

## Affordable Health Choices Act

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# **American Health Choices Act**

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## **Sec. 1. Short Title; Table of Contents**

(a) Short Title.—This Act may be cited as the Affordable Health Choices Act”.

## **Title I – Quality, Affordable, Health Care for All Americans Subtitle A- Effective Coverage for All Americans**

### **Part I – Provisions Applicable to the Individual and Group Markets**

#### **Sec. 101. Amendment to the Public Health Service Act**

*Current Law*

##### ***Pertaining to Sec. 2701-2706, 2709, 2710***

There are no federal rating rules for health insurance. The Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191) established federal rules regarding guaranteed issue, guaranteed renewability, coverage for pre-existing health conditions, and non-discrimination based on health status-related factors for certain persons and groups. Currently, there are a handful of federal benefit mandates, including rules concerning genetic information and dependent coverage. As the primary regulator of the insurance industry, a number of states have enacted a wide range of health insurance rules.

HIPAA requires that coverage sold to small groups (2-50 employees) must be sold on a guaranteed issue basis. That is, the issuer must accept every small employer that applies for coverage. HIPAA also guarantees that each issuer in the individual market make at least two policies available (“guaranteed availability”) to all “HIPAA eligible” individuals. In addition, HIPAA guarantees renewal of group coverage at the option of the plan sponsor (e.g., employer) and individual coverage at the option of the individual, with some exceptions.

HIPAA limits the duration that issuers in the group market may exclude coverage for pre-existing health conditions for “HIPAA eligible” individuals. Group health plans may impose pre-existing condition exclusions for no longer than 12 months (18 months in the case of a late enrollee), and must decrease that exclusion period by the number of months an enrollee had prior “creditable coverage.” HIPAA outright prohibits issuers in the individual market from excluding coverage for pre-existing conditions for HIPAA eligibles.

HIPAA prohibits group issuers from establishing rules for eligibility and premiums based on health status-related factors. Those factors include health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of domestic violence) and disability. In addition, the Genetic Information Nondiscrimination Act of 2008 (GINA, P.L. 110-233) prohibits issuers in the individual health insurance market from establishing eligibility rules (including continued eligibility) based on an individual's genetic information.

Michelle's Law ensures that dependent students enrolled in post-secondary education who take a medically necessary leave of absence do not lose health insurance coverage. The federal law provides that a group health plan may not terminate a college student's health coverage simply because the student takes a leave of absence from school or changes to part-time status. The leave of absence must be medically necessary, begin while the student is suffering from a serious illness or injury, and would otherwise result in a loss of coverage.

A number of states have enacted their own rules related to guaranteed issue and pre-existing condition exclusions, sometimes exceeding federal rules. All states require issuers to offer policies to firms with 2-50 workers on a guaranteed issue basis and reduce the period of time when coverage for pre-existing health conditions may be excluded, in compliance with HIPAA. As of January 2009 in the small group market, 12 states also require issuers to offer policies on a guaranteed issue basis to self-employed "groups of one," and 21 states had pre-existing condition exclusion rules that provided consumer protection above the federal standard. In addition, as of December 2008 in the individual market, 15 states require issuers to offer some or all of their insurance products on a guaranteed issue basis, and 42 states reduce the period of time when coverage for pre-existing health conditions may be excluded for enrollees in that market.

Most states currently impose rating rules on insurance carriers in the small group and individual markets. Existing state rating rules restrict an insurer's ability to price insurance policies according to the risk of the person or group seeking coverage, and vary from state to state. Such restrictions may specify the case characteristics (or risk factors) that may or may not be considered when setting a premium, such as industry. The spectrum of existing state rating limitations ranges from pure community rating, to adjusted (or modified) community rating, to rate bands, to no restrictions. Pure community rating means that premiums cannot vary based on any characteristic, including health. Adjusted community rating means that premiums cannot vary based on health, but may vary based on other key risk factors, such as age. Rate bands allow premium variation based on health, but such variation is limited according to a range specified by the state. Moreover, both adjusted community rating and rate bands allow premium variation based on any other permitted case characteristic, such as gender. And for each characteristic, the state typically specifies the amount of allowable variation. As of January 2009 in the small group market, one state has pure community rating rules, eleven have adjusted community rating rules, and 35 have rate bands. As of December

2008 in the individual market, two states have pure community rating rules, five have adjusted community rating rules, and eleven have rate bands.

