by adding at the end new subsection (f).]

[¶ 15,711] Sec. 1890. Contract With a Consensus-Based Entity Regarding Performance Measurement

[42 U.S.C. §1395aaa]

(b) ***

(5) ***

(A) ***

(ii) the recommendations made under paragraph (1);

(iii) the performance by the entity of the duties required under the contract entered into with the Secretary under subsection (a);

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

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

(vi) the matters described in clauses (i) and (ii) of paragraph (7)(A).
(6) REVIEW AND ENDORSEMENT OF EPISODE GROUPER UNDER THE PHYSICIAN FEEDBACK PROGRAM.—The
entity shall provide for the review and, as appropriate, the endorsement of the episode grouper developed by
the Secretary under section 1848(n)(9)(A). Such review shall be conducted on an expedited basis.

(7) CONVENING MULTI-STAKEHOLDER GROUPS.—

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

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

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

(II) such measures that have not been considered for endorsement by such entity but
are used or proposed to be used by the Secretary for the collection or reporting of quality and
efficiency measures; and

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

(B) QUALITY AND EFFICIENCY MEASURES.—

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

(I) for use pursuant to sections 1814(i)(5)(D), 1833(i)(7), 1833(i)(17), 1848(k)(2)(C),
1866(k)(3), 1881(b)(2)(A)(iii), 1886(b)(3)(B)(viii), 1886(j)(7)(D), 1886(m)(5)(D),
1886(o)(2), 1886(o)(4)(D), and 1895(b)(3)(B)(v); and

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

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

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

(C) REQUIREMENT FOR TRANSPARENCY IN PROCESS.—

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

(ii) SELECTION OF ORGANIZATIONS PARTICIPATING IN MULTI-STAKEHOLDER GROUPS.—The pro-
cess described in clause (i) shall ensure that the selection of representatives comprising such
groups provides for public nominations for, and the opportunity for public comment on, such
selection.

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

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

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[Explanation at ¶ 713, ¶ 717 and 733.]

2010 Amendments:
Sec. 3003(b) of the “Patient Protection and Affordable Care Act” (PubL No 111-148), effective March 23, 2010,
amended sec. 1890(b) by adding new paragraph (6).
Sec. 3014(a)(1) of the “Patient Protection and Affordable Care Act” (PubL No 111-148), effective March 23, 2010,
amended sec. 1890(b)(5)(A) in clause (ii), by striking “and” at the end; in clause (iii), by striking the period at the end
SEC. 15,721 Sec. 1890A. QUALITY AND EFFICIENCY MEASUREMENT

(a) Multi-Stakeholder Group Input into Selection of Quality and Efficiency Measures.—The Secretary shall establish a pre-rulemaking process under which the following steps occur with respect to the selection of quality and efficiency measures described in section 1890(b)(7)(B):

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

(2) Public Availability of Measures Considered for Selection.—Not later than December 1 of each year (beginning with 2011), the Secretary shall make available to the public a list of quality and efficiency measures described in section 1890(b)(7)(B) that the Secretary is considering under this title.

(3) Transmission of Multi-Stakeholder Input.—Pursuant to section 1890(b)(8), not later than February 1 of each year (beginning with 2012), the entity shall transmit to the Secretary the input of multi-stakeholder groups described in paragraph (1).

(4) Consideration of Multi-Stakeholder Input.—The Secretary shall take into consideration the input from multi-stakeholder groups described in paragraph (1) in selecting quality and efficiency measures described in section 1890(b)(7)(B) that have been endorsed by the entity with a contract under section 1890 and measures that have not been endorsed by such entity.

(5) Rationale for Use of Quality and Efficiency Measures.—The Secretary shall publish in the Federal Register the rationale for the use of any quality and efficiency measure described in section 1890(b)(7)(B) that has not been endorsed by the entity with a contract under section 1890.

(6) Assessment of Impact.—Not later than March 1, 2012, and at least once every three years thereafter, the Secretary shall—

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

(B) make such assessment available to the public.

(b) Process for Dissemination of Measures Used by the Secretary.—

(1) In General.—The Secretary shall establish a process for disseminating quality and efficiency measures used by the Secretary. Such process shall include the following:

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

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

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

(c) Review of Quality and Efficiency Measures Used by the Secretary.—

(1) In General.—The Secretary shall—

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

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

(i) maintain the use of such measure; or

(ii) phase out such measure.
(2) CONSIDERATIONS.—In conducting the review under paragraph (1), the Secretary shall take steps to—

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

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

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

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

(f) HOSPITAL ACQUIRED CONDITIONS.—The Secretary shall, to the extent practicable, publicly report on measures for hospital-acquired conditions that are currently utilized by the Centers for Medicare & Medicaid Services for the adjustment of the amount of payment to hospitals based on rates of hospital-acquired infections.

[Explanation at ¶ 731, ¶ 733.]

2010 Amendments:

Sec. 3014(b) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, added new section 1890A.

Sec. 3013(b) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1890A by adding at the end new subsection (e).

Sec. 10303(b) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1890A by adding at the end new subsection (f).

Sec. 10304 of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1890A by striking “quality” each place it appears and inserting “quality and efficiency”.

[¶15,731] Sec. 1893. Medicare Integrity Program

[42 U.S.C. § 1395ddd]

(a) ESTABLISHMENT OF PROGRAM.—There is hereby established the Medicare Integrity Program (in this section referred to as the “Program”) under which the Secretary shall promote the integrity of the medicare program by entering into contracts in accordance with this section with eligible entities, or otherwise, to carry out the activities described in subsection (b).

***

(c)

***

(3) the entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement;

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

(5) the entity meets such other requirements as the Secretary may impose.

In the case of the activity described in subsection (b)(5), an entity shall be deemed to be eligible to enter into a contract under the Program to carry out the activity if the entity is a carrier with a contract in effect under section 1842.

***

(h)

***

(1) IN GENERAL.—Under the Program, the Secretary shall enter into contracts with recovery audit contractors in accordance with this subsection for the purpose of identifying underpay-
ments and overpayments and recouping overpayments under this title with respect to all services for which payment is made under this title. Under the contracts—

***

(2) DISPOSITION OF REMAINING RECOVERIES.—The amounts recovered under such contracts that are not paid to the contractor under paragraph (1) or retained by the Secretary under paragraph (1)(C) shall be applied to reduce expenditures under this title.

(3) NATIONWIDE COVERAGE.—The Secretary shall enter into contracts under paragraph (1) in a manner so as to provide for activities in all States under such a contract by not later than January 1, 2010 (not later than December 31, 2010, in the case of contracts relating to payments made under part C or D).

(4) AUDIT AND RECOVERY PERIODS.—Each such contract shall provide that audit and recovery activities may be conducted during a fiscal year with respect to payments made under this title—

***

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

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

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

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

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

(i) EVALUATIONS AND ANNUAL REPORT.—

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

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

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

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

[Explanation at ¶1825 and ¶1847.]

2010 Amendments:

Sec. 6402(j)(1)(A) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1893(c) in paragraph (3), by striking “and” at the end; by redesignating paragraph (4) as paragraph (5); and by inserting after paragraph (3) new paragraph (4).

Sec. 6402(j)(1)(B) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1893 by adding at the end new subsection (i).

Sec. 6411(b) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1893(b) in paragraph (1), in the matter preceding subparagraph (A), by striking “part A or B” and inserting “this title”, in paragraph (2), by striking “parts A and B” and inserting “this title”, in paragraph (3), by inserting “(not later than December 31, 2010, in the case of contracts relating to payments made under part C or D)” after “2010”, in paragraph (4), in the matter preceding subparagraph (A), by striking “part A or B” and inserting “this title”, and by adding at the end new paragraph (9).
Sec. 1895. Prospective Payment for Home Health Services

[42 U.S.C. §1395fff]

**

(b) ***

(3) ***

(A) ***

(i) ***

(III) Subject to clause (iii), for periods beginning after the period described in subclause (II), such amount (or amounts) shall be equal to the amount (or amounts) that would have been determined under subclause (I) that would have been made for fiscal year 2001 if the system had not been in effect and if section 1861(v)(1)(L)(ix) had not been enacted but if the reduction in limits described in clause (ii) had been in effect, updated under subparagraph (B). Each such amount shall be standardized in a manner that eliminates the effect of variations in relative case mix and area wage adjustments among different home health agencies in a budget neutral manner consistent with the case mix and wage level adjustments provided under paragraph (4)(A). Under the system, the Secretary may recognize regional differences or differences based upon whether or not the services or agency are in an urbanized area.

**

(iii) Adjustment for 2014 and subsequent years.—

(I) In general.—Subject to subclause (II), for 2014 and subsequent years, the amount (or amounts) that would otherwise be applicable under clause (i)(III) shall be adjusted by a percentage determined appropriate by the Secretary to reflect such factors as changes in the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other factors that the Secretary considers to be relevant. In conducting the analysis under the preceding sentence, the Secretary may consider differences between hospital-based and freestanding agencies, between for-profit and nonprofit agencies, and between the resource costs of urban and rural agencies. Such adjustment shall be made before the update under subparagraph (B) is applied for the year.

(II) Transition.—The Secretary shall provide for a 4-year phase-in (in equal increments) of the adjustment under subclause (I), with such adjustment being fully implemented for 2017. During each year of such phase-in, the amount of any adjustment under subclause (I) for the year may not exceed 3.5 percent of the amount (or amounts) applicable
under clause (i)(III) as of the date of enactment of the Patient Protection and Affordable Care Act.

(B) ***

(ii) ***

(V) any subsequent year, subject to clauses (v) and (vi), the home health market basket percentage increase.

***

(vi) ADJUSTMENTS.—After determining the home health market basket percentage increase under clause (iii), and after application of clause (v), the Secretary shall reduce such percentage—

(I) for 2015 and each subsequent year, by the productivity adjustment described in section 1886(b)(3)(B)(x)(II); and

(II) for each of 2011, 2012, and 2013, by 1 percentage point.

The application of this clause may result in the home health market basket percentage increase under clause (iii) being less than 0.0 for a year, and may result in payment rates under the system under this subsection for a year being less than such payment rates for the preceding year.

(C) ADJUSTMENT FOR OUTLIERS.—The Secretary shall reduce the standard prospective payment amount (or amounts) under this paragraph applicable to home health services furnished during a period by such proportion as will result in an aggregate reduction in payments for the period equal to 5 percent of the total payments estimated to be made based on the prospective payment system under this subsection for the period.

***

(5) OUTLIERS.—

(A) IN GENERAL.—Subject to subparagraph (B), the Secretary may provide for an addition or adjustment to the payment amount otherwise made in the case of outliers because of unusual variations in the type or amount of medically necessary care. The total amount of the additional payments or payment adjustments made under this paragraph with respect to a fiscal year or year may not exceed 2.5 percent of the total payments projected or estimated to be made based on the prospective payment system under this subsection for the period.

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[Explanation at ¶ 1005 and ¶ 1325.]

2010 Amendments:

Sec. 3131(a)(1) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23 2010, amended sec. 1895(b)(3)(A) in clause (i)(III), by striking “For periods” and inserting “Subject to clause (iii), for periods”; and by adding at the end new clause (iii).

Sec. 3131(b)(1) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23 2010, amended sec. 1895(b)(3)(C) by striking “the aggregate” and all that follows through the period at the end and inserting “5 percent of the total payments estimated to be made based on the prospective payment system under this subsection for the period.”.

Sec. 3131(b)(2) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23 2010, amended sec. 1895(b)(3)(B) in clause (ii)(V), by striking “clause (v)” and inserting “clauses (v) and (vi)” and by adding at the end new subparagraph (B).

Sec. 3401(e) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23 2010, amended sec. 1895(b)(5) by striking “OUTLIERS.—The Secretary” and inserting “OUTLIERS.—and adding new paragraph (A); in subparagraph (A), as added by subparagraph (A), by striking “5 percent” and inserting “2.5 percent”; and by adding at the end new subparagraph (B).
Sec. 10315(a) of the "Patient Protection and Affordable Care Act" (PubLNo 111-148), effective March 23 2010, amended sec. 1895(b)(3)(A)(iii) in the clause heading, by striking "2013" and inserting "2014"; in subclause (I), by striking "and 2012" and inserting "2012, 2013".

Sec. 10319(d) of the "Patient Protection and Affordable Care Act" (PubLNo 111-148), effective March 23 2010, amended sec. 1895(b)(3)(B)(vi)(II) by striking "and 2012" and inserting ", 2012, 2013".

[¶ 15,761]  Sec. 1898. Medicare Improvement Fund

[42 U.S.C. §1395iii]

*(b) FUNDING.—*

(1) IN GENERAL.—There shall be available to the Fund, for expenditures from the Fund for services furnished during—

(A) fiscal year 2014, $0;

*[Explanation at ¶ 870.]*

2010 Amendments:

Sec. 3112 of the "Patient Protection and Affordable Care Act (PubLNo 111-148), effective March 23, 2010, amended sec. 1898(b)(1)(A), by striking "$22,290,000,000" and inserting "$20,740,000,000".

[CCH Note: Prior to enactment of the Patient Protection and Affordable Care Act (PubLNo 111-148), Social Security Act sec. 1898(b)(1)(A) had been amended by sec. 1011(b) of the "Department of Defense Appropriations Act, 2010" (PubLNo 111-118). That amendment struck the figure "$22,290,000,000" and replaced it with "$20,740,000,000".]

[¶ 15,771]  Sec. 1899. SHARED SAVINGS PROGRAM

(a) ESTABLISHMENT.—

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

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

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

(b) ELIGIBLE ACOs.—

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

(A) ACO professionals in group practice arrangements.

(B) Networks of individual practices of ACO professionals.

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

(D) Hospitals employing ACO professionals.

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

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

(A) The ACO shall be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it.
(B) The ACO shall enter into an agreement with the Secretary to participate in the program for not less than a 3-year period (referred to in this section as the ‘agreement period’).

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

(D) The ACO shall include primary care ACO professionals that are sufficient for the number of Medicare fee-for-service beneficiaries assigned to the ACO under subsection (c). At a minimum, the ACO shall have at least 5,000 such beneficiaries assigned to it under subsection (c) in order to be eligible to participate in the ACO program.

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

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

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

(H) The ACO shall demonstrate to the Secretary that it meets patient-centeredness criteria specified by the Secretary, such as the use of patient and caregiver assessments or the use of individualized care plans.

(3) QUALITY AND OTHER REPORTING REQUIREMENTS.—

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

(i) clinical processes and outcomes;

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

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

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

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

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

(4) NO DUPLICATION IN PARTICIPATION IN SHARED SAVINGS PROGRAMS.—A provider of services or supplier that participates in any of the following shall not be eligible to participate in an ACO under this section:

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

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

§1899(b)(4)(B) ¶15,771
(c) ASSIGNMENT OF MEDICARE FEE-FOR-SERVICE BENEFICIARIES TO ACOs.—The Secretary shall determine an appropriate method to assign Medicare fee-for-service beneficiaries to an ACO based on their utilization of primary care services provided under this title by an ACO professional described in subsection (b)(1)(A).

(d) PAYMENTS AND TREATMENT OF SAVINGS.—

(1) PAYMENTS.—

(A) IN GENERAL.—Under the program, subject to paragraph (3), payments shall continue to be made to providers of services and suppliers participating in an ACO under the original Medicare fee-for-service program under parts A and B in the same manner as they would otherwise be made except that a participating ACO is eligible to receive payment for shared savings under paragraph (2) if—

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

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

(B) SAVINGS REQUIREMENT AND BENCHMARK.—

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

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

(2) PAYMENTS FOR SHARED SAVINGS.—Subject to performance with respect to the quality performance standards established by the Secretary under subsection (b)(3), if an ACO meets the requirements under paragraph (1), a percent (as determined appropriate by the Secretary) of the difference between such estimated average per capita Medicare expenditures in a year, adjusted for beneficiary characteristics, under the ACO and such benchmark for the ACO may be paid to the ACO as shared savings and the remainder of such difference shall be retained by the program under this title. The Secretary shall establish limits on the total amount of shared savings that may be paid to an ACO under this paragraph.

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

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

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

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

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

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

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

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

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

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

(h) Definitions.—In this section:

(1) ACO professional.—The term ‘ACO professional’ means—

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

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

(2) Hospital.—The term ‘hospital’ means a subsection (d) hospital (as defined in section 1886(d)(1)(B)).

(3) Medicare fee-for-service beneficiary.—The term ‘Medicare fee-for-service beneficiary’ means an individual who is enrolled in the original Medicare fee-for-service program under parts A and B and is not enrolled in an MA plan under part C, an eligible organization under section 1876, or a PACe program under section 1894.

(i) Option to Use Other Payment Models.—

(1) In general.—If the Secretary determines appropriate, the Secretary may use any of the payment models described in paragraph (2) or (3) for making payments under the program rather than the payment model described in subsection (d).

(2) Partial capitation model.—

(A) In general.—Subject to subparagraph (B), a model described in this paragraph is a partial capitation model in which an ACO is at financial risk for some, but not all, of the items and services covered under parts A and B, such as at risk for some or all physicians’ services or all items and services under part B. The Secretary may limit a partial capitation model to ACOs that are highly integrated systems of care and to ACOs capable of bearing risk, as determined to be appropriate by the Secretary.

(B) No additional program expenditures.—Payments to an ACO for items and services under this title for beneficiaries for a year under the partial capitation model shall be established in a manner that does not result in spending more for such ACO for such beneficiaries than would otherwise be expended for such ACO for such beneficiaries for such year if the model were not implemented, as estimated by the Secretary.

(3) Other payment models.—

(A) In general.—Subject to subparagraph (B), a model described in this paragraph is any payment model that the Secretary determines will improve the quality and efficiency of items and services furnished under this title.

(B) No additional program expenditures.—Subparagraph (B) of paragraph (2) shall apply to a payment model under subparagraph (A) in a similar manner as such subparagraph (B) applies to the payment model under paragraph (2).

(j) Involvement in Private Payer and Other Third Party Arrangements.—The Secretary may give preference to ACOs who are participating in similar arrangements with other payers.

(k) Treatment of Physician Group Practice Demonstration.—During the period beginning on the date of the enactment of this section and ending on the date the program is established, the Secretary may enter into an agreement with an ACO under the demonstration under section 1866A, subject to rebasing and other modifications deemed appropriate by the Secretary.
Sec. 1899A. INDEPENDENT MEDICARE ADVISORY BOARD

(a) ESTABLISHMENT.—There is established an independent board to be known as the ‘Independent Medicare Advisory Board’.

(b) PURPOSE.—It is the purpose of this section to, in accordance with the following provisions of this section, reduce the per capita rate of growth in Medicare spending—

(1) by requiring the Chief Actuary of the Centers for Medicare & Medicaid Services to determine in each year to which this section applies (in this section referred to as ‘a determination year’) the projected per capita growth rate under Medicare for the second year following the determination year (in this section referred to as ‘an implementation year’);

(2) if the projection for the implementation year exceeds the target growth rate for that year, by requiring the Board to develop and submit during the first year following the determination year (in this section referred to as ‘a proposal year’) a proposal containing recommendations to reduce the Medicare per capita growth rate to the extent required by this section; and

(3) by requiring the Secretary to implement such proposals unless Congress enacts legislation pursuant to this section.

(c) BOARD PROPOSALS.—

(1) DEVELOPMENT.—

(A) IN GENERAL.—The Board shall develop detailed and specific proposals related to the Medicare program in accordance with the succeeding provisions of this section.

(B) ADVISORY REPORTS.—Beginning January 15, 2014, the Board may develop and submit to Congress advisory reports on matters related to the Medicare program, regardless of whether or not the Board submitted a proposal for such year. Such a report may, for years prior to 2020, include recommendations regarding improvements to payment systems for providers of services and suppliers who are not otherwise subject to the scope of the Board’s recommendations in a proposal under this section. Any advisory report submitted under this subparagraph shall not be subject to the rules for congressional consideration under subsection (d). In any year (beginning with 2014) that the Board is not required to submit a proposal under this section, the Board shall submit to Congress an advisory report on matters related to the Medicare program.

(2) PROPOSALS.—

(A) REQUIREMENTS.—Each proposal submitted under this section in a proposal year shall meet each of the following requirements:

(i) If the Chief Actuary of the Centers for Medicare & Medicaid Services has made a determination under paragraph (7)(A) in the determination year, the proposal shall include recommendations so that the proposal as a whole (after taking into account recommendations under clause (v)) will result in a net reduction in total Medicare program spending in the implementation year that is at least equal to the applicable savings target established under paragraph (7)(B) for such implementation year. In determining whether a proposal meets the requirement of the preceding sentence, reductions in Medicare program spending during the 3-month period immediately preceding the implementation year shall be counted to the extent that such reductions are a result of the implementation of recommendations contained in the proposal for a change in the payment rate for an item or service that was effective during such period pursuant to subsection (e)(2)(A).

(ii) The proposal shall not include any recommendation to ration health care, raise revenues or Medicare beneficiary premiums under section 1818, 1818A, or 1839, increase Medicare beneficiary cost-sharing (including deductibles, coinsurance, and copayments), or otherwise restrict benefits or modify eligibility criteria.
(iii) In the case of proposals submitted prior to December 31, 2018, the proposal shall not include any recommendation that would reduce payment rates for items and services furnished, prior to December 31, 2019, by providers of services (as defined in section 1861(u)) and suppliers (as defined in section 1861(d)) scheduled, pursuant to the amendments made by section 3401 of the Patient Protection and Affordable Care Act, to receive a reduction to the inflationary payment updates of such providers of services and suppliers in excess of a reduction due to productivity in a year in which such recommendations would take effect.

(iv) As appropriate, the proposal shall include recommendations to reduce Medicare payments under parts C and D, such as reductions in direct subsidy payments to Medicare Advantage and prescription drug plans specified under paragraph (1) and (2) of section 1860D-13(a) that are related to administrative expenses (including profits) for basic coverage, denying high bids or removing high bids for prescription drug coverage from the calculation of the national average monthly bid amount under section 1860D-13(a)(4), and reductions in payments to Medicare Advantage plans under clauses (i) and (ii) of section 1853(a)(1)(B) that are related to administrative expenses (including profits) and performance bonuses for Medicare Advantage plans under section 1853(a). Any such recommendation shall not affect the base beneficiary premium percentage specified under section 1860D-13(a) or the full premium subsidy under section 1860D-14(a).

(v) The proposal shall include recommendations with respect to administrative funding for the Secretary to carry out the recommendations contained in the proposal.

(vi) The proposal shall only include recommendations related to the Medicare program.

(vii) If the Chief Actuary of the Centers for Medicare & Medicaid Services has made a determination described in subsection (e)(3)(B)(i)(II) in the determination year, the proposal shall be designed to help reduce the growth rate described in paragraph (8) while maintaining or enhancing beneficiary access to quality care under this title.

(B) ADDITIONAL CONSIDERATIONS.

— In developing and submitting each proposal under this section in a proposal year, the Board shall, to the extent feasible—

(i) give priority to recommendations that extend Medicare solvency;

(ii) include recommendations that—

(1) improve the health care delivery system and health outcomes, including by promoting integrated care, care coordination, prevention and wellness, and quality and efficiency improvement; and

(2) protect and improve Medicare beneficiaries’ access to necessary and evidence-based items and services, including in rural and frontier areas;

(iii) include recommendations that target reductions in Medicare program spending to sources of excess cost growth;

(iv) consider the effects on Medicare beneficiaries of changes in payments to providers of services (as defined in section 1861(u)) and suppliers (as defined in section 1861(d));

(v) consider the effects of the recommendations on providers of services and suppliers with actual or projected negative cost margins or payment updates;

(vi) consider the unique needs of Medicare beneficiaries who are dually eligible for Medicare and the Medicaid program under title XIX; and

(vii) take into account the data and findings contained in the annual reports under subsection (n) in order to develop proposals that can most effectively promote the delivery of efficient, high quality care to Medicare beneficiaries.

(C) NO INCREASE IN TOTAL MEDICARE PROGRAM SPENDING.

— Each proposal submitted under this section shall be designed in such a manner that implementation of the recommendations contained in the proposal would not be expected to result, over the 10-year period starting with the implementation year, in any increase in the total amount of net Medicare program spending relative to the total amount of net Medicare program spending that would have occurred absent such implementation.

(D) CONSULTATION WITH MEDPAC.

— The Board shall submit a draft copy of each proposal to be submitted under this section to the Medicare Payment Advisory Commission established under
section 1805 for its review. The Board shall submit such draft copy by not later than September 1 of the determination year.

(E) REVIEW AND COMMENT BY THE SECRETARY.—The Board shall submit a draft copy of each proposal to be submitted to Congress under this section to the Secretary for the Secretary’s review and comment. The Board shall submit such draft copy by not later than September 1 of the determination year. Not later than March 1 of the submission year, the Secretary shall submit a report to Congress on the results of such review, unless the Secretary submits a proposal under paragraph (5)(A) in that year.

(F) CONSULTATIONS.—In carrying out its duties under this section, the Board shall engage in regular consultations with the Medicaid and CHIP Payment and Access Commission under section 1900.

(3) SUBMISSION OF BOARD PROPOSAL TO CONGRESS AND THE PRESIDENT.—

(A) IN GENERAL.—

(i) IN GENERAL.—Except as provided in clause (ii) and subsection (f)(3)(B), the Board shall submit a proposal under this section to Congress and the President on January 15 of each year (beginning with 2014).

(ii) EXCEPTION.—The Board shall not submit a proposal under clause (i) in a proposal year if the year is—

(I) a year for which the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination in the determination year under paragraph (6)(A) that the growth rate described in clause (i) of such paragraph does not exceed the growth rate described in clause (ii) of such paragraph; or

(II) a year in which the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination in the determination year that the projected percentage increase (if any) for the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average) for the implementation year is less than the projected percentage increase (if any) in the Consumer Price Index for All Urban Consumers (all items; United States city average) for such implementation year.

(iii) START-UP PERIOD.—The Board may not submit a proposal under clause (i) prior to January 15, 2014.

(B) REQUIRED INFORMATION.—Each proposal submitted by the Board under subparagraph (A)(i) shall include—

(i) the recommendations described in paragraph (2)(A)(i);

(ii) an explanation of each recommendation contained in the proposal and the reasons for including such recommendation;

(iii) an actuarial opinion by the Chief Actuary of the Centers for Medicare & Medicaid Services certifying that the proposal meets the requirements of subparagraphs (A)(i) and (C) of paragraph (2);

(iv) a legislative proposal that implements the recommendations; and

(v) other information determined appropriate by the Board.

(4) PRESIDENTIAL SUBMISSION TO CONGRESS.—Upon receiving a proposal from the Secretary under paragraph (5), the President shall within 2 days submit such proposal to Congress.

(5) CONTINGENT SECRETARIAL DEVELOPMENT OF PROPOSAL.—If, with respect to a proposal year, the Board is required, but fails, to submit a proposal to Congress and the President by the deadline applicable under paragraph (3)(A)(i), the Secretary shall develop a detailed and specific proposal that satisfies the requirements of subparagraphs (A) and (C) (and, to the extent feasible, subparagraph (B)) of paragraph (2) and contains the information required paragraph (3)(B)). By not later than January 25 of the year, the Secretary shall transmit—

(A) such proposal to the President; and

(B) a copy of such proposal to the Medicare Payment Advisory Commission for its review.
(6) PER CAPITA GROWTH RATE PROJECTIONS BY CHIEF ACTUARY.—

(A) IN GENERAL.—Subject to subsection (f)(3)(A), not later than April 30, 2013, and annually thereafter, the Chief Actuary of the Centers for Medicare & Medicaid Services shall determine in each such year whether—

(i) the projected Medicare per capita growth rate for the implementation year (as determined under subparagraph (B));

(ii) the projected Medicare per capita target growth rate for the implementation year (as determined under subparagraph (C)).

(B) MEDICARE PER CAPITA GROWTH RATE.—

(i) IN GENERAL.—For purposes of this section, the Medicare per capita growth rate for an implementation year shall be calculated as the projected 5-year average (ending with such year) of the growth in Medicare program spending (calculated as the sum of per capita spending under each of parts A, B, and D).

(ii) REQUIREMENT.—The projection under clause (i) shall—

(I) to the extent that there is projected to be a negative update to the single conversion factor applicable to payments for physicians’ services under section 1848(d) furnished in the proposal year or the implementation year, assume that such update for such services is 0 percent rather than the negative percent that would otherwise apply; and

(II) take into account any delivery system reforms or other payment changes that have been enacted or published in final rules but not yet implemented as of the making of such calculation.

(C) MEDICARE PER CAPITA TARGET GROWTH RATE.—For purposes of this section, the Medicare per capita target growth rate for an implementation year shall be calculated as the projected 5-year average percentage increase in—

(i) with respect to a determination year that is prior to 2018, the average of the projected percentage increase (if any) in—

(I) the Consumer Price Index for All Urban Consumers (all items; United States city average); and

(II) the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average); and

(ii) with respect to a determination year that is after 2017, the nominal gross domestic product per capita plus 1.0 percentage point.

(7) SAVINGS REQUIREMENT.—

(A) IN GENERAL.—If, with respect to a determination year, the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination under paragraph (6)(A) that the growth rate described in clause (i) of such paragraph exceeds the growth rate described in clause (ii) of such paragraph, the Chief Actuary shall establish an applicable savings target for the implementation year.

(B) APPLICABLE SAVINGS TARGET.—For purposes of this section, the applicable savings target for an implementation year shall be an amount equal to the product of—

(i) the total amount of projected Medicare program spending for the proposal year; and

(ii) the applicable percent for the implementation year.

(C) APPLICABLE PERCENT.—For purposes of subparagraph (B), the applicable percent for an implementation year is the lesser of—

(i) in the case of—

(I) implementation year 2015, 0.5 percent;

(II) implementation year 2016, 1.0 percent;

(III) implementation year 2017, 1.25 percent; and
(IV) implementation year 2018 or any subsequent implementation year, 1.5 percent; and
(ii) the projected excess for the implementation year (expressed as a percent) determined
under subparagraph (A).

(8) PER CAPITA RATE OF GROWTH IN NATIONAL HEALTH EXPENDITURES.—In each determination year
(beginning in 2018), the Chief Actuary of the Centers for Medicare & Medicaid Services shall project the
per capita rate of growth in national health expenditures for the implementation year. Such rate of growth
for an implementation year shall be calculated as the projected 5-year average (ending with such year)
percentage increase in national health care expenditures.