There are no federally-established rating areas in the private health insurance market. However, some states have enacted rating rules in the individual and small group markets that include geography as a characteristic on which premiums may vary. In these cases, the state has established rating areas. Typically, states use counties or zip codes to define those areas.

A number of states currently require carriers to extend dependent coverage under a family policy to young adults until those individuals reach a certain age or no longer satisfy other eligibility criteria, e.g., full-time college enrollment. As of January 2009, 30 states had coverage rules for dependent adults in either the group market or individual market or both.

***Quality of Care (relating to new PHS “Sec. 2707”):*** Medicare currently has two major programs established in statute that align quality with payment. These are the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program (established in Section 1886(b)(3)(B)(vii)(I) of the Social Security Act) and the Physician Quality Reporting Initiative (PQRI) (established by Section 1848(k)(1) of the Social Security Act). Under both programs, participation is voluntary.

The RHQDAPU program requires hospitals to report on a set of 44 quality measures in order to receive a full annual payment update. The at-risk share of the payment update is 2.0% (Section 1886(b)(3)(B)(viii)(I) of the Social Security Act). PQRI requires eligible professionals to report on certain quality measures in order to receive an incentive payment equal to 2.0% of covered professional services (payment incentives established by Section 1848(m)(1)(A) and (B) of the Social Security Act).

In general, the State Children's Health Insurance Program (CHIP) statute requires states to establish, monitor, and report on the quality and appropriateness of care particularly with respect to well-baby care, well-child care, and immunizations provided under the state plan. As a part of their annual reports, states are required to report data regarding access to primary and specialty services, access to networks of care, and care coordination provided under the State child health plan. To do this, states must use quality care and consumer satisfaction measures included in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

Most recently, the Children's Health Insurance Program Reauthorization Act (CHIPRA, P.L. 111-3) added several requirements designed to improve the quality of care under Medicaid and CHIP. CHIPRA directs the Secretary of HHS to develop (1) child health quality measures, and (2) a standardized format for reporting information, and procedures to encourage states to voluntarily report on the quality of pediatric care in these two programs. Examples of these initiatives include: (1) grants and contracts to develop, test, update and disseminate evidence-based measures; (2) demonstrations to evaluate promising ideas for improving the quality of children's health care under Medicaid and

CHIP; (3) a demonstration to develop a comprehensive and systematic model for reducing child obesity; and (4) a program to encourage the creation and dissemination of a model electronic health record format for children enrolled in these two programs.

The federal share of the costs associated with developing or modifying existing state data systems to store and report child health measures is based on the matching rate applicable to benefits rather than one of the (typically) lower matching rates applied to certain administrative expenses.

***Preventive Health Services (relating to new PHSA “Sec. 2708”):*** Part A of Title XXVII of the Public Health Service Act (PHSA) does not require coverage of specific preventive services by private health insurers.

The U.S. Preventive Services Task Force (USPSTF, PHSA Section 915), administered by the Agency for Healthcare Research and Quality (AHRQ), reviews scientific evidence and makes recommendations to the health care community for the use of clinical preventive services, based on evidence of effectiveness and any harm associated with specific services. The USPSTF grades services as “A” through “D,” or notes that there is insufficient evidence to support a recommendation. Clinical services graded “A” or “B” by the USPSTF are recommended for use in clinical practice.

The Advisory Committee on Immunization Practices (ACIP), administered by the Centers for Disease Control and Prevention (CDC), reviews scientific evidence and makes recommendations to the Secretary and the CDC Director for the routine administration of vaccines to children, adolescents, and adults in the U.S. civilian population. The ACIP is not explicitly authorized; rather, it is based in general authorities of the Secretary in Titles II and III of the PHSA.

### *Proposed Law*

The bill would re-designate existing sections of and add new sections to the PHS Act:

## **Part A – Individual and Group Market Reforms**

### ***Sec. 2705. Prohibition of Preexisting Condition Exclusions or Other Discrimination Based on Health Status.***

This provision would prohibit preexisting condition exclusions in group and individual health insurance coverage.

### ***Sec. 2701. Fair Insurance Coverage.***

This provision would impose adjusted community rating in the group and individual health insurance markets. Premiums would vary only by family structure, community rating area, actuarial value of the benefit, and age (by no more than a 2:1 ratio). Issuers would be prohibited from varying premiums based on health status-related factors, gender, class of business, claims experience, or any other factor not specifically allowed.

The Secretary would promulgate regulations defining community rating area based on recommendations by the National Association of Insurance Commissioners.