(d) CONGRESSIONAL CONSIDERATION.—

(1) INTRODUCTION.—

(A) IN GENERAL.—On the day on which a proposal is submitted by the Board or the President to
the House of Representatives and the Senate under subsection (c)(3)(A)(i) or subsection (c)(4), the
legislative proposal (described in subsection (c)(3)(B)(iv)) contained in the proposal shall be intro-
duced (by request) in the Senate by the majority leader of the Senate or by Members of the Senate
designated by the majority leader of the Senate and shall be introduced (by request) in the House by
the majority leader of the House or by Members of the House designated by the majority leader of the
House.

(B) NOT IN SESSION.—If either House is not in session on the day on which such legislative
proposal is submitted, the legislative proposal shall be introduced in that House, as provided in
paragraph (A), on the first day thereafter on which that House is in session.

(C) ANY MEMBER.—If the legislative proposal is not introduced in either House within 5 days on
which that House is in session after the day on which the legislative proposal is submitted, then any
Member of that House may introduce the legislative proposal.

(D) REFERRAL.—The legislation introduced under this paragraph shall be referred by the
Presiding Officers of the respective Houses to the Committee on Finance in the Senate and to the
Committee on Energy and Commerce and the Committee on Ways and Means in the House of
Representatives.

(2) COMMITTEE CONSIDERATION OF PROPOSAL.—

(A) REPORTING BILL.—Not later than April 1 of any proposal year in which a proposal is
submitted by the Board or the President to Congress under this section, the Committee on Ways and
Means and the Committee on Energy and Commerce of the House of Representatives and the
Committee on Finance of the Senate may report the bill referred to the Committee under paragraph
(1)(D) with committee amendments related to the Medicare program.

(B) CALCULATIONS.—In determining whether a committee amendment meets the requirement of
subparagraph (A), the reductions in Medicare program spending during the 3-month period immedi-
ately preceding the implementation year shall be counted to the extent that such reductions are a
result of the implementation provisions in the committee amendment for a change in the payment rate
for an item or service that was effective during such period pursuant to such amendment.

(C) COMMITTEE JURISDICTION.—Notwithstanding rule XV of the Standing Rules of the Senate, a
committee amendment described in subparagraph (A) may include matter not within the jurisdiction
of the Committee on Finance if that matter is relevant to a proposal contained in the bill submitted
under subsection (c)(3).

(D) DISCHARGE.—If, with respect to the House involved, the committee has not reported the bill
by the date required by subparagraph (A), the committee shall be discharged from further considera-
tion of the proposal.

(3) LIMITATION ON CHANGES TO THE BOARD RECOMMENDATIONS.—

(A) IN GENERAL.—It shall not be in order in the Senate or the House of Representatives to
consider any bill, resolution, or amendment, pursuant to this subsection or conference report thereon,
that fails to satisfy the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2).
(B) LIMITATION ON CHANGES TO THE BOARD RECOMMENDATIONS IN OTHER LEGISLATION.—It shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, amendment, or conference report (other than pursuant to this section) that would repeal or otherwise change the recommendations of the Board if that change would fail to satisfy the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2).

(C) LIMITATION ON CHANGES TO THIS SUBSECTION.—It shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, amendment, or conference report that would repeal or otherwise change this subsection.

(D) WAIVER.—This paragraph may be waived or suspended in the Senate only by the affirmative vote of three-fifths of the Members, duly chosen and sworn.

(E) APPEALS.—An affirmative vote of three-fifths of the Members of the Senate, duly chosen and sworn, shall be required in the Senate to sustain an appeal of the ruling of the Chair on a point of order raised under this paragraph.

(4) EXPEDITED PROCEDURE.—

(A) CONSIDERATION.—A motion to proceed to the consideration of the bill in the Senate is not debatable.

(B) AMENDMENT.—

(i) TIME LIMITATION.—Debate in the Senate on any amendment to a bill under this section shall be limited to 1 hour, to be equally divided between, and controlled by, the mover and the manager of the bill, and debate on any amendment to an amendment, debatable motion, or appeal shall be limited to 30 minutes, to be equally divided between, and controlled by, the mover and the manager of the bill, except that in the event the manager of the bill is in favor of any such amendment, motion, or appeal, the time in opposition thereto shall be controlled by the minority leader or such leader’s designee.

(ii) GERMANE.—No amendment that is not germane to the provisions of such bill shall be received.

(iii) ADDITIONAL TIME.—The leaders, or either of them, may, from the time under their control on the passage of the bill, allot additional time to any Senator during the consideration of any amendment, debatable motion, or appeal.

(iv) AMENDMENT NOT IN ORDER.—It shall not be in order to consider an amendment that would cause the bill to result in a net reduction in total Medicare program spending in the implementation year that is less than the applicable savings target established under subsection (c)(7)(B) for such implementation year.

(v) WAIVER AND APPEALS.—This paragraph may be waived or suspended in the Senate only by the affirmative vote of three-fifths of the Members, duly chosen and sworn. An affirmative vote of three-fifths of the Members of the Senate, duly chosen and sworn, shall be required in the Senate to sustain an appeal of the ruling of the Chair on a point of order raised under this section.

(C) CONSIDERATION BY THE OTHER HOUSE.—

(i) IN GENERAL.—The expedited procedures provided in this subsection for the consideration of a bill introduced pursuant to paragraph (1) shall not apply to such a bill that is introduced in the receiving House if such a bill was not introduced in the Senate.

(ii) BEFORE PASSAGE.—If a bill that is introduced pursuant to paragraph (1) is received by the other House, after introduction but before disposition of such a bill in the receiving House, then the following shall apply:

(I) The receiving House shall consider the bill introduced in that House through all stages of consideration up to, but not including, passage.

(II) The question on passage shall be put on the bill of the other House as amended by the language of the receiving House.

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(iii) After passage.—If a bill introduced pursuant to paragraph (1) is received by one House from the other House, after such a bill is passed by the receiving House, then the vote on passage of the bill that originates in the receiving House shall be considered to be the vote on passage of the bill received from the other House as amended by the language of the receiving House.

(iv) Disposition.—Upon disposition of a bill introduced pursuant to paragraph (1) that is received by one House from the other House, it shall no longer be in order to consider the bill that originates in the receiving House.

(v) Limitation.—Clauses (ii), (iii), and (iv) shall apply only to a bill received by one House from the other House if the bill—

(I) is related only to the program under this title; and

(II) satisfies the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2).

(D) Senate limits on debate.—

(i) In general.—In the Senate, consideration of the bill and on all debatable motions and appeals in connection therewith shall not exceed a total of 30 hours, which shall be divided equally between the majority and minority leaders or their designees.

(ii) Motion to further limit debate.—A motion to further limit debate on the bill is in order and is not debatable.

(iii) Motion or appeal.—Any debatable motion or appeal is debatable for not to exceed 1 hour, to be divided equally between those favoring and those opposing the motion or appeal.

(iv) Final disposition.—After 30 hours of consideration, the Senate shall proceed, without any further debate on any question, to vote on the final disposition thereof to the exclusion of all amendments not then pending before the Senate at that time and to the exclusion of all motions, except a motion to table, or to reconsider and one quorum call on demand to establish the presence of a quorum (and motions required to establish a quorum) immediately before the final vote begins.

(E) Consideration in conference.—

(i) In general.—Consideration in the Senate and the House of Representatives on the conference report or any messages between Houses shall be limited to 10 hours, equally divided and controlled by the majority and minority leaders of the Senate or their designees and the Speaker of the House of Representatives and the minority leader of the House of Representatives or their designees.

(ii) Time limitation.—Debate in the Senate on any amendment under this subparagraph shall be limited to 1 hour, to be equally divided between, and controlled by, the mover and the manager of the bill, and debate on any amendment to an amendment, debatable motion, or appeal shall be limited to 30 minutes, to be equally divided between, and controlled by, the mover and the manager of the bill, except that in the event the manager of the bill is in favor of any such amendment, motion, or appeal, the time in opposition thereto shall be controlled by the minority leader or such leader’s designee.

(iii) Final disposition.—After 10 hours of consideration, the Senate shall proceed, without any further debate on any question, to vote on the final disposition thereof to the exclusion of all motions not then pending before the Senate at that time or necessary to resolve the differences between the Houses and to the exclusion of all other motions, except a motion to table, or to reconsider and one quorum call on demand to establish the presence of a quorum (and motions required to establish a quorum) immediately before the final vote begins.

(iv) Limitation.—Clauses (i) through (iii) shall only apply to a conference report, message or the amendments thereto if the conference report, message, or an amendment thereto—

(I) is related only to the program under this title; and

(II) satisfies the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2).
(F) Veto.—If the President vetoes the bill debate on a veto message in the Senate under this subsection shall be 1 hour equally divided between the majority and minority leaders or their designees.

(5) Rules of the Senate and House of Representatives.—This subsection and subsection (f)(2) are enacted by Congress—

(A) as an exercise of the rulemaking power of the Senate and the House of Representatives, respectively, and is deemed to be part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of an act under this section, and it supersedes other rules only to the extent that it is inconsistent with such rules; and

(B) with full recognition of the constitutional right of either House to change the rules (so far as they relate to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

(e) Implementation of Proposal.—

(1) In general.—Notwithstanding any other provision of law, the Secretary shall, except as provided in paragraph (3), implement the recommendations contained in a proposal submitted by the Board or the President to Congress pursuant to this section on August 15 of the year in which the proposal is so submitted.

(2) Application.—

(A) In general.—A recommendation described in paragraph (1) shall apply as follows:

(i) In the case of a recommendation that is a change in the payment rate for an item or service under Medicare in which payment rates change on a fiscal year basis (or a cost reporting period basis that relates to a fiscal year), on a calendar year basis (or a cost reporting period basis that relates to a calendar year), or on a rate year basis (or a cost reporting period basis that relates to a rate year), such recommendation shall apply to items and services furnished on the first day of the first fiscal year, calendar year, or rate year (as the case may be) that begins after such August 15.

(ii) In the case of a recommendation relating to payments to plans under parts C and D, such recommendation shall apply to plan years beginning on the first day of the first calendar year that begins after such August 15.

(iii) In the case of any other recommendation, such recommendation shall be addressed in the regular regulatory process timeframe and shall apply as soon as practicable.

(B) Interim Final Rulemaking.—The Secretary may use interim final rulemaking to implement any recommendation described in paragraph (1).

(3) Exceptions.—(A) In general.—The Secretary shall not implement the recommendations contained in a proposal submitted in a proposal year by the Board or

(i) prior to August 15 of the proposal year, Federal legislation is enacted that includes the following provision: ‘This Act supersedes the recommendations of the Board contained in the proposal submitted, in the year which includes the date of enactment of this Act, to Congress under section 1899A of the Social Security Act. and

(ii) in the case of implementation year 2020 and subsequent implementation years, a joint resolution described in subsection (f)(1) is enacted not later than August 15, 2017.

(B) Limited additional exception.—

(i) In general.—Subject to clause (ii), the Secretary shall not implement the recommendations contained in a proposal submitted by the Board or the President to Congress pursuant to this section in a proposal year (beginning with proposal year 2019) if—

(I) the Board was required to submit a proposal to Congress under this section in the year preceding the proposal year; and

(II) the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination in the determination year that the growth rate described in subsection (c)(8) exceeds the growth rate described in subsection (c)(6)(A)(i).
(ii) Limited additional exception may not be applied in two consecutive years.—This subparagraph shall not apply if the recommendations contained in a proposal submitted by the Board or the President to Congress pursuant to this section in the year preceding the proposal year were not required to be implemented by reason of this subparagraph.

(iii) No affect on requirement to submit proposals or for congressional consideration of proposals.—Clause (i) and (ii) shall not affect—

(I) the requirement of the Board or the President to submit a proposal to Congress in a proposal year in accordance with the provisions of this section; or

(II) congressional consideration of a legislative proposal (described in subsection (c)(3)(B)(iv)) contained such a proposal in accordance with subsection (d).

(4) No affect on authority to implement certain provisions.—Nothing in paragraph (3) shall be construed to affect the authority of the Secretary to implement any recommendation contained in a proposal or advisory report under this section to the extent that the Secretary otherwise has the authority to implement such recommendation administratively.

(5) Limitation on review.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the implementation by the Secretary under this subsection of the recommendations contained in a proposal.

(f) Joint resolution required to discontinue the Board.—

(1) In general.—For purposes of subsection (e)(3)(B), a joint resolution described in this paragraph means only a joint resolution—

(A) that is introduced in 2017 by not later than February 1 of such year;
(B) which does not have a preamble;
(C) the title of which is as follows: ‘Joint resolution approving the discontinuation of the process for consideration and automatic implementation of the annual proposal of the Independent Medicare Advisory Board under section 1899A of the Social Security Act’; and
(D) the matter after the resolving clause of which is as follows: ‘That Congress approves the discontinuation of the process for consideration and automatic implementation of the annual proposal of the Independent Medicare Advisory Board under section 1899A of the Social Security Act.’.

(2) Procedure.—

(A) Referral.—A joint resolution described in paragraph (1) shall be referred to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

(B) Discharge.—In the Senate, if the committee to which is referred a joint resolution described in paragraph (1) has not reported such joint resolution (or an identical joint resolution) at the end of 20 days after the joint resolution described in paragraph (1) is introduced, such committee may be discharged from further consideration of such joint resolution upon a petition supported in writing by 30 Members of the Senate, and such joint resolution shall be placed on the calendar.

(C) Consideration.—

(i) In general.—In the Senate, when the committee to which a joint resolution is referred has reported, or when a committee is discharged (under subparagraph (C)) from further consideration of a joint resolution described in paragraph (1), it is at any time thereafter in order (even though a previous motion to the same effect has been disagreed to) for a motion to proceed to the consideration of the joint resolution to be made, and all points of order against the joint resolution (and against consideration of the joint resolution) are waived, except for points of order under the Congressional Budget Act of 1974 or under budget resolutions pursuant to that Act. The motion is not debatable. A motion to reconsider the vote by which the motion is agreed to or disagreed to shall not be in order. If a motion to proceed to the consideration of the joint resolution is agreed to, the joint resolution shall remain the unfinished business of the Senate until disposed of.
(ii) **Debate Limitation.**—In the Senate, consideration of the joint resolution, and on all debatable motions and appeals in connection therewith, shall be limited to not more than 10 hours, which shall be divided equally between the majority leader and the minority leader, or their designees. A motion further to limit debate is in order and not debatable. An amendment to, or a motion to postpone, or a motion to proceed to the consideration of other business, or a motion to recommit the joint resolution is not in order.

(iii) **Passage.**—In the Senate, immediately following the conclusion of the debate on a joint resolution described in paragraph (1), and a single quorum call at the conclusion of the debate if requested in accordance with the rules of the Senate, the vote on passage of the joint resolution shall occur.

(iv) **Appeals.**—Appeals from the decisions of the Chair relating to the application of the rules of the Senate to the procedure relating to a joint resolution described in paragraph (1) shall be decided without debate.

(D) **Other House Acts First.**—If, before the passage by 1 House of a joint resolution of that House described in paragraph (1), that House receives from the other House a joint resolution described in paragraph (1), then the following procedures shall apply:

(i) The joint resolution of the other House shall not be referred to a committee.

(ii) With respect to a joint resolution described in paragraph (1) of the House receiving the joint resolution—

(I) the procedure in that House shall be the same as if no joint resolution had been received from the other House; but

(II) the vote on final passage shall be on the joint resolution of the other House.

(E) **Excluded Days.**—For purposes of determining the period specified in subparagraph (B), there shall be excluded any days either House of Congress is adjourned for more than 3 days during a session of Congress.

(F) **Majority Required for Adoption.**—A joint resolution considered under this subsection shall require an affirmative vote of three-fifths of the Members, duly chosen and sworn, for adoption.

(3) **Termination.**—If a joint resolution described in paragraph (1) is enacted not later than August 15, 2017—

(A) the Chief Actuary of the Medicare & Medicaid Services shall not—

(i) make any determinations under subsection (c)(6) after May 1, 2017; or

(ii) provide any opinion pursuant to subsection (c)(3)(B)(iii) after January 16, 2018;

(B) the Board shall not submit any proposals, advisory reports, or advisory recommendations under this section or produce the public report under subsection (n) after January 16, 2018; and

(C) the Board and the consumer advisory council under subsection (k) shall terminate on August 16, 2018.

(g) **Board Membership; Terms of Office; Chairperson; Removal.**—

(1) **Membership.**—

(A) **In General.**—The Board shall be composed of—

(i) 15 members appointed by the President, by and with the advice and consent of the Senate; and

(ii) the Secretary, the Administrator of the Center for Medicare & Medicaid Services, and the Administrator of the Health Resources and Services Administration, all of whom shall serve ex officio as nonvoting members of the Board.

(B) **Qualifications.**—

(i) **In General.**—The appointed membership of the Board shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health
facilities, allopathic and osteopathic physicians, and other providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

(ii) INCLUSION.—The appointed membership of the Board shall include (but not be limited to) physicians and other health professionals, experts in the area of pharmaco-economics or prescription drug benefit programs, employers, third-party payers, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research and expertise in outcomes and effectiveness research and technology assessment. Such membership shall also include representatives of consumers and the elderly.

(iii) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision or management of the delivery of items and services covered under this title shall not constitute a majority of the appointed membership of the Board.

(C) ETHICAL DISCLOSURE.—The President shall establish a system for public disclosure by appointed members of the Board of financial and other potential conflicts of interest relating to such members. Appointed members of the Board shall be treated as officers in the executive branch for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95-521).

(D) CONFLICTS OF INTEREST.—No individual may serve as an appointed member if that individual engages in any other business, vocation, or employment.

(E) CONSULTATION WITH CONGRESS.—In selecting individuals for nominations for appointments to the Board, the President shall consult with—

(i) the majority leader of the Senate concerning the appointment of 3 members;
(ii) the Speaker of the House of Representatives concerning the appointment of 3 members;
(iii) the minority leader of the Senate concerning the appointment of 3 members; and
(iv) the minority leader of the House of Representatives concerning the appointment of 3 members.

(2) TERM OF OFFICE.—Each appointed member shall hold office for a term of 6 years except that—

(A) a member may not serve more than 2 full consecutive terms (but may be reappointed to 2 full consecutive terms after being appointed to fill a vacancy on the Board);

(B) a member appointed to fill a vacancy occurring prior to the expiration of the term for which that member’s predecessor was appointed shall be appointed for the remainder of such term;

(C) a member may continue to serve after the expiration of the member’s term until a successor has taken office; and

(D) of the members first appointed under this section, 5 shall be appointed for a term of 1 year, 5 shall be appointed for a term of 3 years, and 5 shall be appointed for a term of 6 years, the term of each to be designated by the President at the time of nomination.

(3) CHAIRPERSON.—

(A) IN GENERAL.—The Chairperson shall be appointed by the President, by and with the advice and consent of the Senate, from among the members of the Board.

(B) DUTIES.—The Chairperson shall be the principal executive officer of the Board, and shall exercise all of the executive and administrative functions of the Board, including functions of the Board with respect to—

(i) the appointment and supervision of personnel employed by the Board;

(ii) the distribution of business among personnel appointed and supervised by the Chairperson and among administrative units of the Board; and

(iii) the use and expenditure of funds.

(C) GOVERNANCE.—In carrying out any of the functions under subparagraph (B), the Chairperson shall be governed by the general policies established by the Board and by the decisions, findings, and determinations the Board shall by law be authorized to make.
(D) Requests for Appropriations.—Requests or estimates for regular, supplemental, or deficiency appropriations on behalf of the Board may not be submitted by the Chairperson without the prior approval of a majority vote of the Board.

(4) Removal.—Any appointed member may be removed by the President for neglect of duty or malfeasance in office, but for no other cause.

(h) Vacancies; Quorum; Seal; Vice Chairperson; Voting on Reports.—

(1) Vacancies.—No vacancy on the Board shall impair the right of the remaining members to exercise all the powers of the Board.

(2) Quorum.—A majority of the appointed members of the Board shall constitute a quorum for the transaction of business, but a lesser number of members may hold hearings.

(3) Seal.—The Board shall have an official seal, of which judicial notice shall be taken.

(4) Vice Chairperson.—The Board shall annually elect a Vice Chairperson to act in the absence or disability of the Chairperson or in case of a vacancy in the office of the Chairperson.

(5) Voting on Proposals.—Any proposal of the Board must be approved by the majority of appointed members present.

(i) Powers of the Board.—

(1) Hearings.—The Board may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Board considers advisable to carry out this section.

(2) Authority to Inform Research Priorities for Data Collection.—The Board may advise the Secretary on priorities for health services research, particularly as such priorities pertain to necessary changes and issues regarding payment reforms under Medicare.

(3) Obtaining Official Data.—The Board may secure directly from any department or agency of the United States information necessary to enable it to carry out this section. Upon request of the Chairperson, the head of that department or agency shall furnish that information to the Board on an agreed upon schedule.

(4) Postal Services.—The Board may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

(5) Gifts.—The Board may accept, use, and dispose of gifts or donations of services or property.

(6) Offices.—The Board shall maintain a principal office and such field offices as it determines necessary, and may meet and exercise any of its powers at any other place.

(j) Personnel Matters.—

(1) Compensation of Members and Chairperson.—Each appointed member, other than the Chairperson, shall be compensated at a rate equal to the annual rate of basic pay prescribed for level III of the Executive Schedule under section 5315 of title 5, United States Code. The Chairperson shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level II of the Executive Schedule under section 5315 of title 5, United States Code.

(2) Travel Expenses.—The appointed members shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter 1 of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Board.

(3) Staff.—

(A) In General.—The Chairperson may, without regard to the civil service laws and regulations, appoint and terminate an executive director and such other additional personnel as may be necessary to enable the Board to perform its duties. The employment of an executive director shall be subject to confirmation by the Board.
(B) COMPENSATION.—The Chairperson may fix the compensation of the executive director and other personnel without regard to chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates, except that the rate of pay for the executive director and other personnel may not exceed the rate payable for level V of the Executive Schedule under section 5316 of such title.

(4) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Board without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

(5) PROCUREMENT OF TEMPORARY AND INTERMITTENT SERVICES.—The Chairperson may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

(k) CONSUMER ADVISORY COUNCIL.—

(1) IN GENERAL.—There is established a consumer advisory council to advise the Board on the impact of payment policies under this title on consumers.

(2) MEMBERSHIP.—

(A) NUMBER AND APPOINTMENT.—The consumer advisory council shall be composed of 10 consumer representatives appointed by the Comptroller General of the United States, 1 from among each of the 10 regions established by the Secretary as of the date of enactment of this section.

(B) QUALIFICATIONS.—The membership of the council shall represent the interests of consumers and particular communities.

(3) DUTIES.—The consumer advisory council shall, subject to the call of the Board, meet not less frequently than 2 times each year in the District of Columbia.

(4) OPEN MEETINGS.—Meetings of the consumer advisory council shall be open to the public.

(5) ELECTION OF OFFICERS.—Members of the consumer advisory council shall elect their own officers.

(6) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the consumer advisory council except that section 14 of such Act shall not apply.

(l) DEFINITIONS.—In this section:

(1) BOARD; CHAIRPERSON; MEMBER.—The terms ‘Board’, ‘Chairperson’, and ‘Member’ mean the Independent Medicare Advisory Board established under subsection (a) and the Chairperson and any Member thereof, respectively.

(2) MEDICARE.—The term ‘Medicare’ means the program established under this title, including parts A, B, C, and D.

(3) MEDICARE BENEFICIARY.—The term ‘Medicare beneficiary’ means an individual who is entitled to, or enrolled for, benefits under part A or enrolled for benefits under part B.

(4) MEDICARE PROGRAM SPENDING.—The term ‘Medicare program spending’ means program spending under parts A, B, and D net of premiums.

(m) FUNDING.—

(1) IN GENERAL.—There are appropriated to the Board to carry out its duties and functions—

(A) for fiscal year 2012, $15,000,000; and

(B) for each subsequent fiscal year, the amount appropriated under this paragraph for the previous fiscal year increased by the annual percentage increase in the Consumer Price Index for All Urban Consumers (all items; United States city average) as of June of the previous fiscal year.

(2) FROM TRUST FUNDS.—Sixty percent of amounts appropriated under paragraph (1) shall be derived by transfer from the Federal Hospital Insurance Trust Fund under section 1817 and 40 percent of amounts...
appropriated under such paragraph shall be derived by transfer from the Federal Supplementary Medical Insurance Trust Fund under section 1841.

(n) **Annual Public Report.**—

(1) **In general.**—Not later than July 1, 2014, and annually thereafter, the Board shall produce a public report containing standardized information on system-wide health care costs, patient access to care, utilization, and quality-of-care that allows for comparison by region, types of services, types of providers, and both private payers and the program under this title.

(2) **Requirements.**—Each report produced pursuant to paragraph (1) shall include information with respect to the following areas:

(A) The quality and costs of care for the population at the most local level determined practical by the Board (with quality and costs compared to national benchmarks and reflecting rates of change, taking into account quality measures described in section 1890(b)(7)(B)).

(B) Beneficiary and consumer access to care, patient and caregiver experience of care, and the cost-sharing or out-of-pocket burden on patients.

(C) Epidemiological shifts and demographic changes.

(D) The proliferation, effectiveness, and utilization of health care technologies, including variation in provider practice patterns and costs.

(E) Any other areas that the Board determines affect overall spending and quality of care in the private sector.

(o) **Advisory Recommendations for Non-Federal Health Care Programs.**—

(1) **In general.**—Not later than January 15, 2015, and at least once every two years thereafter, the Board shall submit to Congress and the President recommendations to slow the growth in national health expenditures (excluding expenditures under this title and in other Federal health care programs) while preserving or enhancing quality of care, such as recommendations—

(A) that the Secretary or other Federal agencies can implement administratively;

(B) that may require legislation to be enacted by Congress in order to be implemented;

(C) that may require legislation to be enacted by State or local governments in order to be implemented;

(D) that private sector entities can voluntarily implement; and

(E) with respect to other areas determined appropriate by the Board.

(2) **Coordination.**—In making recommendations under paragraph (1), the Board shall coordinate such recommendations with recommendations contained in proposals and advisory reports produced by the Board under subsection (c).

(3) **Available to public.**—The Board shall make recommendations submitted to Congress and the President under this subsection available to the public.

[Explanation at ¶1385.]

2010 Amendments:

Sec. 3403(a)(1) of the “Patient Protection and Affordable Care Act” (PubL No 111-148), effective March 23, 2010, added sec. 1899A.

Sec. 10320(a)(1) of the “Patient Protection and Affordable Care Act” (PubL No 111-148), effective March 23, 2010, amended sec. 1899A by making the following changes:

- in paragraph (c)(1)(B), by adding at the end the following new sentence: “In any year (beginning with 2014) that the Board is not required to submit a proposal under this section, the Board shall submit to Congress an advisory report on matters related to the Medicare program.”;

- in paragraph (c)(2)(A)(iv), by inserting “or the full premium subsidy under section 186D-14(a)” before the period at the end of the last sentence;

by adding at the end of paragraph (c)(2)(A) new clause (vii);

in paragraph (c)(2)(B)(v), by striking “and” at the end;

in paragraph (c)(2)(B)(vi), by striking the period at the end and inserting “; and”;

by adding at the end of section (c)(2)(B) new clause (vii);

in paragraph (c)(3), in the heading, by striking “TRANSMISSION OF BOARD PROPOSAL TO PRESIDENT” and inserting “SUBMISSION OF BOARD PROPOSAL TO CONGRESS AND THE PRESIDENT”; and

in subparagraph (c)(3)(A)(i), by striking “transmit a proposal under this section to the President” and inserting “submit a proposal under this section to Congress and the President”;

§1899A(o)(3) ¶15,781
in subparagraph (c)(3)(A)(ii)(I), by inserting “or” at the end;

in subparagraph (c)(3)(A)(ii)(II), by striking “; or” and inserting a period;

in subparagraph (c)(3)(A)(ii)(III), by striking subclause (II),
in paragraph (c)(4), by striking “the Board under paragraph (3)(A)(i)” and striking “immediately” and inserting “within 2 days”;
in paragraph (c)(5), by striking “to but” and inserting “but” and inserting “Congress and” after “submit a proposal to”;

in subparagraph (c)(6)(B)(i), by striking “per unduplicated enrollee” and inserting “(calculated as the sum of per capita spending under each of parts A, B, and D)”.

Sec. 10320(a)(2) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1899A by making the following changes:
in subsection (f)(3)(B), by striking “or advisory reports to Congress” and inserting “, advisory reports, or advisory recommendations”;

in paragraph (d)(2)(A), by inserting “the Board or” after “a proposal submitted by”;

Sec. 10320(a)(3) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1899A by making the following changes:
in paragraph (e)(1), by inserting “the Board or” after “a proposal submitted by”;
in paragraph (e)(3), by striking “EXCEPTION.—The Secretary shall not be required to implement the recommendations contained in a proposal submitted in a proposal year by” and inserting “EXCEPTIONS.—and inserting new subparagraph (e)(3)(A); by redesigning subparagraphs (A) and (B) as clauses (i) and (ii); and by adding new subparagraph (B).

Sec. 10320(a)(4) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1899A by making the following changes:
in subsection (f)(3)(B), by striking “or advisory reports to Congress” and inserting “, advisory reports, or advisory recommendations”;

in paragraph (d)(2)(A), by inserting “the Board or” after “a proposal submitted by”.

¶15,791 1900(a)

¶15,791 1900(a)

[¶15,791] Sec. 1900. MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION

(b) DUTIES.

(1) REVIEW OF ACCESS POLICIES FOR ALL STATES AND ANNUAL REPORTS.—MACPAC shall

(A) review policies of the Medicaid program established under this title (in this section referred to as Medicaid) and the State Health Insurance Program established under title XXI (in this section referred to as CHIP) affecting access to covered items and services, including topics described in paragraph (2);

(B) make recommendations to Congress, the Secretary, and States concerning such access policies;

(C) by not later than March 15 of each year (beginning with 2010), submit a report to Congress containing the results of such reviews and MACPAC’s recommendations concerning such policies; and

(D) by not later than June 15 of each year (beginning with 2010), submit a report to Congress containing an examination of issues affecting Medicaid and CHIP, including the implications of changes in health care delivery in the United States and in the market for health care services on such programs.