***Sec. 2702. Guaranteed Availability of Coverage.***

This provision would impose guaranteed issue rules in the group and individual markets. It would allow health insurance issuers to restrict enrollment to open or special enrollment periods. The Secretary would promulgate regulations related to such enrollment periods, and health insurance issuers would establish enrollment periods in accordance with such regulations.

***Sec. 2703. Guaranteed Renewability of Coverage.***

This provision would impose guaranteed renewability rules in the group and individual markets.

***Sec. 2704. Bringing Down the Cost of Health Care Coverage.***

This provision would require issuers in the group and individual markets to submit information to the Secretary on the share of total premium revenue spent on (1) health care services (“medical loss ratio”), (2) health care quality activities, and (3) all other non-claims costs. It would require individual and group issuers to provide annual rebates to enrollees if premium revenue spent on all other non-claims costs exceeds standards determined by the Secretary. This provision would require each health plan that fails to provide minimum qualifying coverage to notify enrollees of such failure prior to any enrollment restriction.

***Sec. 2706. Prohibiting Discrimination Against Individual Participants and Beneficiaries Based on Health Status.***

This provision would prohibit discrimination based on health status related factors for eligibility or coverage purposes for group and individual coverage. Those factors include health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), disability, and any other health factor as determined by the Secretary.

***Sec. 2707. Ensuring Quality of Care.***

*Current Law*

Medicare currently has two major programs established in statute that align quality with payment. These are the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program (established in Section 1886(b)(3)(B)(vii)(I) of the Social Security Act) and the Physician Quality Reporting Initiative (PQRI) (established by Section 1848(k)(1) of the Social Security Act). Under both programs, participation is voluntary.

The RHQDAPU program requires hospitals to report on a set of 44 quality measures in order to receive a full annual payment update. The at-risk share of the payment update is 2.0% (Section 1886(b)(3)(B)(viii)(I) of the Social Security Act). PQRI requires eligible professionals to report on certain quality measures in order to receive an incentive

payment equal to 2.0% of covered professional services (payment incentives established by Section 1848(m)(1)(A) and (B) of the Social Security Act).

In addition, Medicare has established payment policies to incentivize the adoption of health information technology (HIT) and e-prescribing.

The Health Information Technology for Economic and Clinical Health (HITECH) Act, part of the American Recovery and Reinvestment Act of 2009 (P.L. 111-5), authorizes, beginning in 2011, Medicare incentive payments to encourage doctors and hospitals to adopt and use certified electronic health records (EHRs). Those incentive payments are phased out over time and replaced by financial penalties for physicians and hospitals that are not using certified EHRs.

The Medicare Improvement for Patients and Providers Act of 2008 (MIPPA; P.L. 110-275) included an e-prescribing mandate and authorized incentive bonus payment for e-prescribers between 2009 and 2013. Beginning in 2012, payments would be reduced for those who fail to e-prescribe.

In general, the State Children's Health Insurance Program (CHIP) statute requires states to establish, monitor, and report on the quality and appropriateness of care particularly with respect to well-baby care, well-child care, and immunizations provided under the state plan. As a part of their annual reports, states are required to report data regarding access to primary and specialty services, access to networks of care, and care coordination provided under the State child health plan. To do this, states must use quality care and consumer satisfaction measures included in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

Most recently, the Children's Health Insurance Program Reauthorization Act (CHIPRA, P.L. 111-3) added several requirements designed to improve the quality of care under Medicaid and CHIP. CHIPRA directs the Secretary of HHS to develop (1) child health quality measures, and (2) a standardized format for reporting information, and procedures to encourage states to voluntarily report on the quality of pediatric care in these two programs. Examples of these initiatives include: (1) grants and contracts to develop, test, update and disseminate evidence-based measures; (2) demonstrations to evaluate promising ideas for improving the quality of children's health care under Medicaid and CHIP; (3) a demonstration to develop a comprehensive and systematic model for reducing child obesity; and (4) a program to encourage the creation and dissemination of a model electronic health record format for children enrolled in these two programs.

The federal share of the costs associated with developing or modifying existing state data systems to store and report child health measures is based on the matching rate applicable to benefits rather than one of the (typically) lower matching rates applied to certain administrative expenses.

*Proposed Law*

This option would require group health plans and health insurance issuers offering group or individual coverage to develop and implement reimbursement structures that align payment with quality.