(2)

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(A)

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(i) the factors affecting expenditures for the efficient provision of items and services in different sectors, including the process for updating payments to medical, dental, and health professionals, hospitals, residential and long-term care providers, providers of home and community based services, Federally-qualified health centers and rural health clinics, managed care entities, and providers of other covered items and services;

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(iii) the relationship of such factors and methodologies to access and quality of care for Medicaid and CHIP beneficiaries (including how such factors and methodologies enable such beneficiaries to obtain the services for which they are eligible, affect, provider supply, and
affect providers that serve a disproportionate share of low-income and other vulnerable populations).

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

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

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

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

(F) INTERACTION OF MEDICAID AND CHIP PAYMENT POLICIES WITH HEALTH CARE DELIVERY GENERALLY.—The effect of Medicaid and CHIP payment policies on access to items and services for children and other Medicaid and CHIP populations other than under this title or title XXI and the implications of changes in health care delivery in the United States and in the general market for health care items and services on Medicaid and CHIP.

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

(H) OTHER ACCESS POLICIES.—The effect of other Medicaid and CHIP policies on access to covered items and services, including policies relating to transportation and language barriers and preventive, acute, and long-term services and supports.

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

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

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

(4) CREATION OF EARLY-WARNING SYSTEM.—MACPAC shall create an early-warning system to identify provider shortage areas, as well as other factors that adversely affect, or have the potential to adversely affect, access to care by, or the health care status of, Medicaid and CHIP beneficiaries. MACPAC shall include in the annual report required under paragraph (1)(D) a description of all such areas or problems identified with respect to the period addressed in the report.

(5) COMMENTS ON CERTAIN SECRETARIAL REPORTS AND REGULATIONS.—(A) CERTAIN SECRETARIAL REPORTS.—If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to access policies, including with respect to payment policies, under Medicaid or CHIP, the Secretary shall transmit a copy of the report to MACPAC. MACPAC shall review the report and, not later than 6 months after the date of submittal of the Secretary’s report to Congress, shall submit to the appropriate committees of Congress and the Secretary written comments on such report. Such comments may include such recommendations as MACPAC deems appropriate.

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

(6) AGENDA AND ADDITIONAL REVIEWS.—MACPAC shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding MACPAC’s agenda and progress towards achieving the agenda. MACPAC may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from

§1900(b)(6) ¶15,791
time to time on such topics relating to the program under this title or title XXI as may be requested by such chairmen and members and as MACPAC deems appropriate.

(7) **AVAILABILITY OF REPORTS.**—MACPAC shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

(8) **APPROPRIATE COMMITTEE OF CONGRESS.**—For purposes of this section, the term appropriate committees of Congress means the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

(9) **VOTING AND REPORTING REQUIREMENTS.**—With respect to each recommendation contained in a report submitted under paragraph (1), each member of MACPAC shall vote on the recommendation, and MACPAC shall include, by member, the results of that vote in the report containing the recommendation.

(10) **EXAMINATION OF BUDGET CONSEQUENCES.**—Before making any recommendations, MACPAC shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities, and shall submit with any recommendations, a report on the Federal and State-specific budget consequences of the recommendations.

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

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

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

Caution: Sec. 2801(a)(1)(H) of the Patient Protection and Affordable Care Act (P.L. 111-148) referred to section 2081; sec. 2602 is the likely correct reference and the text below reflects this.

(13) **COORDINATE AND CONSULT WITH THE FEDERAL COORDINATED HEALTH CARE OFFICE.**—MACPAC shall coordinate and consult with the Federal Coordinated Health Care Office established under section 2602 of the Patient Protection and Affordable Care Act before making any recommendations regarding dual eligible individuals.

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

(c) ***

(2) ***

(A) **IN GENERAL.**—The membership of MACPAC shall include individuals who have had direct experience as enrollees or parents or caregivers of enrollees in Medicaid or CHIP and individuals with national recognition for their expertise in Federal safety net health programs, health finance and economics, actuarial science, health plans and integrated delivery systems, reimbursement for health care, health information technology, and other providers of health services, public health, and other related fields, who provide a mix of different professions, broad geographic representation, and a balance between urban and rural representation.
(B) INCLUSION.—The membership of MACPAC shall include (but not be limited to) physicians, dentists, and other health professionals, employers, third-party payers, and individuals with expertise in the delivery of health services. Such membership shall also include representatives of children, pregnant women, the elderly, individuals with disabilities, caregivers, and dual eligible individuals, current or former representatives of State agencies responsible for administering Medicaid, and current or former representatives of State agencies responsible for administering CHIP.

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(d) ***

(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal and State departments and agencies;

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(e) ***

(1) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—MACPAC may secure directly from any department or agency of the United States and, as a condition for receiving payments under sections 1903(a) and 2105(a), from any State agency responsible for administering Medicaid or CHIP, information necessary to enable it to carry out this section. Upon request of the Chairman, the head of that department or agency shall furnish that information to MACPAC on an agreed upon schedule.

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(f) FUNDING

(1) REQUEST FOR APPROPRIATIONS

MACPAC shall submit requests for appropriations (other than for fiscal year 2010) in the same manner as the Comptroller General of the United States submits requests for appropriations, but amounts appropriated for MACPAC shall be separate from amounts appropriated for the Comptroller General of the United States.

(2) AUTHORIZATION

There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.

(3) FUNDING FOR FISCAL YEAR 2010.—

(A) IN GENERAL.—

Out of any funds in the Treasury not otherwise appropriated, there is appropriated to MACPAC to carry out the provisions of this section for fiscal year 2010, $9,000,000.

(B) TRANSFER OF FUNDS.—

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

(4) AVAILABILITY.—

Amounts made available under paragraphs (2) and (3) to MACPAC to carry out the provisions of this section shall remain available until expended.
facility, physician, Federally-qualified health center, rural health center, and other fees and inserting "payments to medical, dental, and health professionals, hospitals, residen-
tial and long-term care providers, providers of home and community based services, Federally-qualified health cen-
ters and rural health clinics, managed care entities, and providers of other covered items and services"; by redesig-
nating subparagraphs (B) and (C) as subparagraphs (F) and (H), respectively, by inserting after subparagraph (A) new subparagraph (B), (C), (D) and (E); by inserting after subpar-
agraph (F) (as redesignated by clause (ii) of this subpara-
graph) new subparagraph (G); in subparagraph (H) (as so redesignated), by inserting "and preventive, acute, and
long-term services and supports" after "barriers"; by redesig-
nating paragraphs (3) through (9) as paragraphs (4) through (10), respectively, by inserting after paragraph (2),
new paragraph (3); in paragraph (4), as redesignated by subpar-
graph (C), by striking "or any other problems" and all that follows through the period and inserting ", as well as other factors that adversely affect, or have the potential to
adversely affect, access to care by, or the health care status of,
Medicaid and CHIP beneficiaries. MACPAC shall in-
clude in the annual report required under paragraph (1)(D)
a description of all such areas or problems identified with
respect to the period addressed in the report,"; in paragraph
(5), in the paragraph heading, by inserting "AND REGULA-
TIONS" after "REPORTS"; and by striking "IF" and in-
serting new subparagraph (A); and in the second sentence,
by inserting "and the Secretary" after "appropriate commit-
tees of Congress"; by adding at the end new subparagraph
B; in paragraph (10), as so redesignated, by inserting ", and
shall submit with any recommendations, a report on the
Federal and State-specific budget consequences of the rec-
ommendations" before the period; by adding at the end new
paragraph (11), (12), (13) and (14).

Sec. 2801(a)(2) of the "Patient Protection and Affordable
Care Act" (PubLNo 111-148), effective March 23, 2010,
amended sec. 1902(c)(2) by striking original paragraph (A)
and (B) and inserting a new paragraph (A) and (B). Prior to
amendment, sec. 1902(c)(2)(A) and (B) previously read as
follows:

"(A) IN GENERAL.—The membership of MACPAC shall
include individuals who have had direct experience as en-
rollees or parents of enrollees in Medicaid or CHIP and
individuals with national recognition for their expertise in
Federal safety net health programs, health finance and eco-
nomics, actuarial science, health facility management, health
plans and integrated delivery systems, reimbursement of
health facilities, health information technology, pediatric
physicians, dentists, and other providers of health services,
and other related fields, who provide a mix of different
professionals, broad geographic representation, and a bal-
ance between urban and rural representatives.

"(B) INCLUSION.—The membership of MACPAC shall
include (but not be limited to) physicians and other health
professionals, employers, third-party payers, and individu-
als with expertise in the delivery of health services. Such
membership shall also include consumers representing chil-
dren, pregnant women, the elderly, and individuals with
disabilities, current or former representatives of State agen-
cies responsible for administering Medicaid, and current or
former representatives of State agencies responsible for ad-
ministering CHIP."

Sec. 2801(a)(3) of the "Patient Protection and Affordable
Care Act" (PubLNo 111-148), effective March 23, 2010,
amended sec. 1901(d)(2) by inserting "and State" after
"Federal".

Sec. 2801(a)(4) of the "Patient Protection and Affordable
Care Act" (PubLNo 111-148), effective March 23, 2010,
amended sec. 1900(e) in the first sentence, by inserting "and,
as a condition for receiving payments under sections 1903(a)
and 2105(a), from any State agency responsible for adminis-
tering Medicaid or CHIP," after "United States".

Sec. 2801(a)(5) of the "Patient Protection and Affordable
Care Act" (PubLNo 111-148), effective March 23, 2010,
amended sec. 1900(f) in the subsection heading, by striking
"AUTHORIZED OF APPROPRIATIONS" and in-
serting "FUNDING"; in paragraph (1), by inserting "other
than for fiscal year 2010" before "in the same manner"; and
by adding at the end new paragraphs (3) and (4).

¶15,801 Sec. 1902(a). STATE PLANS FOR MEDICAL ASSISTANCE

[42 U.S.C. 1396a]

(a)

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(9)

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(B) for the establishment or designation of a State authority or authorities which shall be
responsible for establishing and maintaining standards, other than those relating to
health, for such institutions,

(C) that any laboratory services paid for under such plan must be provided by a
laboratory which meets the applicable requirements of section 1861(e)(9) or paragraphs (16)
and (17) of section 1861(s), or, in the case of a laboratory which is in a rural health clinic, of
section 1861(aa)(2)(G), and

(D) that the State maintain a consumer-oriented website providing useful information to
consumers regarding all skilled nursing facilities and all nursing facilities in the State, including for
each facility, Form 2567 State inspection reports (or a successor form), complaint investiga-
tion reports, the facility’s plan of correction, and such other information that the State or the Secretary
considers useful in assisting the public to assess the quality of long term care options and the quality
of care provided by individual facilities;

(10)

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¶15,801 1902(a)
(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17), (21), and (28) of section 1905(a), to

(i)

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(VI) who are described in subparagraph (C) of subsection (l)(1) and whose family income does not exceed the income level the State is required to establish under subsection (l)(2)(B) for such a family;

(VII) who are described in subparagraph (D) of subsection (l)(1) and whose family income does not exceed the income level the State is required to establish under subsection (l)(2)(C) for such a family;

(VIII) beginning January 1, 2014, who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII, and are not described in a previous subclause of this clause, and whose income (as determined under section 1902(a)(10)(A)(ii)(XX) ¶15,801)

(ii)

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(VIII) who is a child described in section 1905(a)(i)

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(XI) who receive only an optional State supplementary payment based on need and paid on a regular basis, equal to the difference between the individual’s countable income and the income standard used to determine eligibility for such supplementary payment (with countable income being the income remaining after deductions as established by the State pursuant to standards that may be more restrictive than the standards for supplemental security income benefits under title XVI), which are available to all individuals in the State (but which may be based on different income standards by political subdivision according to cost of living differences), and which are paid by a State that does not have an agreement with the Commissioner of Social Security under section 1616 or 1634;

(XII) who are described in subsection (z)(1) (relating to certain TB-infected individuals);

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(XVIII) who are described in subsection (aa) (relating to certain breast or cervical cancer patients);

(XIX) who are disabled children described in subsection (cc)(1);

(XX) beginning January 1, 2014, who are under 65 years of age and are not described in or enrolled under a previous subclause of this clause, and whose income (as determined...
under subsection (e)(14) exceeds 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved but does not exceed the highest income eligibility level established under the State plan or under a waiver of the plan, subject to subsection (hh); (XXI) who are described in subsection (ii) (relating to individuals who meet certain income standards); or (XXII) who are eligible for home and community-based services under needs-based criteria established under paragraph (1)(A) of section 1915(i), or who are eligible for home and community-based services under paragraph (6) of such section, and who will receive home and community-based services pursuant to a State plan amendment under such subsection; ***

(G) that, in applying eligibility criteria of the supplemental security income program under title XVI for purposes of determining eligibility for medical assistance under the State plan of an individual who is not receiving supplemental security income, the State will disregard the provisions of subsections (c) and (e) of section 1613; except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1905(a) to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, (II) the making available of supplementary medical insurance benefits under part B of title XVIII to individuals eligible therefor (either pursuant to an agreement entered into under section 1843 or by reason of the payment of premiums under such title by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of title XVIII for individuals eligible therefor, shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals, (III) the making available of medical assistance equal in amount, duration, and scope, to any other classification of individuals approved by the Secretary with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals, (IV) the imposition of a deductible, cost sharing, or similar charge for any item or service furnished to an individual not eligible for the exemption under section 1916(a)(2) or (b)(2) shall not require the imposition of a deductible, cost sharing, or similar charge for the same item or service furnished to an individual who is eligible for such exemption, (V) the making available to pregnant women covered under the plan of services relating to pregnancy (including prenatal, delivery, and postpartum services) or to any other condition which may complicate pregnancy shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any other individuals, provided such services are made available (in the same amount, duration, and scope) to all pregnant women covered under the State plan, (VI) with respect to the making available of medical assistance for hospice care to terminally ill individuals who have made a voluntary election described in section 1905(o) to receive hospice care instead of medical assistance for certain other services, such assistance may not be made available in an amount, duration, or scope less than that provided under title XVIII, and the making available of such assistance shall not, by reason of this paragraph (10), require the making available of medical assistance for hospice care to other individuals or the making available of medical assistance for services waived by such terminally ill individuals, (VII) the medical assistance made available to an individual described in subsection (i)(1)(A) who is eligible for medical assistance only because of subparagraph (A)(i)(IV) or (A)(ii)(IX) shall be limited to medical assistance for services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions which may complicate pregnancy, (VIII) the medical assistance made available to a qualified Medicare beneficiary described in section 1905(p)(1) who is only entitled to medical assistance because the individual is such a beneficiary shall be limited to medical assistance for services...
Medicare cost-sharing (described in section 1905(p)(3)), subject to the provisions of subsection (n) and section 1916(b), (IX) the making available of respiratory care services in accordance with subsection (e)(9) shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any individuals not included under subsection (e)(9)(A), provided such services are made available (in the same amount, duration, and scope) to all individuals described in such subsection, (X) if the plan provides for any fixed durational limit on medical assistance for inpatient hospital services (whether or not such a limit varies by medical condition or diagnosis), the plan must establish exceptions to such a limit for medically necessary inpatient hospital services furnished with respect to individuals under one year of age in a hospital defined under the State plan, pursuant to section 1923(a)(1)(A), as a disproportionate share hospital and subparagraph (B) (relating to comparability) shall not be construed as requiring such an exception for other individuals, services, or hospitals, (XI) the making available of medical assistance to cover the costs of premiums, deductibles, coinsurance, and other cost-sharing obligations for certain individuals for private health coverage as described in section 1906 shall not, by reason of paragraph (10), require the making available of any such benefits or the making available of services of the same amount, duration, and scope of such private coverage to any other individuals, (XII) the medical assistance made available to an individual described in subsection (u)(1) who is eligible for medical assistance only because of subparagraph (F) shall be limited to medical assistance for COBRA continuation premiums (as defined in subsection (u)(2) of this section), (XIII) the medical assistance made available to an individual described in subsection (z)(1) who is eligible for medical assistance only because of subparagraph (A)(i)(VIII) shall be limited to medical assistance described in subsection (k)(1), and (XIV) the medical assistance made available to an individual described in subsection (a)(10)(ii)(VIII) shall be limited to primary care services (as defined in subsection (jj)) furnished in 2013 and 2014 by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine at a rate not less than 100 percent of the payment rate that applies to such services and physician under part B of title XVIII (or, if greater, the payment rate that would be applicable under such part if the conversion factor under section 1848(d) for the year involved were the conversion factor under such section for 2009).

(13) provide—

(A)

(iv) in the case of hospitals, such rates take into account (in a manner consistent with section 1923) the situation of hospitals which serve a disproportionate number of low-income patients with special needs;

(B) for payment for hospice care in amounts no lower than the amounts, using the same methodology, used under part A of title XVIII and for payment of amounts under section 1905(o)(3); except that in the case of hospice care which is furnished to an individual who is a resident of a nursing facility or intermediate care facility for the mentally retarded who would be eligible under the plan for nursing facility services or services in an intermediate care facility for the mentally retarded if he had not elected to receive hospice care, there shall be paid an additional amount, to take into account the room and board furnished by the facility, equal to at least 95 percent of the rate that would have been paid by the State under the plan for facility services in that facility for that individual; and

(C) payment for primary care services (as defined in subsection (jj)) furnished in 2013 and 2014 by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine at a rate not less than 100 percent of the payment rate that applies to such services and physician under part B of title XVIII (or, if greater, the payment rate that would be applicable under such part if the conversion factor under section 1848(d) for the year involved were the conversion factor under such section for 2009);
(17) except as provided in subsections (e)(14), (l)(3), (m)(3), and (m)(4), include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, and with respect to whom supplemental security income benefits are not being paid under title XVI, based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this title, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or to have paid with respect to him supplemental security income benefits under title XVI) as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual’s spouse or such individual’s child who is under age 21 or (with respect to States eligible to participate in the State program established under title XVI), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1614 (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums, payments made to the State under section 1905(f)(2)(B) or otherwise and regardless of whether such costs are reimbursed under another public program of the State or political subdivision thereof) incurred for medical care or for any other type of remedial care recognized under State law;

***

(23) provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services, and (B) an enrollment of an individual eligible for medical assistance in a primary care case-management system (described in section 1915(b)(1)), a Medicaid managed care organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive services under section 1905(a)(4)(C), except as provided in subsection (g), in section 1915, and in section 1932(a), except that this paragraph shall not apply in the case of Puerto Rico, the Virgin Islands, and Guam, and except that nothing in this paragraph shall be construed as requiring a State to provide medical assistance for such services furnished by a person or entity convicted of a felony under Federal or State law for an offense which the State agency determines is inconsistent with the best interests of beneficiaries under the State plan or by a provider or supplier to which a moratorium under subsection (ii)(4) is applied during the period of such moratorium;

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(39) provide that the State agency shall exclude any specified individual or entity from participation in the program under the State plan for the period specified by the Secretary, when required by him to do so pursuant to section 1128 or section 1128A, terminate the participation of any individual or entity in such program if (subject to such exceptions as are permitted with respect to exclusion under sections 1128(c)(3)(B) and 1128(d)(3)(B)) participation of such individual or entity is terminated under title XVIII or any other State plan under this title, and provide that no payment may be made under the plan with respect to any item or service furnished by such individual or entity during such period;

***

(42) provide that—
(A) the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan; and

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

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

(ii) provide assurances satisfactory to the Secretary that—

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

(II) from such amounts recovered, payment—

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

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

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

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

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

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

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

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(47) provide—

(A) at the option of the State, for making ambulatory prenatal care available to pregnant women during a presumptive eligibility period in accordance with section 1920 and provide for making medical assistance for items and services described in subsection (a) of section 1920A available to children during a presumptive eligibility period in accordance with such section and provide for making medical assistance available to individuals described in subsection (a) of section 1920B during a presumptive eligibility period in accordance with such section and provide for making medical assistance available to individuals described in subsection (a) of section 1920C during a presumptive eligibility period in accordance with such section; and

(B) that any hospital that is a participating provider under the State plan may elect to be a qualified entity for purposes of determining, on the basis of preliminary information, whether any individual is eligible for medical assistance under the State plan or under a waiver of the plan for purposes of providing the individual with medical assistance during a presumptive eligibility period, in the same manner, and subject to the same requirements, as apply to the State options with respect to populations described in section 1920, 1920A, 1920B, or 1920C (but without regard to whether the State has elected to provide for a presumptive eligibility period under any such sections), subject to such guidance as the Secretary shall establish;
(72) provide that the State will not prevent a Federally qualified health center from entering into contractual relationships with private practice dental providers in the provision of Federally-qualified health center services;

(73) in the case of any State in which 1 or more Indian Health Programs or Urban Indian Organizations furnishes health care services, provide for a process under which the State seeks advice on a regular, ongoing basis from designees of such Indian Health Programs and Urban Indian Organizations on matters relating to the application of this title that are likely to have a direct effect on such Indian Health Programs and Urban Indian Organizations and that; and

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

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

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

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

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

(76) provide that any data collected under the State plan meets the requirements of section 3101 of the Public Health Service Act;

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

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

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

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

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

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

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

(81) provide that the State will comply with such regulations regarding the application of primary and secondary payor rules with respect to individuals who are eligible for medical assistance under this title and are eligible beneficiaries under the CLASS program established under title XXXII of the Public Health Service Act as the Secretary shall establish; and

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

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

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

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

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

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**§ 1902(e)(14)**

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

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

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

(D) EXCEPTIONS.—

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

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

(II) Individuals who have attained age 65.

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

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

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

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

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

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

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

(E) TRANSITION PLANNING AND OVERSIGHT.—Each State shall submit to the Secretary for the Secretary's approval the income eligibility thresholds proposed to be established using modified adjusted gross income and household income, the methodologies and procedures to be used to determine income eligibility using modified adjusted gross income and household income and, if applicable, a State plan amendment establishing an optional eligibility category under subsection (a)(10)(A)(ii)(XX). To the extent practicable, the State shall use the same methodologies and
procedures for purposes of making such determinations as the State used on the date of enactment of the Patient Protection and Affordable Care Act. The Secretary shall ensure that the income eligibility thresholds proposed to be established using modified adjusted gross income and household income, including under the eligibility category established under subsection (a)(10)(A)(ii)(XX), and the methodologies and procedures proposed to be used to determine income eligibility, will not result in children who would have been eligible for medical assistance under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act no longer being eligible for such assistance.

(F) LIMITATION ON SECRETARIAL AUTHORITY.—The Secretary shall not waive compliance with the requirements of this paragraph except to the extent necessary to permit a State to coordinate eligibility requirements for dual eligible individuals (as defined in section 1915(h)(2)(B)) under the State plan or under any waiver of such plan.

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

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

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

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

(I) Treatment Of Portion Of Modified Adjusted Gross Income.—For purposes of determining the income eligibility of an individual for medical assistance whose eligibility is determined based on the application of modified adjusted gross income under subparagraph (A), the State shall—

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

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

(k)(1) The medical assistance provided to an individual described in subclause (VIII) of subsection (a)(10)(A)(i) shall consist of benchmark coverage described in section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2). Such medical assistance shall be provided subject to the requirements of section 1937, without regard to whether a State otherwise has elected the option to provide medical assistance through coverage under that section, unless an individual described in subclause (VIII) of subsection (a)(10)(A)(i) is also an individual for whom, under subparagraph (B) of section 1937(a)(2), the State may not require enrollment in benchmark coverage described in subsection (b)(1) of section 1937 or benchmark equivalent coverage described in subsection (b)(2) of that section.

(2) Beginning with the first day of any fiscal year quarter that begins on or after April 1, 2010, and before January 1, 2014, a State may elect through a State plan amendment to provide medical assistance to individuals who would be described in subclause (VIII) of subsection (a)(10)(A)(i) if that subclause were effective before January 1, 2014. A State may elect to phase-in the extension of eligibility for medical assistance to such individuals based on income, so long as the State does not extend such eligibility to individuals described in such subclause with higher income before making individuals described in such subclause with lower income eligible for medical assistance.
(3) If an individual described in subclause (VIII) of subsection (a)(10)(A)(i) is the parent of a child who is under 19 years of age (or such higher age as the State may have elected) who is eligible for medical assistance under the State plan or under a waiver of such plan (under that subclause or under a State plan amendment under paragraph (2), the individual may not be enrolled under the State plan unless the individual’s child is enrolled under the State plan or under a waiver of the plan or is enrolled in other health insurance coverage. For purposes of the preceding sentence, the term ‘parent’ includes an individual treated as a caretaker relative for purposes of carrying out section 1931.

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(l)(2)(C) For purposes of paragraph (1) with respect to individuals described in subparagraph (D) of that paragraph, the State shall establish an income level which is equal to 133 percent of the income official poverty line described in subparagraph (A) applicable to a family of the size involved.

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(gg) MAINTENANCE OF EFFORT.—

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

(2) CONTINUATION OF ELIGIBILITY STANDARDS FOR CHILDREN UNTIL OCTOBER 1, 2019.—The requirement under paragraph (1) shall continue to apply to a State through September 30, 2019, with respect to the eligibility standards, methodologies, and procedures under the State plan under this title or under any waiver of such plan that are applicable to determining the eligibility for medical assistance of any child who is under 19 years of age (or such higher age as the State may have elected).

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

(4) DETERMINATION OF COMPLIANCE.—

(A) STATES SHALL APPLY modified adjusted gross income.—A State’s determination of income in accordance with subsection (e)(14) shall not be considered to be eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).

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

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

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

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

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

(B) who are not pregnant.

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

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

(jj) PRIMARY CARE SERVICES DEFINED.—For purposes of subsection (a)(13)(C), the term ‘primary care services’ means—

(1) evaluation and management services that are procedure codes (for services covered under title XVIII) for services in the category designated Evaluation and Management in the Healthcare Common Procedure Coding System (established by the Secretary under section 1848(c)(5) as of December 31, 2009, and as subsequently modified); and

(2) services related to immunization administration for vaccines and toxoids for which CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473, or 90474 (as subsequently modified) apply under such System.
1902(a)(10)(A)(ii) in subclause (XX), by striking "or" at the end; and in subclause (XXI), by adding "or" at the end; and by inserting after subclause (XX) new subclause (XXII).


Sec. 2010(a) of the "Patient Protection and Affordable Care Act" (Pub.L. No. 111-148), effective March 1, 2014, amended sec. 1902(a)(10)(A)(ii) by striking "or" at the end of subclause (VII); and by adding "or" at the end of subclause (VIII); and by inserting after subclause (VIII) new subclause (IX).

Sec. 10201(a)(2) of the "Patient Protection and Affordable Care Act" (Pub.L. No. 111-148), effective March 23, 2010, amended sec. 1902(a)(10)(G) by striking "and (XV)" and inserting "(XX)" and by inserting "and (XVI) if an individual is described in subclause (IX) of subparagraph (A)(ii); and is included in subclause (VIII) of that subparagraph, Sec. 2001(a)(5)(B) of the "Patient Protection and Affordable Care Act" (Pub.L. No. 111-148), effective March 23, 2010, amended sec. 1902(a)(47) by striking "at the option of the State, provide" and inserting "provide---"(A) at the option of the State; and by inserting "and" after the semicolon; and by adding at the end subsection (B).

Sec. 2303(b)(2)(A) of the "Patient Protection and Affordable Care Act" (Pub.L. No. 111-148), effective March 23, 2010, amended sec. 1902(a)(47) in subparagraph (A), by inserting before the semicolon at the end the following: "and provide for making medical assistance available to individuals described in subsection (a) of section 1920C during a presumptive eligibility period in accordance with such section" and in subparagraph (B), by striking "or 1920B" and inserting "1920B, or 1920C."

Sec. 2010(b)(1) of the "Patient Protection and Affordable Care Act" (Pub.L. No. 111-148), effective March 23, 2010, amended sec. 1902(a) by striking "and" at the end of paragraph (72).

Sec. 2010(d)(1) of the "Patient Protection and Affordable Care Act" (Pub.L. No. 111-148), effective March 23, 2010, amended sec. 1902(a) by striking "and" at the end of paragraph (73).

Sec. 2010(b)(1) of the "Patient Protection and Affordable Care Act" (Pub.L. No. 111-148), effective March 23, 2010, amended sec. 1902(a) by striking the period at the end of paragraph (73) and inserting "; and".

Sec. 2010(d)(1) of the "Patient Protection and Affordable Care Act" (Pub.L. No. 111-148), effective March 23, 2010, amended sec. 1902(a) by striking the period at the end of paragraph (74) and inserting "; and".

Sec. 2010(b)(1) of the "Patient Protection and Affordable Care Act" (Pub.L. No. 111-148), effective March 23, 2010, amended sec. 1902(a) by adding new paragraph (74).
Sec. 1004(b)(1) of the “Health Care and Education Reconciliation Act of 2010” (Pub.L.No 111-152), effective March 30, 2010, amended secs. 1902(e)(14) and (gg)(4)(A) by replacing “modified gross income” with “modified adjusted gross income” each place it appears.

Sec. 1004(e) of the “Health Care and Education Reconciliation Act of 2010” (Pub.L.No 111-152), effective March 30, 2010, amended secs. 1902(e)(14) in subparagraph (B), by striking “No type” and inserting “Subject to subparagraph (I), no type” and by adding at the end the new subparagraph (I).

Sec. 1202(a)(1) of the “Health Care and Education Reconciliation Act of 2010” (Pub.L.No 111-152), effective March 30, 2010, amended sec. 1902, in subsection (a)(13) by striking “and” at the end of subparagraph (A), by adding “and” at the end of subparagraph (B), and by adding the new subparagraph (C) and by adding at the end new subsection (jj).

¶15,811  Sec. 1903. PAYMENT TO STATES

[42 U.S.C. 1396b]  

[See sec. 1903(a) to sec. 1903(w).]

(a)  

(3)  

[Caution: There is no Social Security Act § 1903(a)(3)(G).]  

(H)(i) 90 percent of the sums expended during the quarter as are attributable to the design, development, or installation of such mechanized verification and information retrieval systems as the Secretary determines are necessary to implement section 1902(ee) (including a system described in paragraph (2)(B) thereof), and  

(ii) 75 percent of the sums expended during the quarter as are attributable to the operation of systems to which clause (i) applies, plus

(d)  

(2)  

(C) For purposes of this subsection, when an overpayment is discovered, which was made by a State to a person or other entity, the State shall have a period of 1 year in which to recover or attempt to recover such overpayment before adjustment is made in the Federal payment to such State on account of such overpayment. Except as otherwise provided in subparagraph (D), the adjustment in the Federal payment shall be made at the end of the 1-year period, whether or not recovery was made.

(D)(i) In any case where the State is unable to recover a debt which represents an overpayment (or any portion thereof) made to a person or other entity on account of such debt having been discharged in bankruptcy or otherwise being uncollectable, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or portion thereof).

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

§1903(d)(2)(D)(ii) ¶15,811
(f) *** 


(i) *** 

(2) *** 

(A) under the plan by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, or XX or under this title pursuant to section 1128, 1128A, 1156, or 1842(j)(2), *** 

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

(23) with respect to amounts expended for medical assistance for covered outpatient drugs (as defined in section 1927(k)(2)) for which the prescription was executed in written (and non-electronic) form unless the prescription was executed on a tamper-resistant pad; 

(24) if a State is required to implement an asset verification program under section 1940 and fails to implement such program in accordance with such section, with respect to amounts expended by such State for medical assistance for individuals subject to asset verification under such section, unless; *** 

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

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

(m) *** 

(2)(A) *** 

(xii) such contract complies with the applicable requirements of section 1932; and 

(xiii) such contract provides for maintenance of sufficient patient encounter data to identify the physician who delivers services to patients for the provision of such data to the State at a frequency and level of detail to be specified by the Secretary; 

(xii) such contract, and the entity complies with the applicable requirements of section 1932; and 

(xiii) such contract provides that (I) covered outpatient drugs dispensed to individuals eligible for medical assistance who are enrolled with the entity shall be subject to the same rebate
required by the agreement entered into under section 1927 as the State is subject to and that the
State shall collect such rebates from manufacturers, (II) capitation rates paid to the entity shall
be based on actual cost experience related to rebates and subject to the Federal regulations
requiring actuarially sound rates, and (III) the entity shall report to the State, on such timely
and periodic basis as specified by the Secretary in order to include in the information submitted
by the State to a manufacturer and the Secretary under section 1927(b)(2)(A), information on
the total number of units of each dosage form and strength and package size by National Drug
Code of each covered outpatient drug dispensed to individuals eligible for medical assistance who
are enrolled with the entity and for which the entity is responsible for coverage of such drug
under this subsection (other than covered outpatient drugs that under subsection (i)(1) of section
1927 are not subject to the requirements of that section) and such other data as the Secretary
determines necessary to carry out this subsection.

**(r)(1)***

**(B)**

(ii) provide liaison between States and carriers and intermediaries with agreements
under title XVIII to facilitate timely exchange of appropriate data;

(iii) provide for exchange of data between the States and the Secretary with respect
to persons sanctioned under this title or title XVIII; and

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

**(F) effective for claims filed on or after January 1, 1999, provide for electronic transmis-
sion of claims data in the format specified by the Secretary and consistent with the Medicaid
Statistical Information System (MSIS) (including detailed individual enrollee encounter data
and other information that the Secretary may find necessary and including, for data submitted
to the Secretary on or after January 1, 2010, data elements from the automated data system that the
Secretary determines to be necessary for program integrity, program oversight, and administration, at
such frequency as the Secretary shall determine).

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

(A) Not later than September 1, 2010:

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

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

(iii) Notify States of—

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

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

(B) Not later than March 1, 2011, submit a report to Congress that includes the notice to States
under clause (iii) of subparagraph (A) and an analysis supporting the identification of the methodo-
lgies made under clauses (i) and (ii) of subparagraph (A)."""
(v) In determining the amount of erroneous excess payments, there shall not be included any erroneous payments made for ambulatory prenatal care provided during a presumptive eligibility period (as defined in section 1920(b)(1)), for items and services described in subsection (a) of section 1920A provided to a child during a presumptive eligibility period under such section, for medical assistance provided to an individual described in subsection (a) of section 1920B during a presumptive eligibility period under such section, or for medical assistance provided to an individual described in subsection (a) of section 1920C during a presumptive eligibility period under such section, or for medical assistance provided to an individual during a presumptive eligibility period resulting from a determination of presumptive eligibility made by a hospital that elects under section 1902(a)(47)(B) to be a qualified entity for such purpose.

[Explanation at ¶ 505, ¶ 506, ¶ 511, ¶ 523, ¶ 533, ¶ 534, ¶ 543, ¶ 565, ¶ 585, ¶ 1813, ¶ 1821, ¶ 1857, ¶ 1861, and ¶ 1863.]

2010 Amendments:

Sec. 6056(a)(1) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1903(d)(2) in subparagraph (C) in the first sentence, by striking “60 days” and inserting “1 year”; and in the second sentence, by striking “60 days” and inserting “1-year period” and in subparagraph (D) inserting “(i)” after “(D)”; and by adding at the end the new clause (ii).


Sec. 6402(c) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1903(i) by paragraph (23), by striking “or” at the end; in paragraph (24), by striking “or” and inserting “or” after “or”; and by adding at the end the new clause (v).

Sec. 201(a)(2)(B) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1903(i)(1)(D)(v) by inserting “or for medical assistance provided to an individual described in subsection (a) of section 1920C during a presumptive eligibility period under such section,” after “1920B during a presumptive eligibility period under such section.”.
For purposes of this title—

(a) The term "medical assistance" means payment of part or all of the cost of the following care and services or the care and services themselves, or both (if provided in or after the third month before the month in which the recipient makes application for assistance or, in the case of Medicare cost-sharing with respect to a qualified Medicare beneficiary described in subsection (p)(1), if provided after the month in which the individual becomes such a beneficiary), for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A)) not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, and with respect to whom Supplemental Security Income benefits are not being paid under title XVI, who are—

(xii) employed individuals with a medically improved disability (as defined in subsection (v)),

(xiii) individuals described in section 1902(aa),

 XIV, or XVI, or part A of title IV, and with respect to whom Supplemental Security Income benefits are not being paid under title XVI, who are—

(xiv) individuals described in section 1902(a)(10)(A)(i)(VIII) or 1902(a)(10)(A)(i)(IX), or

(xv) individuals described in section 1902(a)(10)(A)(ii)(XX),

(xvi) individuals described in section 1902(ii), or

(xvii) individuals who are eligible for home and community-based services under needs-based criteria established under paragraph (1)(A) of section 1915(i), or who are eligible for home and community-based services under paragraph (6) of such section, and who will receive home and community-based services pursuant to a State plan amendment under such subsection, but whose income and resources are insufficient to meet all of such cost—

(b) nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older; (B) early and periodic screening, diagnostic, and treatment services (as defined in subsection (r)) for individuals who are eligible under the plan and are under the age of 21; (C) family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies; and (D) counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in subsection (bb));

(13) other diagnostic, screening, preventive, and rehabilitative services, including—

(A) any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force;

(B) with respect to an adult individual, approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention) and their administration; and

(C) any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level;
(27) subject to subsection (x), primary and secondary medical strategies and treatment and services for individuals who have Sickle Cell Disease;

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

(29) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary;

except as otherwise provided in paragraph (16), such term does not include—

(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution); or

(B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases,

For purposes of clause (vi) of the preceding sentence, a person shall be considered essential to another individual if such person is the spouse of and is living with such individual, the needs of such person are taken into account in determining the amount of aid or assistance furnished to such individual (under a State plan approved under title I, X, XIV, or XVI), and such person is determined under such a State plan, to be essential to the well-being of such individual.

The payment described in the first sentence may include expenditures for Medicare cost-sharing and for premiums under part B of title XVIII for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A), and, except in the case of individuals 65 years of age or older and disabled individuals entitled to health insurance benefits under title XVIII who are not enrolled under part B of title XVIII, other insurance premiums for medical or any other type of remedial care or the cost thereof. No service (including counseling) shall be excluded from the definition of “medical assistance” solely because it is provided as a treatment service for alcoholism or drug dependency.

(b) Subject to subsections (y), (z), and (aa) and section 1933(d), the term “Federal medical assistance percentage” for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum, (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be 55 percent, (3) for purposes of this title and title XXI, the Federal medical assistance percentage for the District of Columbia shall be 70 percent, (4) the Federal medical assistance percentage shall be equal to the enhanced FMAP described in section 2105(b) with respect to medical assistance provided to individuals who are eligible for such assistance only on the basis of section 1902(a)(10)(A)(ii)(XVIII). The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of section 1101(a)(8)(B). Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 4 of the Indian Health Care Improvement Act). Notwithstanding the first sentence of this subsection, in the case of a State plan that meets the condition described in subsection (u)(1), with respect to expenditures (other than expenditures under section 1923) described in subsection (u)(2)(A) or subsection (u)(3) for the State for a fiscal year, and that do not exceed the amount of the State’s available allotment under section 2104, the Federal medical assistance percentage is equal to the enhanced FMAP described in section 2105(b), and (5) in the case of a State that provides medical assistance for services and vaccines described in subparagraphs (A) and (B) of section (a)(13), and prohibits cost-sharing for such services and vaccines, the Federal medical assistance percentage, as determined under this subsection and subsection (y) (without regard to paragraph (1)(C) of such subsection),
shall be increased by 1 percentage point with respect to medical assistance for such services and vaccines and for items and services described in subsection (a)(4)(D).

* * *

(l)

* * *

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

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

(i) that is not a hospital;

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

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

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

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

* * *

(o)(1)(A) Subject to subparagraphs (B) and (C), the term “hospice care” means the care described in section 1861(dd)(1) furnished by a hospice program (as defined in section 1861(dd)(2)) to a terminally ill individual who has voluntarily elected (in accordance with paragraph (2)) to have payment made for hospice care instead of having payment made for certain benefits described in section 1812(d)(2)(A) and for which payment may otherwise be made under title XVIII and intermediate care facility services under the plan. For purposes of such election, hospice care may be provided to an individual while such individual is a resident of a skilled nursing facility or intermediate care facility, but the only payment made under the State plan shall be for the hospice care.

* * *

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

* * *

(y) INCREASED FMAP FOR MEDICAL ASSISTANCE FOR NEWLY ELIGIBLE MANDATORY INDIVIDUALS.—

(1) AMOUNT OF INCREASE.—

Notwithstanding subsection (b), the Federal medical assistance percentage for a State that is one of the 50 States or the District of Columbia, with respect to amounts expended by such State for medical assistance for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i), shall be equal to

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

(B) 95 percent for calendar quarters in 2017;

(C) 94 percent for calendar quarters in 2018;

(D) 93 percent for calendar quarters in 2019; and
(E) 90 percent for calendar quarters in 2020 and each year thereafter.

(2) Definitions.—In this subsection:

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

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

(z) Equitable Support for Certain States.—

(1)(A) During the period that begins on January 1, 2014, and ends on December 31, 2015, notwithstanding subsection (b), the Federal medical assistance percentage otherwise determined under subsection (b) with respect to a fiscal year occurring during that period shall be increased by 2.2 percentage points for any State described in subparagraph (B) for amounts expended for medical assistance for individuals who are not newly eligible (as defined in subsection (y)(2)) individuals described in subclause (VIII) of section 1902(a)(10)(A)(i).

(B) For purposes of subparagraph (A), a State described in this subparagraph is a State that—

(i) is an expansion State described in subsection paragraph (3);

(ii) the Secretary determines will not receive any payments under this title on the basis of an increased Federal medical assistance percentage under subsection (y) for expenditures for medical assistance for newly eligible individuals (as so defined); and

(iii) has not been approved by the Secretary to divert a portion of the DSH allotment for a State to the costs of providing medical assistance or other health benefits coverage under a waiver that is in effect on July 2009.

(2)(A) For calendar quarters in 2014 and each year thereafter, the Federal medical assistance percentage otherwise determined under subsection (b) for an expansion State described in paragraph (3) with respect to medical assistance for individuals described in section 1902(a)(10)(A)(i)(VIII) who are nonpregnant childless adults with respect to whom the State may require enrollment in benchmark coverage under section 1937 shall be equal to the percent specified in subparagraph (B)(i) for such year.

(B)(i) The percent specified in this subparagraph for a State for a year is equal to the Federal medical assistance percentage (as defined in the first sentence of subsection (b)) for the State increased by a number of percentage points equal to the transition percentage (specified in clause (ii) for the year) of the number of percentage points by which—

(I) such Federal medical assistance percentage for the State, is less than

(II) the percent specified in subsection (y)(1)(E) for the year.

(ii) The transition percentage specified in this clause for

(I) 2014 is 50 percent;

(II) 2015 is 60 percent;

(III) 2016 is 70 percent;

(IV) 2017 is 80 percent;

(V) 2018 is 90 percent; and

(VI) 2019 and each subsequent year is 100 percent.

(3) Expansion State defined.—For purposes of the table in subclause (I), a State is an expansion State if, on the date of the enactment of the Patient Protection and Affordable Care Act, the State offers
health benefits coverage statewide to parents and nonpregnant, childless adults whose income is at least 100 percent of the poverty line, that includes inpatient hospital services, is not dependent on access to employer coverage, employer contribution, or employment and is not limited to premium assistance, hospital-only benefits, a high deductible health plan, or alternative benefits under a demonstration program authorized under section 1938. A State that offers health benefits coverage to only parents or only nonpregnant childless adults described in the preceding sentence shall not be considered to be an expansion State.

(aa)(1) Notwithstanding subsection (b), beginning January 1, 2011, the Federal medical assistance percentage for a fiscal year for a disaster-recovery FMAP adjustment State shall be equal to the following:

(A) In the case of the first fiscal year (or part of a fiscal year) for which this subsection applies to the State, the Federal medical assistance percentage determined for the fiscal year without regard to this subsection, subsection (y), subsection (z), and section 10202 of the Patient Protection and Affordable Care Act, increased by 50 percent of the number of percentage points by which the Federal medical assistance percentage determined for the State for the fiscal year without regard to this subsection, subsection (y), subsection (z), and section 10202 of the Patient Protection and Affordable Care Act, is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year after the application of only subsection (a) of section 5001 of Public Law 111-5 (if applicable to the preceding fiscal year and without regard to this subsection, subsection (y), and subsections (b) and (c) of section 5001 of Public Law 111-5.

(B) In the case of the second or any succeeding fiscal year for which this subsection applies to the State, the Federal medical assistance percentage determined for the preceding fiscal year under this subsection for the State, increased by 25 percent of the number of percentage points by which the Federal medical assistance percentage determined for the State for the fiscal year without regard to this subsection, subsection (y), subsection (z), and section 10202 of the Patient Protection and Affordable Care Act, is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year under this subsection.

(2) In this subsection, the term ‘disaster-recovery FMAP adjustment State’ means a State that is one of the 50 States or the District of Columbia, for which, at any time during the preceding 7 fiscal years, the President has declared a major disaster under section 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act and determined as a result of such disaster that every county or parish in the State warrant individual and public assistance or public assistance from the Federal Government under such Act and for which—

(A) in the case of the first fiscal year (or part of a fiscal year) for which this subsection applies to the State, the Federal medical assistance percentage determined for the State for the fiscal year without regard to this subsection, subsection (y), subsection (z), and section 10202 of the Patient Protection and Affordable Care Act, is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year after the application of only subsection (a) of section 5001 of Public Law 111-5 (if applicable to the preceding fiscal year and without regard to this subsection, subsection (y), and subsections (b) and (c) of section 5001 of Public Law 111-5, by at least 3 percentage points; and

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

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

(bb)(1) For purposes of this title, the term ‘counseling and pharmacotherapy for cessation of tobacco use by pregnant women’ means diagnostic, therapy, and counseling services and pharmacotherapy (including the coverage of prescription and nonprescription tobacco cessation agents approved by the Food and Drug Administration) for cessation of tobacco use by pregnant women who use tobacco products or who are being treated for tobacco use that is furnished—

(A) by or under the supervision of a physician; or
(B) by any other health care professional who—

(i) is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished; and

(ii) is authorized to receive payment for other services under this title or is designated by the Secretary for this purpose.

(2) Subject to paragraph (3), such term is limited to—

(A) services recommended with respect to pregnant women in 'Treating Tobacco Use and Dependence: 2008 Update: A Clinical Practice Guideline', published by the Public Health Service in May 2008, or any subsequent modification of such Guideline; and

(B) such other services that the Secretary recognizes to be effective for cessation of tobacco use by pregnant women.

(3) Such term shall not include coverage for drugs or biologicals that are not otherwise covered under this title.

(cc) REQUIREMENT FOR CERTAIN STATES.—Notwithstanding subsections (y), (z), and (aa), in the case of a State that requires political subdivisions within the State to contribute toward the non-Federal share of expenditures required under the State plan under section 1902(a)(2), the State shall not be eligible for an increase in its Federal medical assistance percentage under such subsections if it requires that political subdivisions pay a greater percentage of the non-Federal share of such expenditures, or a greater percentage of the non-Federal share of payments under section 1923, than the respective percentages that would have been required by the State under the State plan under this title, State law, or both, as in effect on December 31, 2009, and without regard to any such increase. Voluntary contributions by a political subdivision to the non-Federal share of expenditures under the State plan under this title or to the non-Federal share of payments under section 1923, shall not be considered to be required contributions for purposes of this subsection. The treatment of voluntary contributions, and the treatment of contributions required by a State under the State plan under this title, or State law, as provided by this subsection, shall also apply to the increases in the Federal medical assistance percentage under section 5001 of the American Recovery and Reinvestment Act of 2009.

(dd) Increased FMAP For Additional Expenditures For Primary Care Services.—Notwithstanding subsection (b), with respect to the portion of the amounts expended for medical assistance for services described in section 1902(a)(13)(C) furnished on or after January 1, 2013, and before January 1, 2015, that is attributable to the amount by which the minimum payment rate required under such section (or, by application, section 1932(f)) exceeds the payment rate applicable to such services under the State plan as of July 1, 2009, the Federal medical assistance percentage for a State that is one of the 50 States or the District of Columbia shall be equal to 100 percent. The preceding sentence does not prohibit the payment of Federal financial participation based on the Federal medical assistance percentage for amounts in excess of those specified in such sentence.

[Explanation at ¶ 505, ¶ 513, ¶ 515, ¶ 519, ¶ 521, ¶ 523, ¶ 525, ¶ 534, ¶ 577, ¶ 1423, and ¶ 1425.]
Sec. 4106(a) of the "Patient Protection and Affordable Care Act" (PubLNo 111-148), effective Jan. 1, 2013, amended sec. 1905(a)(13), by striking original paragraph (13) and inserting a new paragraph (13). Prior to amendment, sec. 1905(a)(13) read as follows: "(13) other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level;"

Sec. 4107(a)(1) of the "Patient Protection and Affordable Care Act" (PubLNo 111-148), effective Oct. 1, 2010, amended sec. 1905(a)(4), by striking "and" before "(b)", and by inserting before the semicolon at the end the following new subparagraph: "; and (D) counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in subsection (b)(2)); and (E) 

Sec. 10201(c)(2) of the "Patient Protection and Affordable Care Act" (PubLNo 111-148), effective March 23, 2010, amended sec. 1905(b), by inserting "subsection (y) and" before "section 1933(d)".

Sec. 2006(1) of the "Patient Protection and Affordable Care Act" (PubLNo 111-148), effective March 23, 2010, amended sec. 1905(b), by striking "subsection (y) and" inserting "sections (y) and (aa)".

Sec. 4106(b) of the "Patient Protection and Affordable Care Act" (PubLNo 111-148), effective Jan. 1, 2013, amended sec. 1905(b), by striking ", and (4)" and inserting ", (4), and" by inserting before the period the following: ", and in the case of a State that provides medical assistance for services and vaccines described in subparagraphs (A) and (B) of subsection (a)(13), and prohibits cost-sharing for such services and vaccines, the Federal medical assistance percentage, as determined under this subsection and subsection (y) (without regard to paragraph (1)(C) of such subsection), shall be increased by 1 percentage point with respect to medical assistance for such services and vaccines and for items and services described in subsection (a)(4)(D))."

Sec. 2301(a)(2) of the "Patient Protection and Affordable Care Act" (PubLNo 111-148), effective March 23, 2010, amended sec. 1905(b), by adding at the end the new paragraph:

Sec. 2302(a) of the "Patient Protection and Affordable Care Act" (PubLNo 111-148), effective March 23, 2010, amended sec. 1905(o)(1), in subparagraph (A), by striking "subparagraph (B) and inserting "subparagraphs (B) and (C)", and by adding at the end the new subparagraph (C).

Sec. 10201(c)(3) of the "Patient Protection and Affordable Care Act" (PubLNo 111-148), effective March 23, 2010, amended sec. 1905(y), in paragraph (1)(B)(ii)(III), in the first sentence, by inserting "includes inpatient hospital services, after "100 percent of the poverty line, that"); and, in paragraph (2)(A), by striking "on the date of enactment of the Patient Protection and Affordable Care Act and inserting "as of December 1, 2009)."


Sec. 10201(c)(4) of the "Patient Protection and Affordable Care Act" (PubLNo 111-148), effective March 23, 2010, amended sec. 1905, by inserting after subsection (y) the new subsection (z).

Sec. 10201(c)(5) of the "Patient Protection and Affordable Care Act" (PubLNo 111-148), effective March 23, 2010, amended sec. 1905(aa), in subsection (aa), by inserting "without regard to this subsection, subsection (y), subsection (z), and section 10202 of the Patient Protection and Affordable Care Act" each place it appears.

Sec. 2006(2) of the "Patient Protection and Affordable Care Act" (PubLNo 111-148), effective March 23, 2010, amended sec. 1905, by adding at the end the new subsection (aa).

Sec. 4107(a)(2) of the "Patient Protection and Affordable Care Act" (PubLNo 111-148), effective Oct. 1, 2010, amended sec. 1905(b), by adding at the end the new subsection (cc).

Sec. 1201 of the "Health Care and Education Reconciliation Act of 2010" (PubLNo 111-152), effective March 30, 2010, amended Sec. 4106(b) of the "Patient Protection and Affordable Care Act" (PubLNo 111-148), effective Jan. 1, 2013, amended sec. 1905(b), by inserting "subsection (y) and" before "section 1933(d)".

Sec. 10201(c)(6) of the "Patient Protection and Affordable Care Act" (PubLNo 111-148), effective March 23, 2010, amended sec. 1905, by adding after subsection (bb), the new subsection (cc).

Prior to removal paragraph (y)(1) and (aa)(2), (3), and (4) read as follows:

"(y)(1) Amount of increase"

"(AA) 100 percent FMAP—During the period that begins on January 1, 2014, and ends on December 31, 2016, notwithstanding subsection (b), the Federal medical assistance percentage determined for a State that is one of the 50 States or the District of Columbia for each fiscal year occurring during that period with respect to amounts expended for medical assistance for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i) shall be equal to 100 percent."

"(BB) 2017 and 2018"

"(ii) Applicable percentage point increase—"

"(B) In general—For purposes of clause (i), the applicable percentage point increase for a quarter is the following:"

---

§ 1905(dd) ¶15,821
For any fiscal year quarter occurring in the calendar year:

<table>
<thead>
<tr>
<th></th>
<th>If the State is an expansion State, the applicable percentage point increase is:</th>
<th>If the State is not an expansion State, the applicable percentage point increase is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>30.3</td>
<td>34.3</td>
</tr>
<tr>
<td>2018</td>
<td>31.3</td>
<td>33.3</td>
</tr>
</tbody>
</table>

“(C) 2019 and succeeding years—Beginning January 1, 2019, notwithstanding subsection (b) but subject to subparagraph (D), the Federal medical assistance percentage determined for a State that is one of the 50 States or the District of Columbia for each fiscal year quarter occurring during that period with respect to amounts expended for medical assistance for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i), shall be increased by 32.3 percentage points.”

“(D) Limitation—The Federal medical assistance percentage determined for a State under subparagraph (B) or (C) shall in no case be more than 95 percent.”

“(z)(2)(A) During the period that begins on January 1, 2014, and ends on December 31, 2016, notwithstanding subsection (b), the Federal medical assistance percentage otherwise determined under subsection (b) with respect to all or any portion of a fiscal year occurring during that period shall be increased by 5 percentage point for a State described in subparagraph (B) for amounts expended for medical assistance under the State plan under this title or under a waiver of that plan during that period.”

“(B) For purposes of subparagraph (A), a State described in this subparagraph is a State that—”

“(i) is described in clauses (i) and (ii) of paragraph (1)(B); and”

“(ii) is the State with the highest percentage of its population insured during 2008, based on the Current Population Survey.”

“(z)(3) Notwithstanding subsection (b) and paragraphs (1) and (2) of this subsection, the Federal medical assistance percentage otherwise determined under subsection (b) with respect to all or any portion of a fiscal year that begins on or after January 1, 2017, for the State of Nebraska, with respect to amounts expended for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i), shall be determined as provided for under subsection (y)(1)(A) (notwithstanding the period provided for in such paragraph).”

“(z)(4) The increase in the Federal medical assistance percentage for a State under paragraphs (1), (2), or (3) shall apply only for purposes of this title and shall not apply with respect to—”

“(A) disproportionate share hospital payments described in section 1923”

“(B) payments under title IV,”

“(C) payments under title XXI; and”

“(D) payments under this title that are based on the enhanced FMAP described in section 2105(b).”

<table>
<thead>
<tr>
<th>¶15,831</th>
<th>Sec. 1906. DEFINITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>[42 U.S.C. §1396e(e)]</td>
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</table>

“(e) ***

(2) The term “cost-effective” has the meaning given that term in section 2105(c)(3)(A).”

[Explanation at ¶566.]

2010 Amendments:

Sec. 10203(b)(1) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective Feb. 4, 2009, amended sec. 1906(e)(2) by striking “means” and all that follows through the period and inserting “has the meaning given that term in section 2105(c)(3)(A).”

<table>
<thead>
<tr>
<th>¶15,851</th>
<th>Sec. 1906A. PREMIUM ASSISTANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) In general.—A State may elect to offer a premium assistance subsidy (as defined in subsection (c)) for qualified employer-sponsored coverage (as defined in subsection (b)) to all individuals who are entitled to medical assistance under this title (and, in the case of an individual under age 19, to the parent of such an individual) who have access to such coverage if the State meets the requirements of this section and the offering of such a subsidy is cost-effective, as defined for purposes of section 2105(c)(3)(A).</td>
<td></td>
</tr>
</tbody>
</table>

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¶15,831 §
(c) **Premium Assistance Subsidy**

In this section, the term premium assistance subsidy means the amount of the employee contribution for enrollment in the qualified employer-sponsored coverage by the individual or by the individual’s family. Premium assistance subsidies under this section shall be considered, for purposes of section 1903(a), to be a payment for medical assistance.

(d) 

***

(2) **Beneficiaries.**—No subsidy shall be provided to an individual under this section unless the individual (or the individual’s parent) voluntarily elects to receive such a subsidy. A State may not require such an election as a condition of receipt of medical assistance. A State may not require, as a condition of an individual (or the individual’s parent) being or remaining eligible for medical assistance under this title, that the individual (or the individual’s parent) apply for enrollment in qualified employer-sponsored coverage under this section.

(3) **Opt-out Permitted for Any Month.**—A State shall establish a process for permitting an individual (or the parent of an individual) receiving a premium assistance subsidy to disenroll the individual from the qualified employer-sponsored coverage.

(e) **Requirement to Pay Premiums and Cost-sharing and Provide Supplemental Coverage.**—In the case of the participation of an individual (or the individual’s parent) in a premium assistance subsidy under this section for qualified employer-sponsored coverage, the State shall provide for payment of all enrollee premiums for enrollment in such coverage and all deductibles, coinsurance, and other cost-sharing obligations for items and services otherwise covered under the State plan under this title (exceeding the amount otherwise permitted under section 1916 or, if applicable, section 1916A). The fact that an individual (or a parent) elects to enroll in qualified employer-sponsored coverage under this section shall not change the individual’s (or parent’s) eligibility for medical assistance under the State plan, except insofar as section 1902(a)(25) provides that payments for such assistance shall first be made under such coverage.

[Explanation at ¶ 509 and ¶ 566.]

### 2010 Amendments:

Sec. 2003(a)(2) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective Jan. 1, 2014, amended sec. 1906A by striking “OPTION FOR CHILDREN” from the section heading.

Sec. 10203(b)(2)(A) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective Feb. 4, 2009, amended sec. 1906A(a) by inserting before the period the following: “and the offering of such a subsidy is cost-effective, as defined for purposes of section 2105(c)(3)(A)”.

Sec. 2003(a)(1) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective Jan. 1, 2014, amended sec. 1906A(a) by striking “may elect to” and inserting “shall”; by striking “under age 19”; and by striking the third sentence, by striking “under age 19”; and by striking the third sentence and inserting “and the offering of such a subsidy is cost-effective, as defined for purposes of section 2105(c)(3)(A)”.

Sec. 10203(b)(2)(B) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, deems the amendment made by Sec. 2003(a)(1)(A), to change “may elect to” to “shall”, as null, void, and of no effect.

### ¶15,861 Sec. 1915. COMPLIANCE WITH STATE PLAN AND PAYMENT PROVISIONS

[42 U.S.C. 1396n]

[See sec. 1915(a) to sec. 1915(h).]

***

(b) 

***

§1906A(e) ¶15,861
No waiver under this subsection may restrict the choice of the individual in receiving services under section 1915(a)(4)(C). Subsection (h)(2) shall apply to a waiver under this subsection.

(c) ***

(3) A waiver granted under this subsection may include a waiver of the requirements of section 1902(a)(1) (relating to statewideness), section 1902(a)(10)(B) (relating to comparability), and section 1902(a)(10)(C)(i)(III) (relating to income and resource rules applicable in the community). A waiver under this subsection (other than a waiver described in subsection (h)(2)) shall be for an initial term of three years and, upon the request of a State, shall be extended for additional five-year periods unless the Secretary determines that for the previous waiver period the assurances provided under paragraph (2) have not been met. A waiver may provide, with respect to post-eligibility treatment of income of all individuals receiving services under that waiver, that the maximum amount of the individual’s income which may be disregarded for any month for the maintenance needs of the individual may be an amount greater than the maximum allowed for that purpose under regulations in effect on July 1, 1985.

(d) ***

(3) A waiver granted under this subsection may include a waiver of the requirements of section 1902(a)(1) (relating to statewideness), section 1902(a)(10)(B) (relating to comparability), and section 1902(a)(10)(C)(i)(III) (relating to income and resource rules applicable in the community). Subject to a termination by the State (with notice to the Secretary) at any time, a waiver under this subsection (other than a waiver described in subsection (h)(2)) shall be for an initial term of 3 years and, upon the request of a State, shall be extended for additional 5-year periods unless the Secretary determines that for the previous waiver period the assurances provided under paragraph (2) have not been met. A waiver may provide, with respect to post-eligibility treatment of income of all individuals receiving services under the waiver, that the maximum amount of the individual’s income which may be disregarded for any month is equal to the amount that may be allowed for that purpose under a waiver under subsection (c).

(h) (1) No waiver (other than a waiver under subsection (c), (d), or (e), or a waiver described in paragraph (2)) under this section may extend over a period of longer than two years unless the State requests continuation of such waiver, and such continuation shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State agency in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. After the date the Secretary receives such additional information, the request shall be deemed granted unless the Secretary, within 90 days of such date, denies such request.

(2)(A) Notwithstanding subsections (c)(3) and (d)(3), any waiver under subsection (b), (c), or (d), or a waiver under section 1115, that provides medical assistance for dual eligible individuals (including any such waivers under which non dual eligible individuals may be enrolled in addition to dual eligible individuals) may be conducted for a period of 5 years and, upon the request of the State, may be extended for additional 5-year periods unless the Secretary determines that for the previous waiver period the conditions for the waiver have not been met or it would no longer be cost-effective and efficient, or consistent with the purposes of this title, to extend the waiver.

(B) In this paragraph, the term ‘dual eligible individual’ means an individual who is entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII, and is eligible for medical assistance under the State plan under this title or under a waiver of such plan.

(i) STATE PLAN AMENDMENT OPTION TO PROVIDE HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND DISABLED INDIVIDUALS.

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, a State may provide through a State plan amendment for the provision of medical assistance for home and community-based services (within the scope of services described in paragraph (4)(B) of subsection (c)
for which the Secretary has the authority to approve a waiver and not including room and board) for individuals eligible for medical assistance under the State plan whose income does not exceed 150 percent of the poverty line (as defined in section 2110(c)(5)), without determining that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded, but only if the State meets the following requirements:

***

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

(D) ***

(ii) ***

(II) the State deems an individual receiving home and community-based services on the basis of the most recent version of the criteria in effect prior to the effective date of the modification to continue to be eligible for such services after the effective date of the modification and until such time as the individual no longer meets the standard for receipt of such services under such premodified criteria; and

***

(3) NONAPPLICATION.—A State may elect in the State plan amendment approved under this section to not comply with the requirements of section 1902(a)(10)(B) (relating to comparability) and section 1902(a)(10)(C)(i)(III) (relating to income and resource rules applicable in the community), but only for purposes of provided home and community-based services in accordance with such amendment. Any such election shall not be construed to apply to the provision of services to an individual receiving medical assistance in an institutionalized setting as a result of a determination that the individual requires the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded.

***

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

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

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

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

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

   (B) **5-YEAR TERM.**—

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

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

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

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

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

   ***

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

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

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

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

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

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

         (iv) the furnishing of which—

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

            (II) is controlled, to the maximum extent possible, by the individual or where appropriate, the individual's representative, regardless of who may act as the employer of record; and
(III) provided by an individual who is qualified to provide such services, including family members (as defined by the Secretary).

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

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

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

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

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

(i) room and board costs for the individual;

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

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

(iv) medical supplies and equipment; or

(v) home modifications.

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

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

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

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

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

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

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

(C) with respect to expenditures during the first full fiscal year in which the State plan amendment is implemented, maintain or exceed the level of State expenditures for medical assistance that is provided under section 1905(a), section 1915, section 1115, or otherwise to individuals with disabilities or elderly individuals attributable to the preceding fiscal year;
(D) establish and maintain a comprehensive, continuous quality assurance system with respect to community-based attendant services and supports that—

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

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

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

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

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

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

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

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

(C) maintenance of general liability insurance; and

(D) occupational health and safety.

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

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

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

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

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

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

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

(C) REPORTS.—Not later than—
(i) December 31, 2013, the Secretary shall submit to Congress and make available to the public an interim report on the findings of the evaluation under subparagraph (A); and
(ii) December 31, 2015, the Secretary shall submit to Congress and make available to the public a final report on the findings of the evaluation under subparagraph (A).

(6) DEFINITIONS.—In this subsection:

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

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

(C) DELIVERY MODELS.—

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

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

(D) HEALTH-RELATED TASKS.—The term ‘health-related tasks’ means specific tasks related to the needs of an individual, which can be delegated or assigned by licensed health-care professionals under State law to be performed by an attendant.

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

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

[Explanation at ¶ 530, ¶ 533, and ¶ 559.]

2010 Amendments:

Sec. 2401 of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1915 in subsection (b), by adding at the end the following new sentence: “Subsection (h)(2) shall apply to a waiver under this subsection.”, in subsection (c)(5) in the second sentence, by inserting “(other than a waiver described in subsection (h)(2))” after “A waiver under this subsection”; in subsection (d)(3) in the second sentence, by inserting “(other than a waiver described in subsection (h)(2))” after “A waiver under this subsection”.

Sec. 2601(b)(1) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1915(b) by inserting “(i)” after “(h)”; by inserting , or a waiver described in paragraph (2) after “(e)”; and by adding at the end of new paragraph (2).

Sec. 2601(a) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1915(b) by inserting “(i)” after “(h)”; by inserting , or a waiver described in paragraph (2) after “(e)”; and by adding at the end of new paragraph (2).

Sec. 2402(e)(1) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective on the first day of the first fiscal year quarter that begins after March 23, 2010, the date of enactment of this Act, amended sec. 1915(i)(1), by striking original subparagraph (C) and inserting a new subparagraph (C).

Prior to amendment, sec. 1915(i)(1) previously read as follows:

“(C) PROJECTION OF NUMBER OF INDIVIDUALS TO BE PROVIDED HOME AND COMMUNITY-BASED SERVICES.—”

“(i) IN GENERAL.—The State submits to the Secretary, in such form and manner, and upon such frequency as the Secretary shall specify, the projected number of individuals who are eligible for such services and may establish waiting lists for the receipt of such services.”

“(ii) AUTHORITY TO LIMIT NUMBER OF ELIGIBLE INDIVIDUALS.—A State may limit the number of individuals who are eligible for such services and may establish waiting lists for the receipt of such services.”

Sec. 2402(e)(2) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective on the first day of the first fiscal year quarter that begins after March 23, 2010, the date of enactment of this Act, amended sec. 1915(i)(1)(D)(ii)(II) by striking “to be eligible for such ser-
Sec. 2402(b) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective on the first day of the first fiscal year quarter that begins after March 23, 2010, the date of enactment of this Act, amended sec. 1916(i)(3) by inserting “1902(a)(4)(B) (relating to comparability)”.

Sec. 1205 of the “Health Care and Education Reconciliation Act of 2010” (PubLNo 111-152), effective March 30, 2010, amended sec. 1915(k)(1) by striking “October 1, 2010” and inserting “October 1, 2011”.

[¶15,871] Sec. 1916. USE OF ENROLLMENT FEES, PREMIUMS, DEDUCTIONS, COST SHARING, AND SIMILAR CHARGES

[42 U.S.C. 1396o]

(a)

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(2)

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(B) services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy, and counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in section 1905(bb)) and covered outpatient drugs (as defined in subsection (k)(2) of section 1927 and including nonprescription drugs described in subsection (d)(2) of such section) that are prescribed for purposes of promoting, and when used to promote, tobacco cessation by pregnant women in accordance with the Guideline referred to in section 1905(bb)(2)(A) (or, at the option of the State, any services furnished to pregnant women),

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(b)

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(2)

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(B) services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy, and counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in section 1905(bb)) and covered outpatient drugs (as defined in subsection (k)(2) of section 1927 and including nonprescription drugs described in subsection (d)(2) of such section) that are prescribed for purposes of promoting, and when used to promote, tobacco cessation by pregnant women in accordance with the Guideline referred to in section 1905(bb)(2)(A) (or, at the option of the State, any services furnished to pregnant women),

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[Explanation at ¶1425.]

2010 Amendments:

Sec. 4107(c)(1) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective Oct. 1, 2010, amended sec. 1916(a)(2)(B) by inserting “, and counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in section 1905(bb)) and covered outpatient drugs (as defined in subsection (k)(2) of section 1927 and including nonprescription drugs described in subsection (d)(2) of such section) that are prescribed for purposes of promoting, and when used to promote, tobacco cessation by pregnant women in accordance with the Guideline referred to in section 1905(bb)(2)(A)” after “complicate the pregnancy”.

Sec. 4107(c)(1) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective Oct. 1, 2010, amended sec. 1916(b)(2)(B) by inserting “, and counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in section 1905(bb)) and covered outpatient drugs (as defined in subsection (k)(2) of section 1927 and including nonprescription drugs described in subsection (d)(2) of such section) that are prescribed for purposes of promoting, and when used to promote, tobacco cessation by pregnant women in accordance with the Guideline referred to in section 1905(bb)(2)(A)” after “complicate the pregnancy”.

¶15,871 §1916(a)
pharmacotherapy for cessation of tobacco use by pregnant women (as defined in section 1905(bb)) and covered outpatient drugs (as defined in subsection (k)(2) of section 1927 and including nonprescription drugs described in subsection (d)(2) of such section) that are prescribed for purposes of promoting, and when used to promote, tobacco cessation by pregnant women in accordance with the Guideline referred to in section 1905(bb)(2)(A)" after "complicate the pregnancy".

[¶15,881] Sec. 1916A. STATE OPTION FOR ALTERNATIVE PREMIUMS AND COST SHARING

[42 U.S.C. 1396o1]

(a)(1) IN GENERAL.—Notwithstanding sections 1916 and 1902(a)(10)(B), but subject to paragraph (2), a State, at its option and through a State plan amendment, may impose premiums and cost sharing for any group of individuals (as specified by the State) and for any type of services (other than drugs for which cost sharing may be imposed under subsection (c) and non-emergency services furnished in a hospital emergency department for which cost sharing may be imposed under subsection (e)), and may vary such premiums and cost sharing among such groups or types, consistent with the limitations established under this section. Nothing in this section shall be construed as superseding (or preventing the application of) subsection (g), (i), or (j) of section 1916.

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(b) ***

(3) ***

(B) ***

(iii) Services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy, and counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in section 1905(bb)).

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[Explanation at ¶585 and ¶1425.]

2010 Amendments:

Sec. 2102(b) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective Feb. 17, 2009, amended sec. 1916A(a)(1) by striking "or (i)" and inserting ", (i), or (j)".

Sec. 4107(c)(2) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective Oct. 1, 2010, amended sec. 1916A(b)(3)(B)(iii) by inserting ", and counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in section 1905(bb))" after “complicate the pregnancy”.

[¶15,891] Sec. 1919. Requirements for Nursing Facilities

[42 U.S.C. §1396r]

[See sec. 1919(a) to sec. 1919(i).]

(b) ***

(5) ***

§1919(b)(5) ¶15,891
(F) Nurse Aide Defined.—In this paragraph, the term “nurse aide” means any individual providing nursing or nursing-related services to residents in a nursing facility, but does not include an individual—

(i) who is a licensed health professional (as defined in subparagraph (G)) or a registered dietician,

(ii) who volunteers to provide such services without monetary compensation.

Such term includes an individual who provides such services through an agency or under a contract with the facility.

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(d)

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(B) Nursing Facility Administrator.—The administrator of a nursing facility must meet standards established by the Secretary under subsection (f)(4).

(V) Availability of Survey, Certification, and Complaint Investigation Reports.—A nursing facility must—

(i) have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years available for any individual to review upon request; and

(ii) post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.

The facility shall not make available under clause (i) identifying information about complainants or residents.

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(f)

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(2)

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(A)

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(i)

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(I) the areas to be covered in such a program (including at least basic nursing skills, personal care skills, recognition of mental health and social service needs, care of cognitively impaired residents, basic restorative services, and residents’ rights) and content of the curriculum (including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training, and patient abuse prevention training),

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§1919(b)(5)(F)
(10) *SPECIAL FOCUS FACILITY PROGRAM.*—

(A) **IN GENERAL.**—The Secretary shall conduct a special focus facility program for enforcement of requirements for nursing facilities that the Secretary has identified as having substantially failed to meet applicable requirements of this Act.

(B) **PERIODIC SURVEYS.**—Under such program the Secretary shall conduct surveys of each facility in the program not less often than once every 6 months.

(g) ***

(5) ***

(E) **SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION TO THE SECRETARY.**—In order to improve the timeliness of information made available to the public under subparagraph (A) and provided on the Nursing Home Compare Medicare website under subsection (i), each State shall submit information respecting any survey or certification made respecting a nursing facility (including any enforcement actions taken by the State) to the Secretary not later than the date on which the State sends such information to the facility. The Secretary shall use the information submitted under the preceding sentence to update the information provided on the Nursing Home Compare Medicare website as expeditiously as practicable but not less frequently than quarterly.

(h) ***

(3) ***

(C) ***

(ii) **AUTHORITY WITH RESPECT TO CIVIL MONEY PENALTIES.**—(I) **IN GENERAL.**—Subject to subclause (II), the Secretary may impose a civil money penalty in an amount not to exceed $10,000 for each day of noncompliance. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(II) **REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.**—Subject to subclause (III), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under this clause not later than 10 calendar days after the date of such imposition, the Secretary may reduce the amount of the penalty imposed by not more than 50 percent.

(III) **PROHIBITIONS ON REDUCTION FOR CERTAIN DEFICIENCIES.**—

(aa) **REPEAT DEFICIENCIES.**—The Secretary may not reduce the amount of a penalty under subclause (II) if the Secretary had reduced a penalty imposed on the facility in the preceding year under such subclause with respect to a repeat deficiency.

(bb) **CERTAIN OTHER DEFICIENCIES.**—The Secretary may not reduce the amount of a penalty under subclause (II) if the penalty is imposed on the facility for a deficiency that is found to result in a pattern of harm or widespread harm, immediately jeopardizes the health or safety of a resident or residents of the facility, or results in the death of a resident of the facility.

(IV) **COLLECTION OF CIVIL MONEY PENALTIES.**—In the case of a civil money penalty imposed under this clause, the Secretary shall issue regulations that—

(aa) subject to item (cc), not later than 30 days after the imposition of the penalty, provide for the facility to have the opportunity to participate in an independent informal dispute resolution process which generates a written record prior to the collection of such penalty;
(bb) in the case where the penalty is imposed for each day of noncompliance, provide that a penalty may not be imposed for any day during the period beginning on the initial day of the imposition of the penalty and ending on the day on which the informal dispute resolution process under item (aa) is completed;

(cc) may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the Secretary on the earlier of the date on which the informal dispute resolution process under item (aa) is completed or the date that is 90 days after the date of the imposition of the penalty;

(dd) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

(ee) in the case where the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

(ff) in the case where all such appeals are unsuccessful, may provide that some portion of such amounts collected may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities implementing quality assurance programs, the appointment of temporary management firms, and other activities approved by the Secretary).

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8) CONSTRUCTION.—The remedies provided under this subsection are in addition to those otherwise available under State or Federal law and shall not be construed as limiting such other remedies, including any remedy available to an individual at common law. The remedies described in clauses (i), (ii)(IV), (iii), and (iv) of paragraph (2)(A) may be imposed during the pendency of any hearing. The provisions of this subsection shall apply to a nursing facility (or portion thereof) notwithstanding that the facility (or portion thereof) also is a skilled nursing facility for purposes of title XVIII.

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(i) NURSING HOME COMPARE WEBSITE.——(1) INCLUSION OF ADDITIONAL INFORMATION.——

(A) IN GENERAL.—The Secretary shall ensure that the Department of Health and Human Services includes, as part of the information provided for comparison of nursing homes on the official Internet website of the Federal Government for Medicare beneficiaries (commonly referred to as the ‘Nursing Home Compare’ Medicare website) (or a successor website), the following information in a manner that is prominent, updated on a timely basis, easily accessible, readily understandable to consumers of long-term care services, and searchable:

(i) Staffing data for each facility (including resident census data and data on the hours of care provided per resident per day) based on data submitted under section 1128I(q), including information on staffing turnover and tenure, in a format that is clearly understandable to consumers of long-term care services and allows such consumers to compare differences in staffing between facilities and State and national averages for the facilities. Such format shall include—

(I) concise explanations of how to interpret the data (such as plain English explanation of data reflecting ‘nursing home staff hours per resident day’);

(II) differences in types of staff (such as training associated with different categories of staff);

(III) the relationship between nurse staffing levels and quality of care; and

(IV) an explanation that appropriate staffing levels vary based on patient case mix.
(ii) Links to State Internet websites with information regarding State survey and certification programs, links to Form 2567 State inspection reports (or a successor form) on such websites, information to guide consumers in how to interpret and understand such reports, and the facility plan of correction or other response to such report. Any such links shall be posted on a timely basis.

(iii) The standardized complaint form developed under section 1128I(f), including explanatory material on what complaint forms are, how they are used, and how to file a complaint with the State survey and certification program and the State long-term care ombudsman program.

(iv) Summary information on the number, type, severity, and outcome of substantiated complaints.

(v) The number of adjudicated instances of criminal violations by a facility or the employees of a facility—

(I) that were committed inside of the facility; and

(II) with respect to such instances of violations or crimes committed outside of the facility, that were violations or crimes that resulted in the serious bodily injury of an elder.

(B) DEADLINE FOR PROVISION OF INFORMATION.—

(i) IN GENERAL.—Except as provided in clause (ii), the Secretary shall ensure that the information described in subparagraph (A) is included on such website (or a successor website) not later than 1 year after the date of the enactment of this subsection.

(ii) EXCEPTION.—The Secretary shall ensure that the information described in subparagraph (A)(i) is included on such website (or a successor website) not later than the date on which the requirements under section 1128I(g) are implemented.

(2) REVIEW AND MODIFICATION OF WEBSITE.—

(A) IN GENERAL.—The Secretary shall establish a process—

(i) to review the accuracy, clarity of presentation, timeliness, and comprehensiveness of information reported on such website as of the day before the date of the enactment of this subsection; and

(ii) not later than 1 year after the date of the enactment of this subsection, to modify or revamp such website in accordance with the review conducted under clause (i).

(B) CONSULTATION.—In conducting the review under subparagraph (A)(i), the Secretary shall consult with—

(i) State long-term care ombudsman programs;

(ii) consumer advocacy groups;

(iii) provider stakeholder groups;

(iv) skilled nursing facility employees and their representatives; and

(v) any other representatives of programs or groups the Secretary determines appropriate.

(j) CONSTRUCTION.—Where requirements or obligations under this section are identical to those provided under section 1819 of this Act, the fulfillment of those requirements or obligations under section 1819 shall be considered to be the fulfillment of the corresponding requirements or obligations under this section.

[Explanation at ¶1640, ¶1665, and ¶1670.]

2010 Amendments:

Sec. 6121(b)(2) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective one year after March 23, 2010, amended sec. 1919(b)(5)(F) by adding at the end following flush sentence:

“Such term includes an individual who provides such services through an agency or under a contract with the facility.”.
amended sec. 1919(d)(1) by adding at the end new subparagraph (V).

Sec. 6103(b)(3) of the "Patient Protection and Affordable Care Act" (PubL No 111-148), effective March 23, 2010, amended sec. 1919(f) by adding at the end new paragraph (II).

Sec. 6121(b)(1) of the "Patient Protection and Affordable Care Act" (PubL No 111-148), effective one year after March 23, 2010, amended sec. 1919(h)(3)(C)(ii) by making following changes:

graph (V). following changes:

Sec. 6103(b)(2)(A) of the "Patient Protection and Affordable Care Act" (PubL No 111-148), effective one year after March 23, 2010, amended sec. 1919(f)(2)(A)(i)(I) by inserting "including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training, and patient abuse prevention training" before "(III)."

Sec. 6103(b)(2)(A) of the "Patient Protection and Affordable Care Act" (PubL No 111-148), effective one year after March 23, 2010, amended sec. 1919(g)(5) by adding at the end new subparagraph (E).

Sec. 6111(b)(1) of the "Patient Protection and Affordable Care Act" (PubL No 111-148), effective one year after the March 23, 2010, amended sec. 1919(h)(3)(C)(ii) by making following changes:

by striking "PENALTIES.—The Secretary” and inserting "PENALTIES.—Subject to 16 subclause (II), the Secretary”.

by adding at the end the new subclauses (II), (III) and (IV).

Sec. 6103(b)(1) of the "Patient Protection and Affordable Care Act" (PubL No 111-148), effective March 23, 2010, amended sec. 1919 by redesignating subsection (i) as subsection (j).

Sec. 6103(b)(1) of the "Patient Protection and Affordable Care Act" (PubL No 111-148), effective March 23, 2010, amended sec. 1919 by inserting after subsection (h) new subsection (i).

Sec. 6111(b)(2) of the "Patient Protection and Affordable Care Act" (PubL No 111-148) amended sec. 1919(b) by adding "(II)(IV)” after “(I)”.

¶ 15,901 Sec. 1920. PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN

[42 U.S.C. §1396r-1]

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

[Explanation at ¶ 505, ¶ 511, and ¶ 534.]

2010 Amendments:

Sec. 2001(a)(4)(B) of the "Patient Protection and Affordable Care Act" (PubL No 111-148), effective March 23, 2010, amended sec. 1920 by adding at the end new subsection (e).

Sec. 2001(c)(2)(C) of the "Patient Protection and Affordable Care Act" (PubL No 111-148), effective March 23, 2010, amended sec. 1920(e) by inserting "or clause (ii)(XX)” after “clause (i)(VIII)."

Sec. 2004(b) of the "Patient Protection and Affordable Care Act" (PubL No 111-148), effective Jan. 1, 2019, amended sec. 1920(e) by inserting "clause (i)(IX),” after “clause (i)(VIII)."

¶ 15,911 Sec. 1920C. PRESUMPTIVE ELIGIBILITY FOR FAMILY PLANNING SERVICES

[42 U.S.C. §1396r-1c]

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

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

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

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

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

(i) the day on which a determination is made with respect to the eligibility of such individual for services under the State plan; or
(ii) in the case of such an individual who does not file an application by the last day of the
month following the month during which the entity makes the determination referred to in
subparagraph (A), such last day.

(2) QUALIFIED ENTITY.—

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

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

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

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

(c) ADMINISTRATION.—

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

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

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

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

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

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

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

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

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

(A) during a presumptive eligibility period; and

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

(2) is included in the care and services covered by the State plan,

shall be treated as medical assistance provided by such plan for purposes of clause (4) of the first sentence of
section 1905(b).

[Explanation at ¶ 523.]

2010 Amendments:
Sec. 2303(b)(1) of the “Patient Protection and Affordable
Care Act” (PubLNo 111-148), effective March 23, 2010,
added new sec. 1921C.

¶ 15,921 Sec. 1921. INFORMATION CONCERNING SANCTIONS TAKEN BY
STATE LICENSING AUTHORITIES AGAINST HEALTH CARE PRACTITIONERS
AND PROVIDERS

[42 U.S.C. § 1396r-2]

(a)

***

§ 1921(a) ¶ 15,921
(1) INFORMATION REPORTING SYSTEM.—(A) LICENSING OR CERTIFICATION ACTIONS.—The State must have in effect a system of reporting the following information with respect to formal proceedings (as defined by the Secretary in regulations) concluded against a health care practitioner or entity by a State licensing or certification agency:

(i) Any adverse action taken by such licensing authority as a result of the proceeding, including any revocation or suspension of a license (and the length of any such suspension), reprimand, censure, or probation.

(ii) Any dismissal or closure of the proceedings by reason of the practitioner or entity surrendering the license or leaving the State or jurisdiction.

(iii) Any other loss of license or the right to apply for, or renew, a license by the practitioner or entity, whether by operation of law, voluntary surrender, nonrenewability, or otherwise.

(iv) Any negative action or finding by such authority, organization, or entity regarding the practitioner or entity.

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

(2) ACCESS TO DOCUMENTS.—The State must provide the Secretary (or an entity designated by the Secretary) with access to such documents of a State licensing or certification agency or State law or fraud enforcement agency as may be necessary for the Secretary to determine the facts and circumstances concerning the actions and determinations described in such paragraph for the purpose of carrying out this Act.

(b) FORM OF INFORMATION.—

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

***

(4) to utilization and quality control peer review organizations described in part B of title XI and to appropriate entities with contracts under section 1154(a)(4)(C) with respect to eligible organizations reviewed under the contracts, but only with respect to information provided pursuant to subsection (a)(1)(A),

(5) to State law or fraud enforcement agencies,

(6) to hospitals and other health care entities (as defined in section 431 of the Health Care Quality Improvement Act of 1986), with respect to physicians or other licensed health care practitioners that have entered (or may be entering) into an employment or affiliation relationship with, or have applied for clinical privileges or appointments to the medical staff of, such hospitals or other health care entities (and such information shall be deemed to be disclosed pursuant to section 427 of, and be subject to the provisions of, that Act), but only with respect to information provided pursuant to subsection (a)(1)(A),

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

(8) to the Attorney General and such other law enforcement officials as the Secretary deems appropriate, and

(9) upon request, to the Comptroller General, in order for such authorities to determine the fitness of individuals to provide health care services, to protect the health and safety of individuals receiving health care through such programs, and to protect the fiscal integrity of such programs.

***
(d) Disclosure and Correction of Information.—

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

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

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

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

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

(f) Protection From Liability for Reporting.—No person or entity, including any agency designated by the Secretary in subsection (b), shall be held liable in any civil action with respect to any reporting of information as required under this section, without knowledge of the falsity of the information contained in the report.

(g) References.—For purposes of this section:

(1) State licensing or certification agency.—The term ‘State licensing or certification agency’ includes any authority of a State (or of a political subdivision thereof) responsible for the licensing of health care practitioners (or any peer review organization or private accreditation entity reviewing the services provided by health care practitioners) or entities.

(2) State law or fraud enforcement agency.—The term ‘State law or fraud enforcement agency’ includes—

(A) a State law enforcement agency; and

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

(3) Final adverse action.—

(A) In general.—Subject to subparagraph (B), the term ‘final adverse action’ includes—

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

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

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

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

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

(B) Exception.—Such term does not include any action with respect to a malpractice claim.

(h) Appropriate Coordination.—“In implementing this section, the Secretary shall provide for the maximum appropriate coordination with part B of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11131 et seq.) and section 1128E.”

[Explanation at ¶ 1831.]

2010 Amendments:

Sec. 6403(b)(1) of the “Patient Protection and Affordable Care Act” (Pub.L.No 111-148), effective on the first day after the final day of the transition period noted in Act Sec. 6403(d), amended sec. 1921(a) by making the following changes: by striking “SYSTEM.—The State” and all that follows through the colon and inserting SYSTEM.—and
“(A) LICENSING OR CERTIFICATION ACTIONS.—The State must have in effect a system of reporting the following information with respect to formal proceedings (as defined by the Secretary in regulations) concluded against a health care practitioner or entity by a State licensing or certification agency:"

by redesignating subparagraphs (A) through (D) as clauses (i) through (iv);

in paragraph (A)(iii) by striking “the license of” and inserting “license or the right to apply for, or renew, a license by”;

by inserting “nonrenewability,” after “voluntary surrender,”;

by adding at the end new subparagraph (B); and

in paragraph (2), by striking “the authority described in paragraph (1)” and inserting “a State licensing or certification agency or State law or fraud enforcement agency”.

Sec. 6403(b)(2) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective on the first day after the final day of the transition period noted in Act Sec. 6403(d), amended sec. 1921 by redesignating subsection (d) as subsection (h), and by inserting after subsection (c) the following new subsections: (d), (e), (f) and (g).

Sec. 6403(b)(4) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective on the first day after the final day of the transition period noted in Act Sec. 6403(d), amended sec. 1921 by redesigning subsection (d) as subsection (h), and by inserting after subsection (c) the following new subsections: (d), (e), (f) and (g).

¶15,931 Sec. 2023. Limitation on Federal Financial Participation

[42 U.S.C. 1396r-4(f)]

(f)(1) IN GENERAL.—Payment under section 1903(a) shall not be made to a State with respect to any payment adjustment made under this section for hospitals in a State for quarters in a fiscal year in excess of the disproportionate share hospital (in this subsection referred to as “DSH”) allotment for the State for the fiscal year, as specified in paragraphs (2), (3), and (7).

***

(3)(A) IN GENERAL.—Except as provided in paragraphs (6) and (7) and subparagraph (E), the DSH allotment for any State for fiscal year 2003 and each succeeding fiscal year is equal to the DSH allotment for the State for the preceding fiscal year under paragraph (2) or this paragraph, increased, subject to subparagraphs (B) and (C) and paragraph (5), by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average), for the previous fiscal year.

***

(6) ALLOTMENT ADJUSTMENTS

(A)

***

(v) Allotment For 2d, 3rd, And 4th Quarters Of Fiscal Year 2012 And For Fiscal Year 2013

Notwithstanding the table set forth in paragraph (2):

(I) 2d, 3rd, and 4th Quarters Of Fiscal Year 2012

In the case of a State that has a DSH allotment of $0 for the 2d, 3rd, and 4th quarters of fiscal year 2012, the DSH allotment shall be $47,200,000 for such quarters.

(II) Fiscal Year 2013

In the case of a State that has a DSH allotment of $0 for fiscal year 2013, the DSH allotment shall be $53,100,000 for such fiscal year.
(B) HAWAII.

(i) IN GENERAL.—Only with respect to each of fiscal years 2007 through 2011, the DSH allotment for Hawaii for such fiscal year, notwithstanding the table set forth in paragraph (2), shall be $10,000,000. Only with respect to fiscal year 2012 for the period ending on December 31, 2011, the DSH allotment for Hawaii for such portion of the fiscal year, notwithstanding the table set forth in paragraph (2), shall be $2,500,000.

(ii) STATE PLAN AMENDMENT.—The Secretary shall permit Hawaii to submit an amendment to its State plan under this title that describes the methodology to be used by the State to identify and make payments to disproportionate share hospitals, including children’s hospitals and institutions for mental diseases or other mental health facilities. The Secretary may not approve such plan amendment unless the methodology described in the amendment is consistent with the requirements under this section for making payments to disproportionate share hospitals.

(iii) ALLOTMENT FOR 2D, 3RD, AND 4TH QUARTER OF FISCAL YEAR 2012, FISCAL YEAR 2013, AND SUCCEEDING FISCAL YEARS.—Notwithstanding the table set forth in paragraph (2):

(I) 2D, 3RD, AND 4TH QUARTER OF FISCAL YEAR 2012.—The DSH allotment for Hawaii for the 2d, 3rd, and 4th quarters of fiscal year 2012 shall be $7,500,000.

(II) TREATMENT AS A LOW-DSH STATE FOR FISCAL YEAR 2013 AND SUCCEEDING FISCAL YEARS.—With respect to fiscal year 2013, and each fiscal year thereafter, the DSH allotment for Hawaii shall be increased in the same manner as allotments for low DSH States are increased for such fiscal year under clause (iii) of paragraph (5)(B).

(III) CERTAIN HOSPITAL PAYMENTS.—The Secretary may not impose a limitation on the total amount of payments made to hospitals under the QUEST section 1115 Demonstration Project except to the extent that such limitation is necessary to ensure that a hospital does not receive payments in excess of the amounts described in subsection (g), or as necessary to ensure that such payments under the waiver and such payments pursuant to the allotment provided in this clause do not, in the aggregate in any year, exceed the amount that the Secretary determines is equal to the Federal medical assistance percentage component attributable to disproportionate share hospital payment adjustments for each year that is reflected in the budget neutrality provision of the QUEST Demonstration Project.

(7) MEDICAID DSH REDUCTIONS.—

(A) REDUCTIONS.—(i) IN GENERAL

For each of fiscal years 2014 through 2020 the Secretary shall effect the following reductions:

(I) REDUCTION IN DSH ALLOTMENTS

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

(II) REDUCTIONS IN PAYMENTS

The Secretary shall reduce payments to States under section 1903(a) for each calendar quarter in the fiscal year, in the manner specified in clause (iii), in an amount equal to 1/4 of the DSH allotment reduction under subclause (I) for the State for the fiscal year.

(ii) AGGREGATE REDUCTIONS

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

(I) $500,000,000 for fiscal year 2014;

(II) $600,000,000 for fiscal year 2015;

(III) $600,000,000 for fiscal year 2016;
(IV) $1,800,000,000 for fiscal year 2017;
(V) $5,000,000,000 for fiscal year 2018;
(VI) $5,600,000,000 for fiscal year 2019; and
(VII) $4,000,000,000 for fiscal year 2020.

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

(iii) Manner Of Payment Reduction

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

(iv) Definition

In this paragraph, the term ‘State’ means the 50 States and the District of Columbia.

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

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

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

(II) do not target their DSH payments on

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

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

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

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

(8) DEFINITION OF STATE.—In this subsection, the term “State” means the 50 States and the District of Columbia.

[Explanation at ¶ 567.]

2010 Amendments:

Sec. 2551(a) of the “Patient Protection and Affordable Care Act” (Pub.L.No 111-148, effective Oct. 1, 2011, amended sec. 1923(f) in paragraph (1), by striking “and (3)” and inserting “, (3), and (7)”; in paragraph (3)(A), by striking “paragraph (6)” and inserting “paragraphs (6) and (7)”; redesignating paragraph (7) as paragraph (8); and inserting after paragraph (6) new paragraph (7). Sec. 12020(e)(1) of the “Patient Protection and Affordable Care Act” (Pub.L.No 111-148, effective Oct. 1, 2011, amended sec. 1923(f) in paragraph (6) by striking the paragraph heading “FISCAL YEARS 2007 THROUGH 2011 AND THE FIRST CALENDAR QUARTER OF FISCAL YEAR 2010” and inserting the following new heading: “ALLOTMENT ADJUSTMENTS”; in paragraph (8), by adding at the end new clause (iii); in paragraph (7) in subparagraph (A), in the matter preceding clause (i), by striking “subparagraph (E)” and inserting “subparagraphs (E) and (G)”; in subparagraph (B)(i) and (ii), by striking subclauses (I) and (II), and inserting new subclauses (I) – (IV); in subparagraph (E), by striking “35 percent” and inserting “50 percent”; and by adding at the end new paragraph (7)(G).

Sec. 1203(a) of the “Health Care and Education Reconciliation Act of 2010” (Pub.L.No 111-152), effective March 30, 2010, amended sec. 1923(f) in paragraph (6)(B)(iii), in the matter preceding subclause (I), by striking “or paragraph (7)” and by striking paragraph (7) and inserting a new paragraph (7). Prior to replacement the original paragraph (7) read as follows:

“(7) Reduction of state DSH allotments once reduction in uninsured threshold reached”

“(A) In general—Subject to subparagraphs (E) and (G), the DSH allotment for a State for fiscal years beginning with the fiscal year described in subparagraph (C) (with respect to the State), is equal to—”

¶15,931 §1923(f)(7)(A)(ii)(IV)
“(i) in the case of the first fiscal year described in subparagraph (C) with respect to a State, the DSH allotment that would be determined under this subsection for the State for the fiscal year without application of this paragraph (but after the application of this paragraph (B)(ii)) and has spent not more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to 35 percent;”

“(ii) in the case of any subsequent fiscal year with respect to the State, the DSH allotment determined under this paragraph for the State for the preceding fiscal year, reduced by the applicable percentage determined for the State for the fiscal year under subparagraph (B)(ii).”

“(B) Applicable percentage -- For purposes of subparagraph (A), the applicable percentage for a State for a fiscal year is the following:”

“(i) Uninsured reduction threshold fiscal year -- In the case of the first fiscal year described in subparagraph (C) with respect to the State—

“(II) if the State is a low DSH State described in paragraph (5)(B) and has spent not more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to 25 percent;”

“(II) if the State is a low DSH State described in paragraph (5)(B) and has spent not more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to 17.5 percent;”

“(III) if the State is not a low DSH State described in paragraph (5)(B) and has spent not more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to 50 percent; and

“(IV) if the State is not a low DSH State described in paragraph (5)(B) and has spent more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to 0 percent;”

“(B) Applicable percentage -- For purposes of subparagraph (A), the applicable percentage for a State for a fiscal year is the following:”

“(i) In the case of any fiscal year after the first fiscal year described in subparagraph (C) with respect to a State, if the Secretary determines on the basis of the most recent American Community Survey of the Bureau of the Census, that the percentage of uncovered individuals residing in the State is less than the percentage of such individuals determined for the State for the fiscal year before the fiscal year."

“(E) Minimum allotment -- In no event shall the DSH allotment determined for a State in accordance with this subsection for fiscal year 2013 or any succeeding fiscal year be less than the amount equal to 50 percent of the DSH allotment determined for the State for fiscal year 2012 under this subsection (and after the application of this paragraph (and prior to any such reduction) shall not include any portion of the allotment for which the Secretary has approved the State’s diversion to the costs of providing medical assistance or other health benefits coverage under a waiver that is in effect on July 2009.”

“(F) Uncovered individuals -- In this paragraph, the term ‘uncovered individuals’ means individuals with no health insurance coverage at any time during a year (as determined by the Secretary based on the most recent data available).”

“(G) Nonapplication — The preceding provisions of this paragraph shall not apply to the DSH allotment determined for the State of Hawaii for a fiscal year under paragraph (v)."

Sec. 1203(b) of the “Health Care and Education Reconciliation Act of 2010” (Pub.L.No 111-152), effective March 30, 2010, amended sec. 1923(f)(6)(A) by adding at the end new paragraph (v)."

¶15,941 Sec. 1924. TREATMENT OF INCOME AND RESOURCES FOR CERTAIN INSTITUTIONALIZED SPOUSES

[42 U.S.C. §1396r-5]

[See sec. 1924(a) to sec. 1924(h).]

(h) ** **
Caution: Sec. 2404 of the “Patient Protection and Affordable Care Act of 2010” (PubL No 111-148) provides that during the 5-year period that begins on January 1, 2014, section 1924(h)(1)(A) of the Social Security Act (42 U.S.C. 1396r-5(h)(1)(A)) shall be applied as though “is eligible for medical assistance for home and community-based services provided under subsection (c), (d), or (i) of section 1915, under a waiver approved under section 1115, or who is eligible for such medical assistance by reason of being determined eligible under section 1902(a)(10)(C) or by reason of section 1902(f) or otherwise on the basis of a reduction of income based on costs incurred for medical or other remedial care, or who is eligible for medical assistance for home and community-based attendant services and supports under section 1915(k)” were substituted in such section for “(at the option of the State) is described in section 1902(a)(10)(A)(ii)(VI)”. 

(A) is in a medical institution or nursing facility or who (at the option of the State) is described in section 1902(a)(10)(A)(ii)(VI), and

**Explanation at ¶ 537.**

2010 Amendments:
Sec. 2404 of the “Patient Protection and Affordable Care Act” (PubL No 111-148), effective March 23, 2010, impacts sec. 1924(h)(1)(A); refer to the CCH caution note listed above this section for further information.

¶15,951 Sec. 1927. Payment for Covered Outpatient Drugs
[42 U.S.C. §1396r-8]

[See sec. 1927(a) to sec. 1927(k).]

**Explanation at ¶ 537.**

2010 Amendments:
Sec. 2404 of the “Patient Protection and Affordable Care Act” (PubL No 111-148), effective March 23, 2010, impacts sec. 1924(h)(1)(A); refer to the CCH caution note listed above this section for further information.

¶15,951 §1927
such quarter was greater or less than the amount of payment reduction that should have been made.

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

(2)(A) **STATE RESPONSIBILITY.**—Each State agency under this title shall report to each manufacturer not later than 60 days after the end of each rebate period and in a form consistent with a standard reporting format established by the Secretary, information on the total number of units of each dosage form and strength and package size of each covered outpatient drug dispensed after December 31, 1990, for which payment was made under the plan during the period, including such information reported by each Medicaid managed care organization, and shall promptly transmit a copy of such report to the Secretary.

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**§1927(c)(1)(B)(VI)** ¶15,951

(IV) after December 31, 1994, and before January 1, 1996, is 15.2 percent;
(V) after December 31, 1995, and before January 1, 2010 is 15.1 percent; and
(VI) except as provided in clause (iii), after December 31, 2009, 23.1 percent.
(iii) **Minimum Rebate Percentage for Certain Drugs.—**

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

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

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

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

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(C)(i)(VI) any prices charged which are negotiated by a prescription drug plan under part D of title XVIII, by an MA-PD plan under part C of such title with respect to covered part D drugs or by a qualified retiree prescription drug plan (as defined in section 1860D-22(a)(2)) with respect to such drugs on behalf of individuals entitled to benefits under part A or enrolled under part B of such title, or any discounts provided by manufacturers under the Medicare coverage gap discount program under section 1860D-14A.

(2) ***

Caution: Sec. 1927(c)(2)(C), as added by sec 2501(d)(1) of the Patient Protection and affordable Care Act (PubLNo 111-148) and then replaced by sec. 1206(a) of the Health Care Reconciliation Act of 2010 (PubLNo 111-152), applies to drugs that are paid for by a state after December 31, 2009.

(C) **Treatment of New Formulations.—**

In the case of a drug that is a line extension of a single source drug or an innovator multiple source drug that is an oral solid dosage form, the rebate obligation with respect to such drug under this section shall be the amount computed under this section for such new drug or, if greater, the product of

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

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

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

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

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

(3) ***

(B) ***

(i) before January 1, 1994, is 10 percent,

(ii) after December 31, 1993, and before January 1, 2010, is 11 percent; and

(iii) after December 31, 2009, is 13 percent.
(d) Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.

(F) Nonprescription drugs, except, in the case of pregnant women when recommended in accordance with the Guideline referred to in section 1905(bb)(2)(A), agents approved by the Food and Drug Administration under the over-the-counter monograph process for purposes of promoting, and when used to promote, tobacco cessation.

(G) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.

(H) Agents when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition, other than sexual or erectile dysfunction, for which the agents have been approved by the Food and Drug Administration.

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

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

(B) Barbiturates.

(C) Benzodiazepines.

(e) [Reserved]

[[4]] ESTABLISHMENT OF UPPER PAYMENT LIMITS.—Subject to paragraph (5), the Secretary shall establish a Federal upper reimbursement limit for each multiple source drug for which the FDA has rated three or more products therapeutically and pharmaceutically equivalent, regardless of whether all such additional formulations are rated as such and shall use only such formulations when determining any such upper limit.

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

(f)(1)(A)(i) with respect to a retail community pharmacy, the determination on a monthly basis of retail survey prices for covered outpatient drugs that represent a nationwide average of consumer purchase prices for such drugs, net of all discounts and rebates (to the extent any information with respect to such discounts and rebates is available); and

(i) working with retail community pharmacies, commercial payers, and States in obtaining and disseminating such price information; and

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

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

(B) subject to discounts under section 340B of the Public Health Service Act.
(k)(1)(A) Subject to subparagraph (B), the term “average manufacturer price” means, with respect to a covered outpatient drug of a manufacturer for a rebate period, the average price paid to the manufacturer for the drug in the United States by—

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

(ii) retail community pharmacies that purchase drugs directly from the manufacturer.

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

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

(I) customary prompt pay discounts extended to wholesalers;

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

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

(IV) payments received from, and rebates or discounts provided to, pharmacy benefit managers, managed care organizations, health maintenance organizations, insurers, hospitals, clinics, mail order pharmacies, long term care providers, manufacturers, or any other entity that does not conduct business as a wholesaler or a retail community pharmacy;

(V) discounts provided by manufacturers under section 1860D-14A.

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

(7)(A)(i)

(III) is sold or marketed in the United States during the period.

(C)

(i) drug products are pharmaceutically equivalent if the products contain identical amounts of the same active drug ingredient in the same dosage form and meet compendial or other applicable standards of strength, quality, purity, and identity; and

(ii) drugs are bioequivalent if they do not present a known or potential bioequivalence problem, or, if they do present such a problem, they are shown to meet an appropriate standard of bioequivalence.

(10) RETAIL COMMUNITY PHARMACY.—The term ‘retail community pharmacy’ means an independent pharmacy, a chain pharmacy, a supermarket pharmacy, or a mass merchandiser pharmacy that is licensed as a pharmacy by the State and that dispenses medications to the general public at retail prices. Such term does not include a pharmacy that dispenses prescription medications to patients primarily through the mail, nursing home pharmacies, long-term care facility pharmacies, hospital pharmacies, clinics, charitable or not-for-profit pharmacies, government pharmacies, or pharmacy benefit managers.
(11) WHOLESALE.—The term ‘wholesaler’ means a drug wholesaler that is engaged in wholesale distribution of prescription drugs to retail community pharmacies, including (but not limited to) manufacturers, repackers, distributors, own-label distributors, private-label distributors, jobbers, brokers, warehouses (including manufacturer’s and distributor’s warehouses, chain drug warehouses, and wholesale drug warehouses) independent wholesale drug traders, and retail community pharmacies that conduct wholesale distributions.

[Explanation at ¶ 543, ¶ 545, ¶ 547, ¶ 1205, and ¶ 1425.]

2010 Amendments:

Sec. 2501(a)(1) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1927(c)(1)(B) in clause (i), in subclause (IV), by striking “and” at the end, in subclause (VI) by inserting “and before January 1, 2010,” after “December 31, 1995,” by striking the period at the end and inserting “; and”, and by adding at the end the new subclause (VII).

Sec. 2501(a)(2) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1927(b)(1) by adding at the end the new subparagraph (C).

Sec. 2501(b) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1927(c)(3)(B) in clause (i), by striking “and” at the end; in clause (ii) by inserting “and before January 1, 2010,” after “December 31, 1993,” by striking the period and inserting “; and”, and by adding at the end the new clause (iii).

Sec. 2501(c)(2) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1927(c)(2) by adding at the end the new subparagraph (C).

Sec. 2501(d)(1) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective for drugs that are paid for by a state after Dec. 31, 2009, amended sec. 1927(c)(2) by adding at the end the new subparagraph (C).

Sec. 2501(e) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1927(c)(2) by adding at the end the new subparagraph (D).

Sec. 2502(a) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective for services furnished on or after Jan. 1, 2014, amended sec. 1927(d) in paragraph (2) by striking subparagraphs (E), (F), and (J), respectively, prior to amendment, sec. 1927(d)(1) previously read as follows: “EXEMPTION OF ORGANIZED HEALTH CARE SETTINGS.—Covered outpatient drugs dispensed by health maintenance organizations, including Medicaid managed care organizations that contract under section 1903(m), are not subject to the requirements of this section.”

Sec. 2501(d)(1) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective for drugs that are paid for by a state after Dec. 31, 2009, amended sec. 1927(c)(2) by adding at the end the new subparagraph (C).

Sec. 2501(e) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1927(c)(2) by adding at the end the new subparagraph (D).

Sec. 2502(a) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective on the first day of the first calendar year quarter that begins at least 180 days after the date of enactment of this Act, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date, amended sec. 1927(k)(1) in subparagraph (A), by striking “by” and all that follows through the period and inserting “by— and clauses (i) and (ii) and striking original subparagraphs (B) and inserting a new subparagraph (B). Prior to amendment, sec. 1927(k)(1)(B) previously read as follows: “EXCLUSION OF CUSTOMARY PROMPT PAY DISCOUNTS EXTENDED TO WHOLESALERS.—The average manufacturer price for a covered outpatient drug shall be determined without regard to customary prompt pay discounts extended to wholesalers.”

Sec. 2503(a)(3) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective on the first day of the first calendar year quarter that begins at least 180 days after the date of enactment of this Act, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date, amended sec. 1927(k)(7) in subparagraph (A)(ii)(III), by striking “the State” and inserting “the United States”; in subparagraph (C), in clause (ii), by inserting “and” after the semicolon and in clause (ii), by striking “; and” and inserting a period; and by striking original clause (iii) and inserting a new clause (iii). Prior to amendment, sec. 1927(k)(7)(C)(iii) previously read as follows: “a drug product is considered to be sold or marketed in a State if it appears in a published national listing of average wholesale prices selected by the Secretary, provided that the listed product is generally available to the public through retail pharmacies in that State.”

Sec. 2503(a)(4) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective on the first day of the first calendar year quarter that begins at least 180 days after the date of enactment of this Act, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date, amended sec. 1927(k) by adding at the end new paragraphs (10) and (11).

Sec. 2503(b)(1) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective on the first day of the first calendar year quarter that begins at least 180 days after the date of enactment of this Act, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date, amended sec. 1927(b)(3)(A) in the first sentence, by inserting after clause (iv) and in the second sentence, by inserting “(relating to the weighted average of the most recently reported monthly average manufacturer prices)” after “(D)(v)”.}

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average retail survey price determined for each multiple source drug in accordance with subsection (f)".

Sec. 2503(c)(1) of the "Patient Protection and Affordable Care Act" (PubLNo 111-148), effective on the first day of the first calendar year quarter that begins at least 180 days after the date of enactment of this Act, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date, amended sec. 1927(f)(1)(A)(i) by inserting "with respect to a retail community pharmacy," before "the determination";

Sec. 2503(c)(2) of the "Patient Protection and Affordable Care Act" (PubLNo 111-148), effective on the first day of the first calendar year quarter that begins at least 180 days after the date of enactment of this Act, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date, amended sec. 1927(f)(1)(C)(ii) by striking "retail pharmacies" and inserting "retail community pharmacies".

Sec. 3301(d)(2) of the "Patient Protection and Affordable Care Act" (PubLNo 111-148), effective for drugs dispensed on or after July 1, 2010, amended sec. 1927(c)(1)(C)(vi) by inserting ", or any discounts provided by manufacturers under the Medicare coverage gap discount program under section 1860D-14A," before the period at the end.

Sec. 4107(b) of the "Patient Protection and Affordable Care Act" (PubLNo 111-148), effective Oct. 1, 2010, amended sec. 1927(d)(2)(F) by inserting before the period at the end the following: ", except, in the case of pregnant women who recommended in accordance with the Guideline referred to in section 1905(b)(2)(A), agents approved by the Food and Drug Administration under the over-the-counter monograph process for purposes of promoting, and when used to promote, tobacco cessation".

Sec. 1101(c) of the "Health Care and Education Reconciliation Act of 2010" (PubLNo 111-152), effective March 23, 2010, amended sec. 1927(k)(1)(F)(i) by striking "with respect to a retail community pharmacy," before "the determination"; and by inserting before the period at the end the following: "and, in the case of primary care services described in section 1902(a)(13)(C), consistent with the minimum payment rates specified in such section (regardless of the manner in which such payments are made, including in the form of capitation or partial capitation)").

Sec. 1206 of the "Health Care and Education Reconciliation Act of 2010" (PubLNo 111-152), effective March 23, 2010, amended sec. 1927(c)(2) by replacing subparagraph (C), which had been added by sec. 2501(d)(1) of the "Patient Protection and Affordable Care Act" (PubLNo 111-148).

Sec. 1932. PROVISIONS RELATING TO MANAGED CARE

[42 U.S.C. 1396u-2]

(f) TIMELINESS OF PAYMENT; ADEQUACY OF PAYMENT FOR PRIMARY CARE SERVICES.—A contract under section 1903(m) with a Medicaid managed care organization shall provide that the organization shall make payment to health care providers for items and services which are subject to the contract and that are furnished to individuals eligible for medical assistance under the State plan under this title who are enrolled with the organization on a timely basis consistent with the claims payment procedures described in section 1902(a)(37)(A), unless the health care provider and the organization agree to an alternate payment schedule and, in the case of primary care services described in section 1902(a)(13)(C), consistent with the minimum payment rates specified in such section (regardless of the manner in which such payments are made, including in the form of capitation or partial capitation).

[Explanation at ¶1250.]

2010 Amendments:

Sec. 1202(a)(2) of the "Health Care and Education Reconciliation Act of 2010" (PubLNo 111-152), effective March 23, 2010, amended sec. 1932(f) in the heading, by adding at the end the following: ", ADEQUACY OF PAYMENT FOR PRIMARY CARE SERVICES" and by inserting before the period at the end the following: "and, in the case of primary care services described in section 1902(a)(13)(C), consistent with the minimum payment rates specified in such section (regardless of the manner in which such payments are made, including in the form of capitation or partial capitation)").

Sec. 1936. MEDICAID INTEGRITY PROGRAM

[42 U.S.C. 1396v]

(c)

(2)

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

(E) The entity meets such other requirements as the Secretary may impose.
Medical Assistance Programs (Medicaid) 271

***

e) Appropriation

(1) In general.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated to carry out the Medicaid Integrity Program under this section, without further appropriation

(A) for fiscal year 2006, $5,000,000;

(B) for each of fiscal years 2007 and 2008, $50,000,000;

(C) for each of fiscal years 2009 and 2010, $75,000,000; and

(D) for each fiscal year after fiscal year 2010, the amount appropriated under this paragraph for the previous fiscal year, increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over the previous year.

***

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

(5) Annual Report.—Not later than 180 days after the end of each fiscal year (beginning with fiscal year 2006), the Secretary shall submit a report to Congress which identifies

(A) the use of funds appropriated pursuant to paragraph (1); and

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

[Explanation at ¶ 1825.]

2010 Amendments:

Sec. 6402(j)(2)(A) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1936(e)(2) by redesignating subparagraph (D) as subparagraph (E) and by inserting after subparagraph (C) new subparagraph (D).

Sec. 6402(j)(2)(B) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 1936(e) by redesignating paragraph (4) as paragraph (5) and by inserting after paragraph (3) new paragraph (4).

Sec. 1303(b) of the Health Care and Education Reconciliation Act of 2010 (PubLNo 111-152) amended sec. 1936(e)(1) as follows—

in subparagraph (B), by striking at the end “and”;

in subparagraph (C), by striking “for each fiscal year thereafter” and inserting “for each of fiscal years 2009 and 2010”; by striking the period and inserting “; and”; by adding at the end the following new subparagraph: “(D) for each fiscal year after fiscal year 2010, the amount appropriated under this paragraph for the previous fiscal year, increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over the previous year.”.

[¶ 15,971] Sec. 1937. STATE FLEXIBILITY IN BENEFIT PACKAGES

[42 U.S.C. § 1396w]

(a)(1)

***

(B) Limitation.—The State may only exercise the option under subparagraph (A) for an individual eligible under subclause (VIII) of section 1902(a)(10)(A)(i) or under an eligibility category that had been established under the State plan on or before the date of the enactment of this section.

***

(2) Application.—

***

(B)

***
(viii) CHILDREN IN FOSTER CARE RECEIVING CHILD WELFARE SERVICES AND CHILDREN RECEIVING FOSTER CARE OR ADOPTION ASSISTANCE.—The individual is an individual with respect to whom child welfare services are made available under part B of title IV on the basis of being a child in foster care or with respect to whom adoption or foster care assistance is made available under part E of such title, without regard to age, or the individual qualifies for medical assistance on the basis of section 1902(a)(10)(A)(i)(IX).

***

(b)(1) IN GENERAL.—For purposes of subsection (a)(1), subject to paragraphs (5) and (6), each of the following coverages shall be considered to be benchmark coverage:

***

(2) BENCHMARK-EQUIVALENT COVERAGE.—For purposes of subsection (a)(1) subject to paragraphs (5) and (6), coverage that meets the following requirement shall be considered to be benchmark-equivalent coverage:

(A)

***

(iv) Coverage of prescription drugs.

(v) Mental health services.

(vi) Well-baby and well-child care, including age-appropriate immunizations.

(vii) Other appropriate preventive services, as designated by the Secretary.

***

(C)

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(i) Vision services.

(ii) Hearing services.

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

(6) MENTAL HEALTH SERVICES PARITY.—

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

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

(7) COVERAGE OF FAMILY PLANNING SERVICES AND SUPPLIES.—Notwithstanding the previous provisions of this section, a State may not provide for medical assistance through enrollment of an individual with benchmark coverage or benchmark-equivalent coverage under this section unless such coverage includes for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.
Sec. 1941. MEDICAID IMPROVEMENT FUND

[42 U.S.C. 1396w-1]

(b)(1)

(A) for fiscal year 2014, $0; and
(B) for each of fiscal years 2015 through 2018, $0.

[Explanation at ¶ 517.]

2010 Amendments:

- Sec. 2001(a)(5)(E) of the “Patient Protection and Affordable Care Act” (Pub.L. No. 111-148), effective March 23, 2010, amended sec. 1937(a)(1)(B) by inserting “subject to paragraphs (5) and (6),” before “each”.
- Sec. 2007(b) of the “Emergency Aid to Survivors of the Haiti Earthquake Act of 2010” (Pub.L. No. 111-127), effective Jan. 27, 2010, amended sec. 1941(b)(1)(A) by striking “$100,000,000” and inserting “$10,000,000”.
- Sec. 4 of the “Emergency Aid to Survivors of the Haiti Earthquake Act of 2010” (Pub.L. No. 111-127), effective Jan. 27, 2010, amended sec. 1941(b)(1)(A) by striking “$100,000,000” and inserting “$10,000,000”.

[¶ 15,981] Sec. 1943. ENROLLMENT SIMPLIFICATION AND COORDINATION WITH STATE HEALTH INSURANCE EXCHANGES.

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

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

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

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

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

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

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

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

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

(F) conducting outreach to and enrolling vulnerable and underserved populations eligible for medical assistance under this title XIX or for child health assistance under title XXI, including children, unaccompanied homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS.

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

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

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

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

[Explanation at ¶63.]

2010 Amendments:

Sec. 2201 of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, added new section 1943.

[¶ 16,001] SEC. 1945. STATE OPTION TO PROVIDE COORDINATED CARE THROUGH A HEALTH HOME FOR INDIVIDUALS WITH CHRONIC CONDITIONS.

(a) **IN GENERAL.**—Notwithstanding section 1902(a)(1) (relating to statewideness), section 1902(a)(10)(B) (relating to comparability), and any other provision of this title for which the Secretary determines it is necessary to waive in order to implement this section, beginning January 1, 2011, a State, at its option as a State plan amendment, may provide for medical assistance under this title to eligible individuals with chronic conditions who select a designated provider (as described under subsection (h)(5)), a team of health care professionals (as described under subsection (h)(6)) operating with such a provider, or a health team (as described under subsection (h)(7)) as the individual’s health home for purposes of providing the individual with health home services.

(b) **HEALTH HOME QUALIFICATION STANDARDS.**—The Secretary shall establish standards for qualification as a designated provider for the purpose of being eligible to be a health home for purposes of this section.

(c) **PAYMENTS.**—

(1) **IN GENERAL.**—A State shall provide a designated provider, a team of health care professionals operating with such a provider, or a health team with payments for the provision of health home services to each eligible individual with chronic conditions that selects such provider, team of health care professionals, or health team as the individual’s health home. Payments made to a designated provider, a team of health care professionals operating with such a provider, or a health team for such services shall be treated as medical assistance for purposes of section 1903(a), except that, during the first 8 fiscal year quarters that the State plan amendment is in effect, the Federal medical assistance percentage applicable to such payments shall be equal to 90 percent.

(2) **METHODOLOGY.**—

(A) **IN GENERAL.**—The State shall specify in the State plan amendment the methodology the State will use for determining payment for the provision of health home services. Such methodology for determining payment—

(i) may be tiered to reflect, with respect to each eligible individual with chronic conditions provided such services by a designated provider, a team of health care professionals operating with such a provider, or a health team, as well as the severity or number of each such individual’s chronic conditions or the specific capabilities of the provider, team of health care professionals, or health team; and

(ii) shall be established consistent with section 1902(a)(30)(A).

(B) **ALTERNATE MODELS OF PAYMENT.**—The methodology for determining payment for provision of health home services under this section shall not be limited to a per-member per-month basis and may provide (as proposed by the State and subject to approval by the Secretary) for alternate models of payment.

(3) **PLANNING GRANTS.**—

(A) **IN GENERAL.**—Beginning January 1, 2011, the Secretary may award planning grants to States for purposes of developing a State plan amendment under this section. A planning grant awarded to a State under this paragraph shall remain available until expended.

(B) **STATE CONTRIBUTION.**—A State awarded a planning grant shall contribute an amount equal to the State percentage determined under section 1905(b) (without regard to section 5001 of Public Law 111-5) for each fiscal year for which the grant is awarded.
(C) LIMITATION.—The total amount of payments made to States under this paragraph shall not exceed $25,000,000.

(d) HOSPITAL REFERRALS.—A State shall include in the State plan amendment a requirement for hospitals that are participating providers under the State plan or a waiver of such plan to establish procedures for referring any eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated providers.

(e) COORDINATION.—A State shall consult and coordinate, as appropriate, with the Substance Abuse and Mental Health Services Administration in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

(f) MONITORING.—A State shall include in the State plan amendment—

(1) a methodology for tracking avoidable hospital readmissions and calculating savings that result from improved chronic care coordination and management under this section; and

(2) a proposal for use of health information technology in providing health home services under this section and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

(g) REPORT ON QUALITY MEASURES.—As a condition for receiving payment for health home services provided to an eligible individual with chronic conditions, a designated provider shall report to the State, in accordance with such requirements as the Secretary shall specify, on all applicable measures for determining the quality of such services. When appropriate and feasible, a designated provider shall use health information technology in providing the State with such information.

(h) DEFINITIONS.—In this section:

(1) ELIGIBLE INDIVIDUAL WITH CHRONIC CONDITIONS.—

(A) IN GENERAL.—Subject to subparagraph (B), the term ‘eligible individual with chronic conditions’ means an individual who—

(i) is eligible for medical assistance under the State plan or under a waiver of such plan; and

(ii) has at least—

(I) 2 chronic conditions;

(II) 1 chronic condition and is at risk of having a second chronic condition; or

(III) 1 serious and persistent mental health condition.

(B) RULE OF CONSTRUCTION.—Nothing in this paragraph shall prevent the Secretary from establishing higher levels as to the number or severity of chronic or mental health conditions for purposes of determining eligibility for receipt of health home services under this section.

(2) CHRONIC CONDITION.—The term ‘chronic condition’ has the meaning given that term by the Secretary and shall include, but is not limited to, the following:

(A) A mental health condition.

(B) Substance use disorder.

(C) Asthma.

(D) Diabetes.

(E) Heart disease.

(F) Being overweight, as evidenced by having a Body Mass Index (BMI) over 25.

(3) HEALTH HOME.—The term ‘health home’ means a designated provider (including a provider that operates in coordination with a team of health care professionals) or a health team selected by an eligible individual with chronic conditions to provide health home services.
(4) Health Home Services.—

(A) In General.—The term ‘health home services’ means comprehensive and timely high-quality services described in subparagraph (B) that are provided by a designated provider, a team of health care professionals operating with such a provider, or a health team.

(B) Services Described.—The services described in this subparagraph are—
   (i) comprehensive care management;
   (ii) care coordination and health promotion;
   (iii) comprehensive transitional care, including appropriate follow-up, from inpatient to other settings;
   (iv) patient and family support (including authorized representatives);
   (v) referral to community and social support services, if relevant; and
   (vi) use of health information technology to link services, as feasible and appropriate.

(5) Designated Provider.—The term ‘designated provider’ means a physician, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, home health agency, or any other entity or provider (including pediatricians, gynecologists, and obstetricians) that is determined by the State and approved by the Secretary to be qualified to be a health home for eligible individuals with chronic conditions on the basis of documentation evidencing that the physician, practice, or clinic—
   (A) has the systems and infrastructure in place to provide health home services; and
   (B) satisfies the qualification standards established by the Secretary under subsection (b).

(6) Team of Health Care Professionals.—The term ‘team of health care professionals’ means a team of health professionals (as described in the State plan amendment) that may—
   (A) include physicians and other professionals, such as a nurse care coordinator, nutritionist, social worker, behavioral health professional, or any professionals deemed appropriate by the State; and
   (B) be free standing, virtual, or based at a hospital, community health center, community mental health center, rural clinic, clinical practice or clinical group practice, academic health center, or any entity deemed appropriate by the State and approved by the Secretary.

(7) Health Team.—The term ‘health team’ has the meaning given such term for purposes of section 3502 of the Patient Protection and Affordable Care Act.

[Explanation at ¶ 555.]

2010 Amendments:

Sec. 2703(a) of the Patient Protection and Affordable Care Act (PubLNo 111-148), effective March 23, 2010, added new section 1945.

***

Subtitle B—Elder Justice

¶16,002 Sec. 2011. DEFINITIONS

[42 U.S.C. §1397]

In this subtitle:

(1) Definitions.—The term “abuse” means the knowing infliction of physical or psychological harm or the knowing deprivation of goods or services that are necessary to meet essential needs or to avoid physical or psychological harm.

(2) Adult Protective Services.—The term “adult protective services” means such services provided to adults as the Secretary may specify and includes services such as—
   (A) receiving reports of adult abuse, neglect, or exploitation;
   (B) investigating the reports described in subparagraph (A);
(C) case planning, monitoring, evaluation, and other case work and services; and

(D) providing, arranging for, or facilitating the provision of medical, social service, economic, legal, housing, law enforcement, or other protective, emergency, or support services.

(3) CAREGIVER.—The term “caregiver” means an individual who has the responsibility for the care of an elder, either voluntarily, by contract, by receipt of payment for care, or as a result of the operation of law, and means a family member or other individual who provides (on behalf of such individual or of a public or private agency, organization, or institution) compensated or uncompensated care to an elder who needs supportive services in any setting.

(4) DIRECT CARE.—The term “direct care” means care by an employee or contractor who provides assistance or long-term care services to a recipient.

(5) ELDER.—The term “elder” means an individual age 60 or older.

(6) ELDER JUSTICE.—The term “elder justice” means—

(A) from a societal perspective, efforts to—

(i) prevent, detect, treat, intervene in, and prosecute elder abuse, neglect, and exploitation; and

(ii) protect elders with diminished capacity while maximizing their autonomy; and

(B) from an individual perspective, the recognition of an elder’s rights, including the right to be free of abuse, neglect, and exploitation.

(7) ELIGIBLE ENTITY.—The term “eligible entity” means a State or local government agency, Indian tribe or tribal organization, or any other public or private entity that is engaged in and has expertise in issues relating to elder justice or in a field necessary to promote elder justice efforts.

(8) EXPLOITATION.—The term “exploitation” means the fraudulent or otherwise illegal, unauthorized, or improper act or process of an individual, including a caregiver or fiduciary, that uses the resources of an elder for monetary or personal benefit, profit, or gain, or that results in depriving an elder of rightful access to, or use of, benefits, resources, belongings, or assets.

(9) FIDUCIARY.—The term “fiduciary”—

(A) means a person or entity with the legal responsibility—

(i) to make decisions on behalf of and for the benefit of another person; and

(ii) to act in good faith and with fairness; and

(B) includes a trustee, a guardian, a conservator, an executor, an agent under a financial power of attorney or health care power of attorney, or a representative payee.

(10) GRANT.—The term “grant” includes a contract, cooperative agreement, or other mechanism for providing financial assistance.

(11) GUARDIANSHIP.—The term “guardianship” means—

(A) the process by which a State court determines that an adult individual lacks capacity to make decisions about self-care or property, and appoints another individual or entity known as a guardian, as a conservator, or by a similar term, as a surrogate decisionmaker;

(B) the manner in which the court-appointed surrogate decisionmaker carries out duties to the individual and the court; or

(C) the manner in which the court exercises oversight of the surrogate decisionmaker.

(12) INDIAN TRIBE.—

(A) IN GENERAL.—The term “Indian tribe” has the meaning given such term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b).

(B) INCLUSION OF PUEBLO AND RANCHERIA.—The term “Indian tribe” includes any Pueblo or Rancheria.

(13) LAW ENFORCEMENT.—The term “law enforcement” means the full range of potential responders to elder abuse, neglect, and exploitation including—

(A) police, sheriffs, detectives, public safety officers, and corrections personnel;

(B) prosecutors;

(C) medical examiners;

(D) investigators; and
(E) coroners.

(14) LONG-TERM CARE.—

(A) In general.—The term “long-term care” means supportive and health services specified by the Secretary for individuals who need assistance because the individuals have a loss of capacity for self-care due to illness, disability, or vulnerability.

(B) LOSS OF CAPACITY FOR SELF-CARE.—For purposes of subparagraph (A), the term “loss of capacity for self-care” means an inability to engage in 1 or more activities of daily living, including eating, dressing, bathing, management of one’s financial affairs, and other activities the Secretary determines appropriate.

(15) LONG-TERM CARE FACILITY.—The term “long-term care facility” means a residential care provider that arranges for, or directly provides, long-term care.

(16) NEGLECT.—The term “neglect” means—

(A) the failure of a caregiver or fiduciary to provide the goods or services that are necessary to maintain the health or safety of an elder; or

(B) self-neglect.

(17) NURSING FACILITY.—

(A) IN GENERAL.—The term “nursing facility” has the meaning given such term under section 1919(a).

(B) INCLUSION OF SKILLED NURSING FACILITY.—The term “nursing facility” includes a skilled nursing facility (as defined in section 1819(a)).

(18) SELF-NEGLECT.—The term “self-neglect” means an adult’s inability, due to physical or mental impairment or diminished capacity, to perform essential self-care tasks including—

(A) obtaining essential food, clothing, shelter, and medical care

(B) obtaining goods and services necessary to maintain physical health, mental health, or general safety; or

(C) managing one’s own financial affairs.

(19) SERIOUS BODILY INJURY.—

(A) IN GENERAL.—The term “serious bodily injury” means an injury—

(i) involving extreme physical pain;

(ii) involving substantial risk of death;

(iii) involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; or

(iv) requiring medical intervention such as surgery, hospitalization, or physical rehabilitation.

(B) CRIMINAL SEXUAL ABUSE.—Serious bodily injury shall be considered to have occurred if the conduct causing the injury is conduct described in section 2241 (relating to aggravated sexual abuse) or 2242 (relating to sexual abuse) of title 18, United States Code, or any similar offense under State law.

(20) SOCIAL.—The term “social”, when used with respect to a service, includes adult protective services.

(21) STATE LEGAL ASSISTANCE DEVELOPER.—The term “State legal assistance developer” means an individual described in section 731 of the Older Americans Act of 1965.

(22) STATE LONG-TERM CARE OMBUDSMAN.—The term “State Long-Term Care Ombudsman” means the State Long-Term Care Ombudsman described in section 712(a)(2) of the Older Americans Act of 1965.
[Explanation at ¶ 1905.]
2010 Amendments:
Sec. 6701(a) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148) added sec. 2011.

¶16,003 Sec. 2012. GENERAL PROVISIONS

[42 U.S.C. §1397j–1]

(a) PROTECTION OF PRIVACY.—In pursuing activities under this subtitle, the Secretary shall ensure the protection of individual health privacy consistent with the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 and applicable State and local privacy regulations.

(b) RULE OF CONSTRUCTION.—Nothing in this subtitle shall be construed to interfere with or abridge an elder’s right to practice his or her religion through reliance on prayer alone for healing when this choice—

(1) is contemporaneously expressed, either orally or in writing, with respect to a specific illness or injury which the elder has at the time of the decision by an elder who is competent at the time of the decision;

(2) is previously set forth in a living will, health care proxy, or other advance directive document that is validly executed and applied under State law; or

(3) may be unambiguously deduced from the elder’s life history.

[Explanation at ¶ 1905.]
2010 Amendments:
Sec. 6701(a) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148) added sec. 2012.

Part I—NATIONAL COORDINATION OF ELDER JUSTICE ACTIVITIES AND RESEARCH

Subpart A—Elder Justice Coordinating Council and Advisory Board on Elder Abuse, Neglect, and Exploitation

¶16,004 Sec. 2021. ELDER JUSTICE COORDINATING COUNCIL

[42 U.S.C. §1397k]

(a) ESTABLISHMENT.—There is established within the Office of the Secretary an Elder Justice Coordinating Council (in this section referred to as the “Council”).

(b) MEMBERSHIP.—(1) IN GENERAL.—The Council shall be composed of the following members:

(A) The Secretary (or the Secretary’s designee).

(B) The Attorney General (or the Attorney General’s designee).

(C) The head of each Federal department or agency or other governmental entity identified by the Chair referred to in subsection (d) as having responsibilities, or administering programs, relating to elder abuse, neglect, and exploitation.

(2) REQUIREMENT.—Each member of the Council shall be an officer or employee of the Federal Government.

(c) VACANCIES.—Any vacancy in the Council shall not affect its powers, but shall be filled in the same manner as the original appointment was made.

(d) CHAIR.—The member described in subsection (b)(1)(A) shall be Chair of the Council.

(e) MEETINGS.—The Council shall meet at least 2 times per year, as determined by the Chair.

(f) DUTIES.—(1) IN GENERAL.—The Council shall make recommendations to the Secretary for the coordination of activities of the Department of Health and Human Services, the Department of Justice, and other relevant Federal, State, local, and private agencies and entities, relating to elder abuse, neglect, and exploitation and other crimes against elders.
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(2) REPORT.—Not later than the date that is 2 years after the date of enactment of the Elder Justice Act of 2009 and every 2 years thereafter, the Council shall submit to the Committee on Finance of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report that—
   (A) describes the activities and accomplishments of, and challenges faced by—
      (i) the Council; and
      (ii) the entities represented on the Council; and
   (B) makes such recommendations for legislation, model laws, or other action as the Council determines to be appropriate.

(g) POWERS OF THE COUNCIL.—(1) INFORMATION FROM FEDERAL AGENCIES.—Subject to the requirements of section 2012(a), the Council may secure directly from any Federal department or agency such information as the Council considers necessary to carry out this section. Upon request of the Chair of the Council, the head of such department or agency shall furnish such information to the Council.

(2) POSTAL SERVICES.—The Council may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

(h) TRAVEL EXPENSES.—The members of the Council shall not receive compensation for the performance of services for the Council. The members shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Council. Notwithstanding section 1342 of title 31, United States Code, the Secretary may accept the voluntary and uncompensated services of the members of the Council.

(i) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Council without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

(j) STATUS AS PERMANENT COUNCIL.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Council.

(k) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.

[Explanation at ¶ 1905.]
2010 Amendments:
Sec. 6701(a) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148) added sec. 2021.

[¶ 16,005] Sec. 202. ADVISORY BOARD ON ELDER ABUSE, NEGLECT, AND EXPLOITATION

[42 U.S.C. §1397k-1]

(a) ESTABLISHMENT.—There is established a board to be known as the “Advisory Board on Elder Abuse, Neglect, and Exploitation” (in this section referred to as the “Advisory Board”) to create short-and long-term multidisciplinary strategic plans for the development of the field of elder justice and to make recommendations to the Elder Justice Coordinating Council established under section 2021.

(b) COMPOSITION.—The Advisory Board shall be composed of 27 members appointed by the Secretary from among members of the general public who are individuals with experience and expertise in elder abuse, neglect, and exploitation prevention, detection, treatment, intervention, or prosecution.

(c) SOLICITATION OF NOMINATIONS.—The Secretary shall publish a notice in the Federal Register soliciting nominations for the appointment of members of the Advisory Board under subsection (b).

(d) TERMS.—Terms.—

(1) IN GENERAL.—Each member of the Advisory Board shall be appointed for a term of 3 years, except that, of the members first appointed—
   (A) 9 shall be appointed for a term of 3 years;
(B) 9 shall be appointed for a term of 2 years; and
(C) 9 shall be appointed for a term of 1 year.

(2) VACANCIES.—
(A) IN GENERAL.—Any vacancy on the Advisory Board shall not affect its powers, but shall be filled in the same manner as the original appointment was made.
(B) FILLING UNEXPIRED TERM.—An individual chosen to fill a vacancy shall be appointed for the unexpired term of the member replaced.

(3) EXPIRATION OF TERMS.—The term of any member shall not expire before the date on which the member’s successor takes office.

(e) ELECTION OF OFFICERS.—The Advisory Board shall elect a Chair and Vice Chair from among its members. The Advisory Board shall elect its initial Chair and Vice Chair at its initial meeting.

(f) DUTIES.—(1) ENHANCE COMMUNICATION ON PROMOTING QUALITY OF, AND PREVENTING ABUSE, NEGLECT, AND EXPLOITATION IN, LONG-TERM CARE.—The Advisory Board shall develop collaborative and innovative approaches to improve the quality of, including preventing abuse, neglect, and exploitation in, long-term care.

(A) IN GENERAL.—The Advisory Board shall establish multidisciplinary panels to address, and develop consensus on, subjects relating to improving the quality of long-term care. At least 1 such panel shall address, and develop consensus on, methods for managing resident-to-resident abuse in long-term care.

(B) ACTIVITIES CONDUCTED.—The multidisciplinary panels established under subparagraph (A) shall examine relevant research and data, identify best practices with respect to the subject of the panel, determine the best way to carry out those best practices in a practical and feasible manner, and determine an effective manner of distributing information on such subject.

(3) REPORT.—Not later than the date that is 18 months after the date of enactment of the Elder Justice Act of 2009, and annually thereafter, the Advisory Board shall prepare and submit to the Elder Justice Coordinating Council, the Committee on Finance of the Senate, and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report containing—

(A) information on the status of Federal, State, and local public and private elder justice activities;
(B) recommendations (including recommended priorities) regarding—
   (i) elder justice programs, research, training, services, practice, enforcement, and coordination;
   (ii) coordination between entities pursuing elder justice efforts and those involved in related areas that may inform or overlap with elder justice efforts, such as activities to combat violence against women and child abuse and neglect; and
   (iii) activities relating to adult fiduciary systems, including guardianship and other fiduciary arrangements;
(C) recommendations for specific modifications needed in Federal and State laws (including regulations) or for programs, research, and training to enhance prevention, detection, and treatment (including diagnosis) of, intervention in (including investigation of), and prosecution of elder abuse, neglect, and exploitation;
(D) recommendations on methods for the most effective coordinated national data collection with respect to elder justice, and elder abuse, neglect, and exploitation; and
(E) recommendations for a multidisciplinary strategic plan to guide the effective and efficient development of the field of elder justice.

(g) POWERS OF THE ADVISORY BOARD.—(1) INFORMATION FROM FEDERAL AGENCIES.—Subject to the requirements of section 2012(a), the Advisory Board may secure directly from any Federal department or agency such information as the Advisory Board considers necessary to carry out this section. Upon request of the Chair of the Advisory Board, the head of such department or agency shall furnish such information to the Advisory Board.
(2) **SHARING OF DATA AND REPORTS.**—The Advisory Board may request from any entity pursuing elder justice activities under the Elder Justice Act of 2009 or an amendment made by that Act, any data, reports, or recommendations generated in connection with such activities.

(3) **POSTAL SERVICES.**—The Advisory Board may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

(b) **TRAVEL EXPENSES.**—The members of the Advisory Board shall not receive compensation for the performance of services for the Advisory Board. The members shall be allowed travel expenses for up to 4 meetings per year, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Advisory Board. Notwithstanding section 1342 of title 31, United States Code, the Secretary may accept the voluntary and uncompensated services of the members of the Advisory Board.

(i) **DETAIL OF GOVERNMENT EMPLOYEES.**—Any Federal Government employee may be detailed to the Advisory Board without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

(j) **STATUS AS PERMANENT ADVISORY COMMITTEE.**—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the advisory board.

(k) **AUTHORIZATION OF APPROPRIATIONS.**—There are authorized to be appropriated such sums as are necessary to carry out this section.

[Explanation at ¶ 1905.]

2010 Amendments:

Sec. 6701(a) of the “Patient Protection and Affordable Care Act” (Pub.L. No. 111-148) added sec. 2023.

[¶ 16,006] Sec. 2023. **RESEARCH PROTECTIONS**

[42 U.S.C. §1397k-2]

(a) **GUIDELINES.**—The Secretary shall promulgate guidelines to assist researchers working in the area of elder abuse, neglect, and exploitation, with issues relating to human subject protections.

(b) **DEFINITION OF LEGALLY AUTHORIZED REPRESENTATIVE FOR APPLICATION OF REGULATIONS.**—For purposes of the application of subpart A of part 46 of title 45, Code of Federal Regulations, to research conducted under this subpart, the term “legally authorized representative” means, unless otherwise provided by law, the individual or judicial or other body authorized under the applicable law to consent to medical treatment on behalf of another person.

[Explanation at ¶ 1905.]

2010 Amendments:

Sec. 6701(a) of the “Patient Protection and Affordable Care Act” (Pub.L. No. 111-148) added sec. 2023.

[¶ 16,008] Sec. 2024. **AUTHORIZATION OF APPROPRIATIONS**

[42 U.S.C. §1397k-3]

There are authorized to be appropriated to carry out this subpart—

(1) for fiscal year 2011, $6,500,000; and

(2) for each of fiscal years 2012 through 2014, $7,000,000.
Subpart B—Elder Abuse, Neglect, and Exploitation Forensic Centers

Sec. 2031. ESTABLISHMENT AND SUPPORT OF ELDER ABUSE, NEGLECT, AND EXPLOITATION FORENSIC CENTERS

[42 U.S.C. §1397l]  
(a) IN GENERAL.—The Secretary, in consultation with the Attorney General, shall make grants to eligible entities to establish and operate stationary and mobile forensic centers, to develop forensic expertise regarding, and provide services relating to, elder abuse, neglect, and exploitation.

(b) STATIONARY FORENSIC CENTERS.—The Secretary shall make 4 of the grants described in subsection (a) to institutions of higher education with demonstrated expertise in forensics or commitment to preventing or treating elder abuse, neglect, or exploitation, to establish and operate stationary forensic centers.

(c) MOBILE CENTERS.—The Secretary shall make 6 of the grants described in subsection (a) to appropriate entities to establish and operate mobile forensic centers.

(d) AUTHORIZED ACTIVITIES.—(1) DEVELOPMENT OF FORENSIC MARKERS AND METHODOLOGIES.—An eligible entity that receives a grant under this section shall use funds made available through the grant to assist in determining whether abuse, neglect, or exploitation occurred and whether a crime was committed and to conduct research to describe and disseminate information on—

(A) forensic markers that indicate a case in which elder abuse, neglect, or exploitation may have occurred; and

(B) methodologies for determining, in such a case, when and how health care, emergency service, social and protective services, and legal service providers should intervene and when the providers should report the case to law enforcement authorities.

(2) DEVELOPMENT OF FORENSIC EXPERTISE.—An eligible entity that receives a grant under this section shall use funds made available through the grant to develop forensic expertise regarding elder abuse, neglect, and exploitation in order to provide medical and forensic evaluation, therapeutic intervention, victim support and advocacy, case review, and case tracking.

(3) COLLECTION OF EVIDENCE.—The Secretary, in coordination with the Attorney General, shall use data made available by grant recipients under this section to develop the capacity of geriatric health care professionals and law enforcement to collect forensic evidence, including collecting forensic evidence relating to a potential determination of elder abuse, neglect, or exploitation.

(e) APPLICATION.—To be eligible to receive a grant under this section, an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

(1) for fiscal year 2011, $4,000,000;

(2) for fiscal year 2012, $6,000,000;

(3) for each of fiscal years 2013 and 2014, $8,000,000.
Part II—PROGRAMS TO PROMOTE ELDER JUSTICE

[¶ 16,010] Sec. 2041. ENHANCEMENT OF LONG-TERM CARE

[42 U.S.C. §1397m]

(a) GRANTS AND INCENTIVES FOR LONG-TERM CARE STAFFING.—(1) IN GENERAL.—The Secretary shall carry out activities, including activities described in paragraphs (2) and (3), to provide incentives for individuals to train for, seek, and maintain employment providing direct care in long-term care.

(2) SPECIFIC PROGRAMS TO ENHANCE TRAINING, RECRUITMENT, AND RETENTION OF STAFF.—

(A) COORDINATION WITH SECRETARY OF LABOR TO RECRUIT AND TRAIN LONG-TERM CARE STAFF.—The Secretary shall coordinate activities under this subsection with the Secretary of Labor in order to provide incentives for individuals to train for and seek employment providing direct care in long-term care.

(B) CAREER LADDERS AND WAGE OR BENEFIT INCREASES TO INCREASE STAFFING IN LONG-TERM CARE.—

(i) IN GENERAL.—The Secretary shall make grants to eligible entities to carry out programs through which the entities

(I) offer, to employees who provide direct care to residents of an eligible entity or individuals receiving community-based long-term care from an eligible entity, continuing training and varying levels of certification, based on observed clinical care practices and the amount of time the employees spend providing direct care; and

(II) provide, or make arrangements to provide, bonuses or other increased compensation or benefits to employees who achieve certification under such a program.

(ii) APPLICATION.—To be eligible to receive a grant under this subparagraph, an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require (which may include evidence of consultation with the State in which the eligible entity is located with respect to carrying out activities funded under the grant).

(iii) AUTHORITY TO LIMIT NUMBER OF APPLICANTS.—Nothing in this subparagraph shall be construed as prohibiting the Secretary from limiting the number of applicants for a grant under this subparagraph.

(3) SPECIFIC PROGRAMS TO IMPROVE MANAGEMENT PRACTICES.—

(A) IN GENERAL.—The Secretary shall make grants to eligible entities to enable the entities to provide training and technical assistance.

(B) AUTHORIZED ACTIVITIES.—An eligible entity that receives a grant under subparagraph (A) shall use funds made available through the grant to provide training and technical assistance regarding management practices using methods that are demonstrated to promote retention of individuals who provide direct care, such as—

(i) the establishment of standard human resource policies that reward high performance, including policies that provide for improved wages and benefits on the basis of job reviews;

(ii) the establishment of motivational and thoughtful work organization practices;

(iii) the creation of a workplace culture that respects and values caregivers and their needs;

(iv) the promotion of a workplace culture that respects the rights of residents of an eligible entity or individuals receiving community-based long-term care from an eligible entity and results in improved care for the residents or the individuals; and

(v) the establishment of other programs that promote the provision of high quality care, such as a continuing education program that provides additional hours of training, including on-the-job training, for employees who are certified nurse aides.
(C) **APPLICATION.**—To be eligible to receive a grant under this paragraph, an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require (which may include evidence of consultation with the State in which the eligible entity is located with respect to carrying out activities funded under the grant).

(D) **AUTHORITY TO LIMIT NUMBER OF APPLICANTS.**—Nothing in this paragraph shall be construed as prohibiting the Secretary from limiting the number of applicants for a grant under this paragraph.

(4) **ACCOUNTABILITY MEASURES.**—The Secretary shall develop accountability measures to ensure that the activities conducted using funds made available under this subsection benefit individuals who provide direct care and increase the stability of the long-term care workforce.

(5) **DEFINITIONS.**—In this subsection:

(A) **COMMUNITY-BASED LONG-TERM CARE.**—The term “community-based long-term care” has the meaning given such term by the Secretary.

(B) **ELIGIBLE ENTITY.**—The term “eligible entity” means the following:

(i) A long-term care facility.

(ii) A community-based long-term care entity (as defined by the Secretary).

(b) **CERTIFIED EHR TECHNOLOGY GRANT PROGRAM.**—(1) **GRANTS AUTHORIZED.**—The Secretary is authorized to make grants to long-term care facilities for the purpose of assisting such entities in offsetting the costs related to purchasing, leasing, developing, and implementing certified EHR technology (as defined in section 1848(o)(4)) designed to improve patient safety and reduce adverse events and health care complications resulting from medication errors.

(2) **USE OF GRANT FUNDS.**—Funds provided under grants under this subsection may be used for any of the following:

(A) Purchasing, leasing, and installing computer software and hardware, including handheld computer technologies.

(B) Making improvements to existing computer software and hardware.

(C) Making upgrades and other improvements to existing computer software and hardware to enable e-prescribing.

(D) Providing education and training to eligible long-term care facility staff on the use of such technology to implement the electronic transmission of prescription and patient information.

(3) **APPLICATION.**—

(A) **IN GENERAL.**—To be eligible to receive a grant under this subsection, a long-term care facility shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require (which may include evidence of consultation with the State in which the long-term care facility is located with respect to carrying out activities funded under the grant).

(B) **AUTHORITY TO LIMIT NUMBER OF APPLICANTS.**—Nothing in this subsection shall be construed as prohibiting the Secretary from limiting the number of applicants for a grant under this subsection.

(4) **PARTICIPATION IN STATE HEALTH EXCHANGES.**—A long-term care facility that receives a grant under this subsection shall, where available, participate in activities conducted by a State or a qualified State-designated entity (as defined in section 3013(f) of the Public Health Service Act) under a grant under section 3013 of the Public Health Service Act to coordinate care and for other purposes determined appropriate by the Secretary.

(5) **ACCOUNTABILITY MEASURES.**—The Secretary shall develop accountability measures to ensure that the activities conducted using funds made available under this subsection help improve patient safety and reduce adverse events and health care complications resulting from medication errors.

(c) **ADOPTION OF STANDARDS FOR TRANSACTIONS INVOLVING CLINICAL DATA BY LONG-TERM CARE FACILITIES.**—

(1) **STANDARDS AND COMPATIBILITY.**—The Secretary shall adopt electronic standards for the exchange of clinical data by long-term care facilities, including, where available, standards for messaging and nomenclature. Standards adopted by the Secretary under the preceding sentence shall be compatible with standards established under part C of title XI, standards established under subsections (b)(2)(B)(i) and

¶16,010 §2041(a)(3)(C)
(e)(4) of section 1860D-4, standards adopted under section 3004 of the Public Health Service Act, and general health information technology standards.

(2) **Electronic Submission of Data to the Secretary.**—
   (A) In general.—Not later than 10 years after the date of enactment of the Elder Justice Act of 2009, the Secretary shall have procedures in place to accept the optional electronic submission of clinical data by long-term care facilities pursuant to the standards adopted under paragraph (1).
   
   (B) Rule of construction.—Nothing in this subsection shall be construed to require a long-term care facility to submit clinical data electronically to the Secretary.

(3) **Regulations.**—The Secretary shall promulgate regulations to carry out this subsection. Such regulations shall require a State, as a condition of the receipt of funds under this part, to conduct such data collection and reporting as the Secretary determines are necessary to satisfy the requirements of this subsection.

(d) **Authorization of Appropriations.**—There are authorized to be appropriated to carry out this section—
   
   (1) for fiscal year 2011, $20,000,000;
   (2) for fiscal year 2012, $17,500,000; and
   (3) for each of fiscal years 2013 and 2014, $15,000,000.

[Explanation at ¶ 1905.]

2010 Amendments:
Sec. 6701(a) of the “Patient Protection and Affordable Care Act” (Pub.L. No. 111-148) added sec. 2041.

[¶ 16,011] Sec. 2042. **ADULT PROTECTIVE SERVICES FUNCTIONS AND GRANT PROGRAMS**

[42 U.S.C. §1397m-1]

(a) **Secretaryial Responsibilities.**—(1) **In General.**—The Secretary shall ensure that the Department of Health and Human Services—
   
   (A) provides funding authorized by this part to State and local adult protective services offices that investigate reports of the abuse, neglect, and exploitation of elders;
   
   (B) collects and disseminates data annually relating to the abuse, exploitation, and neglect of elders in coordination with the Department of Justice;
   
   (C) develops and disseminates information on best practices regarding, and provides training on, carrying out adult protective services;
   
   (D) conducts research related to the provision of adult protective services; and
   
   (E) provides technical assistance to States and other entities that provide or fund the provision of adult protective services, including through grants made under subsections (b) and (c).

(2) **Authorization of Appropriations.**—There are authorized to be appropriated to carry out this subsection, $3,000,000 for fiscal year 2011 and $4,000,000 for each of fiscal years 2012 through 2014.

(b) **Grants to Enhance the Provision of Adult Protective Services.**—(1) **Establishment.**—There is established an adult protective services grant program under which the Secretary shall annually award grants to States in the amounts calculated under paragraph (2) for the purposes of enhancing adult protective services provided by States and local units of government.

(2) **Amount of Payment.**—
   
   (A) In general.—Subject to the availability of appropriations and subparagraphs (B) and (C), the amount paid to a State for a fiscal year under the program under this subsection shall equal the amount appropriated for that year to carry out this subsection multiplied by the percentage of the total number of elders who reside in the United States who reside in that State.

   (B) Guaranteed Minimum Payment Amount.—
   
   (i) 50 States.—Subject to clause (ii), if the amount determined under subparagraph (A) for a State for a fiscal year is less than 0.75 percent of the amount appropriated for such year, the
Secretary shall increase such determined amount so that the total amount paid under this subsection to the State for the year is equal to 0.75 percent of the amount so appropriated.

(ii) TERRITORIES.—In the case of a State other than 1 of the 50 States, clause (i) shall be applied as if each reference to “0.75” were a reference to “0.1”.

(C) PRO RATA REDUCTIONS.—The Secretary shall make such pro rata reductions to the amounts described in subparagraph (A) as are necessary to comply with the requirements of subparagraph (B).

(3) AUTHORIZED ACTIVITIES.—

(A) ADULT PROTECTIVE SERVICES.—Funds made available pursuant to this subsection may only be used by States and local units of government to provide adult protective services and may not be used for any other purpose.

(B) USE BY AGENCY.—Each State receiving funds pursuant to this subsection shall provide such funds to the agency or unit of State government having legal responsibility for providing adult protective services within the State.

(C) SUPPLEMENT NOT SUPPLANT.—Each State or local unit of government shall use funds made available pursuant to this subsection to supplement and not supplant other Federal, State, and local public funds expended to provide adult protective services in the State.

(4) STATE REPORTS.—Each State receiving funds under this subsection shall submit to the Secretary, at such time and in such manner as the Secretary may require, a report on the number of elders served by the grants awarded under this subsection.

(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, $100,000,000 for each of fiscal years 2011 through 2014.

(c) STATE DEMONSTRATION PROGRAMS.—(1) ESTABLISHMENT.—The Secretary shall award grants to States for the purposes of conducting demonstration programs in accordance with paragraph (2).

(2) DEMONSTRATION PROGRAMS.—Funds made available pursuant to this subsection may be used by States and local units of government to conduct demonstration programs that test—

(A) training modules developed for the purpose of detecting or preventing elder abuse;

(B) methods to detect or prevent financial exploitation of elders;

(C) methods to detect elder abuse;

(D) whether training on elder abuse forensics enhances the detection of elder abuse by employees of the State or local unit of government; or

(E) other matters relating to the detection or prevention of elder abuse.

(3) APPLICATION.—To be eligible to receive a grant under this subsection, a State shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(4) STATE REPORTS.—Each State that receives funds under this subsection shall submit to the Secretary a report at such time, in such manner, and containing such information as the Secretary may require on the results of the demonstration program conducted by the State using funds made available under this subsection.

(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, $25,000,000 for each of fiscal years 2011 through 2014.

[Explanation at ¶ 1905.]
2010 Amendments:
Sec. 6701(a) of the “Patient Protection and Affordable Care Act” (Pub.L.No 111-148) added sec. 2042.

¶16,012 §2043. LONG-TERM CARE OMBUDSMAN PROGRAM GRANTS AND TRAINING

[42 U.S.C. §1397m-2]

(a) GRANTS TO SUPPORT THE LONG-TERM CARE OMBUDSMAN PROGRAM.—(1) IN GENERAL.—The Secretary shall make grants to eligible entities with relevant expertise and experience in abuse and neglect in long-term care facilities or long-term care ombudsman programs and responsibilities, for the purpose of—
improving the capacity of State long-term care ombudsman programs to respond to and resolve complaints about abuse and neglect;

(B) conducting pilot programs with State long-term care ombudsman offices or local ombudsman entities; and

(C) providing support for such State long-term care ombudsman programs and such pilot programs (such as through the establishment of a national long-term care ombudsman resource center).

(2) **Authorization of Appropriations.**—There are authorized to be appropriated to carry out this subsection—

(A) for fiscal year 2011, $5,000,000;

(B) for fiscal year 2012, $7,500,000; and

(C) for each of fiscal years 2013 and 2014, $10,000,000.

(b) **Ombudsman Training Programs.**—(1) In general.—The Secretary shall establish programs to provide and improve ombudsman training with respect to elder abuse, neglect, and exploitation for national organizations and State long-term care ombudsman programs.

(2) **Authorization of appropriations.**—There are authorized to be appropriated to carry out this subsection, for each of fiscal years 2011 through 2014, $10,000,000.
(c) **Evaluations and Audits of Certified EHR Technology Grant Program by the Secretary.**

(1) **Evaluations.** The Secretary shall conduct an evaluation of the activities funded under the certified EHR technology grant program under section 2041(b). Such evaluation shall include an evaluation of whether the funding provided under the grant is expended only for the purposes for which it is made.

(2) **Audits.** The Secretary shall conduct appropriate audits of grants made under section 2041(b).

[Explanation at ¶ 1905.]

2010 Amendments:
Sec. 6701(a) of the "Patient Protection and Affordable Care Act" (PubL No 111-148) added sec. 2044.

¶16,014 **Sec. 2045. REPORT**

**[42 U.S.C. §1397m-4]**

Not later than October 1, 2014, the Secretary shall submit to the Elder Justice Coordinating Council established under section 2021, the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives, and the Committee on Finance of the Senate a report—

(1) compiling, summarizing, and analyzing the information contained in the State reports submitted under subsections (b)(4) and (c)(4) of section 2042; and

(2) containing such recommendations for legislative or administrative action as the Secretary determines to be appropriate.

[Explanation at ¶ 1905.]

2010 Amendments:
Sec. 6701(a) of the "Patient Protection and Affordable Care Act" (PubL No 111-148) added sec. 2045.

¶16,015 **Sec. 2046. RULE OF CONSTRUCTION**

**[42 U.S.C. §1397m-5]**

Nothing in this subtitle shall be construed as—

(1) limiting any cause of action or other relief related to obligations under this subtitle that is available under the law of any State, or political subdivision thereof; or

(2) creating a private cause of action for a violation of this subtitle.

[Explanation at ¶ 1905.]

2010 Amendments:
Sec. 6701(a) of the "Patient Protection and Affordable Care Act" (PubL No 111-148) added sec. 2046.

¶16,031 **Sec. 2102. GENERAL CONTENTS OF STATE CHILD HEALTH PLAN; ELIGIBILITY; OUTREACH**

**[42 U.S.C. §1397bb]**

### (b)(1)

### (B)

(iii) may not apply a waiting period (including a waiting period to carry out paragraph (3)(C)) in the case of a targeted low-income pregnant woman provided pregnancy-related assistance under section 2112;

(iv) at State option, may not apply a waiting period in the case of a child provided dental-only supplemental coverage under section 2110(b)(5); and

¶16,014 §2044(c)
(v) shall, beginning January 1, 2014, use modified adjusted gross income and household income (as defined in section 36B(d)(2) of the Internal Revenue Code of 1986) to determine eligibility for child health assistance under the State child health plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required, including with respect to the imposition of premiums and cost-sharing, consistent with section 1902(e)(14).

***

[Explanation at ¶ 507 and ¶ 580.]

2010 Amendments:

Sec. 2101(d)(1) of the “Patient Protection and Affordable Care Act” (Pub.L. No. 111-148), effective March 23, 2010, amended sec. 2102(b)(1)(B), in clause (iii), by striking “and” after the semicolon, in clause (iv), by striking the period and inserting “; and” and by adding at the end the new clause (v).


¶ 16,041 Sec. 2104. Allotments

[42 U.S.C. §1397dd]

(a) **

(15) for fiscal year 2012, $14,982,000,000;
(16) for fiscal year 2013, $17,406,000,000;
(17) for fiscal year 2014, $19,147,000,000; and
(18) for fiscal year 2015, for purposes of making 2 semi-annual allotments—
  (A) $2,850,000,000 for the period beginning on October 1, 2014, and ending on March 31, 2015, and
  (B) $2,850,000,000 for the period beginning on April 1, 2015, and ending on September 30, 2015.

***

(m) Allotments for Fiscal Years 2009 Through 2015—

***

(2) For fiscal years 2010 through 2014—

***

(B) Fiscal Years 2013 and 2014.—Subject to paragraphs (4) and (6), from the amount made available under paragraphs (16) and (17) of subsection (a) for fiscal years 2013 and 2014, respectively, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and territory) for each such fiscal year as follows:

(i) Rebasing in Fiscal Year 2013.—For fiscal year 2013, the allotment of the State is equal to the Federal payments to the State that are attributable to (and countable towards) the total amount of allotments available under this section to the State in fiscal year 2012 (including payments made to the State under subsection (n) for fiscal year 2012 as well as amounts redistributed to the State in fiscal year 2012), multiplied by the allotment increase factor under paragraph (5) for fiscal year 2013.

(ii) Growth Factor Update for Fiscal Year 2014.—For fiscal year 2014, the allotment of the State is equal to the sum of—
  (I) the amount of the State allotment under clause (i) for fiscal year 2013; and
  (II) the amount of any payments made to the State under subsection (n) for fiscal year 2013,
multiplied by the allotment increase factor under paragraph (5) for fiscal year 2014.
(3) FOR FISCAL YEAR 2015—

(A) FIRST HALF.—Subject to paragraphs (4) and (6), from the amount made available under subparagraph (A) of paragraph (18) of subsection (a) for the semi-annual period described in such paragraph, increased by the amount of the appropriation for such period under section 108 of the Children’s Health Insurance Program Reauthorization Act of 2009, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and territory) for such semi-annual period in an amount equal to the first half ratio (described in subparagraph (D)) of the amount described in subparagraph (C).

(B) SECOND HALF.—Subject to paragraphs (4) and (6), from the amount made available under subparagraph (B) of paragraph (18) of subsection (a) for the semi-annual period described in such paragraph, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and territory) for such semi-annual period in an amount equal to the amount made available under such subparagraph, multiplied by the ratio of—


(C) FULL YEAR AMOUNT BASED ON REBASED AMOUNT.—The amount described in this subparagraph for a State is equal to the Federal payments to the State that are attributable to (and countable towards) the total amount of allotments available under this section to the State in fiscal year 2014 (including payments made to the State under subsection (n) for fiscal year 2012 as well as amounts redistributed to the State in fiscal year 2014), multiplied by the allotment increase factor under paragraph (5) for fiscal year 2015.

(D) 

(i) 

(I) the amount made available under subsection (a)(18)(A); and

(ii) 

(II) the amount made available under subsection (a)(18)(B).

(4) PRORATION RULE.—If, after the application of this subsection without regard to this paragraph, the sum of the allotments determined under paragraph (1), (2), or (3) for a fiscal year (or, in the case of fiscal year 2015, for a semi-annual period in such fiscal year) exceeds the amount available under subsection (a) for such fiscal year or period, the Secretary shall reduce each allotment for any State under such paragraph for such fiscal year or period on a proportional basis.

(6) 

(A) has submitted to the Secretary, and has approved by the Secretary, a State plan amendment or waiver request relating to an expansion of eligibility for children or benefits under this title that becomes effective for a fiscal year (beginning with fiscal year 2010 and ending with fiscal year 2015); and

(B) 

(ii)
subject to paragraph (4), the amount of the allotment of the State or District under this subsection for such fiscal year shall be increased by the excess amount described in subparagraph (B)(i). A State or District may only obtain an increase under this paragraph for an allotment for fiscal year 2010, fiscal year 2012, or fiscal year 2014.

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

(8) AVAILABILITY OF AMOUNTS FOR SEMI-ANNUAL PERIODS IN FISCAL YEAR 2015.—Each semi-annual allotment made under paragraph (3) for a period in fiscal year 2015 shall remain available for expenditure under this title for periods after the end of such fiscal year in the same manner as if the allotment had been made available for the entire fiscal year.

\( (\text{n}) \)

\( (\text{2}) (A) \)

\( (\text{ii}) \) for each of fiscal years 2010 through 2014 (and for each of the semi-annual allotment periods for fiscal year 2015), such sums as are necessary for making payments to eligible States for such fiscal year or period, but not in excess of the aggregate cap described in subparagraph (B).

\( (B) \) AGGREGATE CAP.—The total amount available for payment from the Fund for each of fiscal years 2010 through 2014 (and for each of the semi-annual allotment periods for fiscal year 2015), taking into account deposits made under subparagraph (C), shall not exceed 20 percent of the amount made available under subsection (a) for the fiscal year or period.

\[ \text{Explanation at \( \S \) 566 and \( \S \) 585.} \]

2010 Amendments:

Sec. 10203(d)(1) of the “Patient Protection and Affordable Care Act of 2010” (PubLNo 111-148), effective March 23, 2010, amended sec. 2104(a), by striking “and” at the end in paragraph (15), and by striking original paragraph (16) and inserting the new paragraph (16), (17), and (18). Prior to amendment, Act Sec. 2104(a)(16) read as follows:

"(16) for fiscal year 2013, for purposes of making 2 semi-annual allotments—"

"(A)$2,850,000,000 for the period beginning on October 1, 2010, and ending on March 31, 2011; fiscal year 2011, fiscal year 2012, fiscal year 2013, fiscal year 2014, or a semi-annual allotment period for fiscal year 2015, exceed the total amount of allotments available under this section to the State in the fiscal year or period (determined without regard to any redistribution it receives under subsection (f) that is available for expenditure during such fiscal year or period, but including any carryover from a previous fiscal year) and if the average monthly unduplicated number of children enrolled under the State plan under this title (including children receiving health care coverage through funds under this title pursuant to a waiver under section 1115) during such fiscal year or period exceeds its target average number of such enrollees (as determined under subparagraph (B)) for that fiscal year or period, subject to subparagraph (D), the Secretary shall pay to the State from the Fund an amount equal to the product of—"

"(B)$2,850,000,000 for the period beginning on April 1, 2013, and ending on September 30, 2013."

Sec. 10203(d)(2)(A) of the “Patient Protection and Affordable Care Act of 2010” (PubLNo 111-148), effective March 23, 2010, made the following changes:

Sec. 2102(a)(1) of the “Patient Protection and Affordable Care Act of 2010” (PubLNo 111-148), effective February 4, 2009, amended sec. 2104(m), by redesignating paragraph (7) as paragraph (8), and by inserting after paragraph (6), the new paragraph (7).

Sec. 10203(d)(2)(A) of the “Patient Protection and Affordable Care Act of 2010” (PubLNo 111-148), effective March 23, 2010, made the following changes:
in sec. 2104(m), by striking “2013” and inserting “2015” in the subsection heading;

in the paragraph (2) heading, by striking “2012” and inserting “2014”; and by adding at the end the new subparagraph (B);

in the paragraph (3) heading, by striking “2013” and inserting “2015”; in subparagraphs (A) and (B), by striking “paragraph (16)” each place it appears and inserting “paragraph (18)”;

in paragraph (4), by striking “2013” and inserting “2015”;

in paragraph (6), in subparagraph (A), by striking “2013” and inserting “2015”; in the flush language after and below subparagraph (B)(ii), by striking “or fiscal year 2012” and inserting “, fiscal year 2012, or fiscal year 2014”; and by striking “2013” and inserting “2015”;

in paragraph (8), in the paragraph heading, by striking “2013” and inserting “2015”; by striking “2013” and inserting “2015”.


in subparagraph (B), by striking “2012” and inserting “2014”; by striking “2013” and inserting “2015”;

in paragraph (3)(A), by striking “or a semi-annual allotment period for fiscal year 2013” and inserting “fiscal year 2013, fiscal year 2014, or a semi-annual allotment period for fiscal year 2015”.

[¶ 16,051] Sec. 2105. PAYMENTS TO STATES

[42 U.S.C. § 1397ee]

(a)

***

(3)

***

(C)

***

(i)

***

(I) the monthly average unduplicated number of qualifying children (as defined in subparagraph (F)) enrolled during the fiscal year under the State plan under title XIX; exceeds

(II) the baseline number of enrollees described in clause (iii) for the State and fiscal year under title XIX; but not to exceed 10 percent of the baseline number of enrollees described in subclause (II).

***

(E)

***

(ii)

***

(F)

***

(iii) EXCLUSION.—Such term does not include any children for whom the State has made an election to provide medical assistance under paragraph (4) of section 1903(v) or any children enrolled on or after October 1, 2013.

***

(b) ENHANCED FMAP.—For purposes of subsection (a), the “enhanced FMAP”, for a State for a fiscal year, is equal to the Federal medical assistance percentage (as defined in the first sentence of section 1905(b)) for the State increased by a number of percentage points equal to 30 percent of the number of percentage points by which (I) such Federal medical assistance percentage for the State, is less than (II) 100 percent; but in no case shall the enhanced FMAP for a State exceed 85 percent. Notwithstanding the preceding sentence, during the period that begins on October 1, 2015, and ends on September 30, 2019, the enhanced FMAP determined for a State for a fiscal year (or for any portion of a fiscal year occurring during such period) shall be increased by 23 percentage points, but in no case shall exceed 100

¶16,051 §2105
percent. The increase in the enhanced FMAP under the preceding sentence shall not apply with respect to determining the payment to a State under subsection (a)(1) for expenditures described in subparagraph (D)(iv), paragraphs (8), (9), (11) of subsection (c), or clause (4) of the first sentence of section 1905(b).

(c) ***

(3) ***

(A) purchase of such coverage is cost-effective relative to—

(ii) the aggregate amount of expenditures that the State would have made under the State child health plan, including administrative expenditures, for providing coverage under such plan for all such children or families;

(9) ***

(B) ENHANCED PAYMENTS. — Notwithstanding subsection (b), the enhanced FMAP with respect to payments under subsection (a) for expenditures described in clause (i) or (ii) of section 1903(a)(3)(G) necessary to comply with subparagraph (A) shall in no event be less than 90 percent and 75 percent, respectively.

(10)(A) IN GENERAL. — A State may elect to offer a premium assistance subsidy (as defined in subparagraph (C)) for qualified employer-sponsored coverage (as defined in subparagraph (B)) to all targeted low-income children who are eligible for child health assistance under the plan and have access to such coverage in accordance with the requirements of this paragraph if the offering of such a subsidy is cost-effective, as defined for purposes of paragraph (3)(A). No subsidy shall be provided to a targeted low-income child under this paragraph unless the child (or the child’s parent) voluntarily elects to receive such a subsidy. A State may not require such an election as a condition of receipt of child health assistance.

(M) COORDINATION WITH MEDICAID. — In the case of a targeted low-income child who receives child health assistance through a State plan under title XIX and who voluntarily elects to receive a premium assistance subsidy under this section, the provisions of section 1906A shall apply and shall supersede any other provisions of this paragraph that are inconsistent with such section.

(d)(1) IN MEDICAID ELIGIBILITY STANDARDS. — No payment may be made under subsection (a) with respect to child health assistance provided under a State child health plan if the State adopts income and resource standards and methodologies for purposes of determining a child’s eligibility for medical assistance under the State plan under title XIX that are more restrictive than those applied as of June 1, 1997, except as required under section 1902(e)(14).

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

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

(ii) after September 30, 2015, enrolling children eligible to be targeted low-income children under the State child health plan in a qualified health plan that has been certified by the Secretary under subparagraph (C); or

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

(B) ASSURANCE OF EXCHANGE COVERAGE FOR TARGETED LOW-INCOME CHILDREN UNABLE TO BE PROVIDED CHILD HEALTH ASSISTANCE AS A RESULT OF FUNDING SHORTFALLS.—In the event that allotments provided under section 2104 are insufficient to provide coverage to all children who are eligible to be targeted low-income children under the State child health plan under this title, a State shall establish procedures to ensure that such children are screened for eligibility for medical assistance under the State plan under title XIX or a waiver of that plan and, if found eligible, enrolled in such plan or a waiver. In the case of such children who, as a result of such screening, are determined to not be eligible for medical assistance under the State plan or a waiver under title XIX, the State shall establish procedures to ensure that the children are enrolled in a qualified health plan that has been certified by the Secretary under subparagraph (C) and is offered through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act. For purposes of eligibility for premium assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 and reduced cost-sharing under section 1402 of the Patient Protection and Affordable Care Act, children described in the preceding sentence shall be deemed to be ineligible for coverage under the State child health plan.

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

(4) OPTION FOR ALLOTMENTS FOR FISCAL YEARS 2009 THROUGH 2015.

(A) PAYMENT OF ENHANCED PORTION OF MATCHING RATE FOR CERTAIN EXPENDITURES.—In the case of expenditures described in subparagraph (B), a qualifying State (as defined in paragraph (2)) may elect to be paid from the State’s allotment made under section 2104 for any of fiscal years 2009 through 2015 (insofar as the allotment is available to the State under subsections (e) and (m) of such section) an amount each quarter equal to the additional amount that would have been paid to the State under title XIX with respect to such expenditures if the enhanced FMAP (as determined under subsection (b)) had been substituted for the Federal medical assistance percentage (as defined in section 1905(b)).
Sec. 2101(c) of the “Patient Protection and Affordable Care Act” (Pub.L. No. 111-148), effective March 23, 2010, amended sec. 2105(c)(3)(F), by inserting “or any children enrolled on or after October 1, 2013” before the period.

Sec. 2101(a) of the “Patient Protection and Affordable Care Act” (Pub.L. No. 111-148), effective March 23, 2010, amended sec. 2105(b), by adding at the end the following: “Notwithstanding the preceding sentence, during the period that begins on October 1, 2013, and ends on September 30, 2019, the enhanced FMAP determined for a State for a fiscal year (or for any portion of a fiscal year occurring during such period) shall be increased by 23 percentage points, but in no case shall exceed 100 percent. The increase in the enhanced FMAP under the preceding sentence shall not apply with respect to determining the payment to a State under subsection (a)(1) for expenditures described in subparagraph (D)(iv), paragraphs (8), (9), (11) of subsection (c), or clause (4) of the first sentence of section 1905(b).”

Sec. 2105(c)(1) of the “Patient Protection and Affordable Care Act” (Pub.L. No. 111-148), effective March 23, 2010, amended sec. 2105(b), by striking “2013” and inserting “2015”.

Sec. 2105(b)(3) of the “Patient Protection and Affordable Care Act” (Pub.L. No. 111-148), effective Feb. 4, 2009, amended sec. 2105(c)(10), in subparagraph (A), in the first sentence, by inserting before the period the following: “if the offering of such a subsidy is cost-effective, as defined for purposes of paragraph (3)(A);” by striking subparagraph (M); and by redesignating subparagraph (N) as subparagraph (M). Prior to amendment, Act Sec. 2105(c)(10)(M) previously read as follows:

“M SATISFACTION OF COST-EFFECTIVENESS TEST.—Premium assistance subsidies for qualified employer-sponsored coverage offered under this paragraph shall be deemed to meet the requirement of subparagraph (A) of paragraph (3).”

Sec. 2105(b)(4) of the “Patient Protection and Affordable Care Act” (Pub.L. No. 111-148), effective Feb. 4, 2009, amended sec. 2105(c)(10)(A), in the matter preceding clause (i), by striking “to” and inserting “to—”, and in clause (ii), by striking the period and inserting a semicolon.


Sec. 2101(b)(1) of the “Patient Protection and Affordable Care Act” (Pub.L. No. 111-148), effective March 23, 2010, amended sec. 2105(d), by adding at the end the new paragraph (5).

Sec. 10201(g) of the “Patient Protection and Affordable Care Act” (Pub.L. No. 111-148), effective March 23, 2010, amended sec. 2105(d)(3), by adding at the end the following: “For purposes of eligibility for premium assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 and reduced cost-sharing under section 1402 of the Patient Protection and Affordable Care Act, children described in the preceding sentence shall be deemed to be ineligible for coverage under the State child health plan.”


Sec. 10203(b)(3) of the “Patient Protection and Affordable Care Act” (Pub.L. No. 111-148), effective March 23, 2010, amended sec. 2105(c)(3)(A), in the matter preceding clause (i), by striking “to” and inserting “to—”, and in clause (ii), by striking the period and inserting a semicolon.

Sec. 10203(b)(4) of the “Patient Protection and Affordable Care Act” (Pub.L. No. 111-148), in the paragraph heading, by striking “2013” and inserting “2015”.

Sec. 10203(d)(2)(C) of the “Patient Protection and Affordable Care Act” (Pub.L. No. 111-148), effective March 23, 2010, amended sec. 2105(g)(4), in subparagraph (A), by inserting “as a condition of receiving payments under section 1903(a),” after “2013,”, in clause (i), by striking “or” at the end, by redesignating clause (ii) as clause (iii), and by inserting after clause (i), the new clause (ii), in subparagraph (B), by striking “provided coverage” and inserting “screened for eligibility for medical assistance under the State plan under title XIX or a waiver of that plan and, if found eligible, enrolled in such plan or a waiver. In the case of such children who, as a result of such screening, are determined to not be eligible for medical assistance under the State plan or a waiver under title XIX, the State shall establish procedures to ensure that the children are enrolled in a qualified health plan that has been certified by the Secretary under subparagraph (C) and is offered”, and by adding at the end the new subparagraph (C).
(G) Section 1902(bb) (relating to payment for services provided by Federally-qualified health centers and rural health clinics).

(H) Section 1902(ff) (relating to disregard of certain property for purposes of making eligibility determinations).

(I) Paragraphs (2), (16), and (17) of section 1903(i) (relating to limitations on payment).

(J) Paragraph (4) of section 1903(v) (relating to optional coverage of categories of lawfully residing immigrant children or pregnant women), but only if the State has elected to apply such paragraph with respect to such category of children or pregnant women under title XIX.

(K) Section 1903(w) (relating to limitations on provider taxes and donations).

(L) Section 1920(A) (relating to presumptive eligibility for children).

(M) Subsections (a)(2)(C) and (h) of section 1932.

Caution: Secs. 2101(e) and 6401(c) of the Patient Protection and Affordable Care Act (PubLNo 111-148) both added a new SSA sec. 2107(e)(1)(N). Both new subparagraphs (N) are added below.

(N) Section 1942 (relating to authorization to receive data directly relevant to eligibility determinations).

(N) Section 1943(b) (relating to coordination with State Exchanges and the State Medicaid agency).
(B) Make appropriate adjustments to the Current Population Survey to improve the survey estimates used to determine a high-performing State under section 2111(b)(3)(B) and any other data necessary for carrying out this title.

**§2110(c)(9)(B) ¶16,081**
(v) A local educational agency (as defined under section 9101 of the Elementary and Secondary Education Act of 1965.

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[Explanation at ¶ 521, ¶ 566, and ¶ 585.]

2010 Amendments: Sec. 2302(b) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 2110(b), in paragraph (2)(B), by inserting “except as provided in paragraph (6),” before “a child”, and by adding at the end the new paragraph (6). Sec. 2102(a)(7) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 2110(c)(9)(B)(v), by striking “school or school system” and inserting “local educational agency (as defined under section 9101 of the Elementary and Secondary Education Act of 1965”.

¶16,101 Sec. 2113. GRANTS TO IMPROVE OUTREACH AND ENROLLMENT

[42 U.S.C. § 1397mm]

(a)(1) IN GENERAL.—From the amounts appropriated under subsection (g), subject to paragraph (2), the Secretary shall award grants to eligible entities during the period of fiscal years 2009 through 2015 to conduct outreach and enrollment efforts that are designed to increase the enrollment and participation of eligible children under this title and title XIX.

(g) APPROPRIATION.—There is appropriated, out of any money in the Treasury not otherwise appropriated, $140,000,000 for the period of fiscal years 2009 through 2015, for the purpose of awarding grants under this section. Amounts appropriated and paid under the authority of this section shall be in addition to amounts appropriated under section 2104 and paid to States in accordance with section 2105, including with respect to expenditures for outreach activities in accordance with subsections (a)(1)(D)(iii) and (c)(2)(C) of that section.

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[Explanation at ¶ 564 and ¶ 566.]

2010 Amendments: Sec. 10203(d)(2)(D) of the “Patient Protection and Affordable Care Act” (PubLNo 111-148), effective March 23, 2010, amended sec. 2113, in subsection (a)(1), by striking “2013” and inserting “2015”, and in subsection (g), by striking “$100,000,000 for the period of fiscal years 2009 through 2013” and inserting “$140,000,000 for the period of fiscal years 2009 through 2015”.

¶16,101 §2110(c)(9)(B)(v)