Specifically, it would require the reimbursement structure to incentivize the provision of high quality health care under the plan or coverage, including: 1) implementing case management, care coordination, chronic disease management activities, and medication and care compliance activities that includes the use of the medical home model as defined in Section 212 of Title II; (2) implementing activities to reduce preventable hospital admissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling comprehensive discharge planning and post-discharge reinforcement by an appropriate health care professional; (3) implementing activities to improve patient safety and reduce medical errors through use of evidence based medicine, HIT and best clinical practices; (4) child health measures under section 1139A of the Social Security Act; and (5) culturally and linguistically appropriate care, as defined by the Secretary.

These reimbursement structures must substantially reflect the payment policies of both Medicare and CHIP with respect to any generally implemented incentive policy to promote high quality care.

The Secretary of HHS would be required to promulgate regulations, not later than 180 days after the date of enactment of the Affordable Health Choices Act, to:) define the term “generally implemented”; 2) to require the expiration of a minimum period of time between the date on which a Medicare or CHIP policy is generally implemented and the date on which that policy shall then apply to health insurance coverage offered in the group or individual market; and 3) that provide criteria for determining whether a payment policy is described in section (a)(2) (requiring that reimbursement structures must substantially reflect the payment policies of both Medicare and CHIP with respect to any generally implemented incentive policy to promote high quality care).

***Sec. 2708. Coverage of Preventive Health Services:***

This provision would require a group health plan and a health insurance issuer offering group or individual health insurance coverage to cover certain preventive services, as specified below, without any cost-sharing requirements (other than minimal cost sharing according to guidelines developed by the Secretary). Preventive services that must be covered would include: (1) items or services that have a current grade of “A” or “B” from the United States Preventive Services task Force (USPSTF); (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) with respect to the individual involved; and (3) with respect to infants, children and adolescents, preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA). For plan years beginning on and after January 1, 2010, the Secretary would establish a minimum interval (not less than one year) for requiring coverage of recommendations or guidelines that are issued under this section.

***Sec. 2709. Extension of Dependent Coverage.***

This provision would require issuers offering group and individual coverage to extend dependent coverage to young adults through age 26. The Secretary would promulgate regulations to define the scope of this provision.

***Sec. 2710. No Lifetime or Annual Limits.***

This provision would prohibit the imposition of lifetime or annual limits on benefits in group or individual health insurance coverage.

## **Part II – Provision Applicable to the Group Market**

### **Sec. 121. Amendment to the Public Health Service Act**

*Current Law*

Under the Internal Revenue Code (IRC), the contribution that an employer provides toward an employee's health benefits is excluded from that employee's gross income for individual income tax purposes. However, in cases when an employer self-funds health benefits (i.e., the employer retains the insurance risk and is responsible for paying medical claims) and discriminates in favor of highly compensated employees (HCEs) in either eligibility or benefits, the HCE must include some/all of the value of those benefits in determining their income tax liability.

*Proposed Law*

Adds new section to the PHS Act:

***Sec. 2719. Prohibition of Discrimination Based on Salary.***

This provision would prohibit discrimination based on wages or salary for eligibility purposes for group coverage. It does not prohibit lower-compensated employees to contribute less towards the premium than higher-compensated employees.

## **Part III – Other Provisions**

### **Sec. 131. No Changes to Existing Coverage**

*Current Law*

None

*Proposed Law*

Individuals enrolled in a group health plan or health insurance coverage prior to passage of this bill could retain their current coverage (thus “grandfathering” these plans). These group health plans and health insurance coverage would not be subject to the amendments of Subtitle A of this Act (relating to changes in the individual and group

market). Family members of such individuals could enroll in these grandfathered plans. [reference Par 1, which is not here].

### **Sec. 132. Applicability**

#### *Current Law*

HIPAA defines small group size as firms with 2-50 employees. Federal health insurance rules apply to group coverage generally, with exceptions made for public-sector or church plans and in other instances as specified in statute.

#### *Proposed Option*

This provision would eliminate the current federal application of group rules to groups with two or more employees. It would incorporate the new health insurance requirements on individual and group coverage under Subpart 1 into the existing exceptions to federal health insurance requirements. Would delay the applicability of the new federal health insurance requirements on collective bargaining agreements until after the date that either coverage under such an agreement terminates or is 12 months after enactment, whichever is later.

### **Sec. 133. Conforming Amendments.**

#### *Current Law*

Not applicable.

#### *Proposed Law*

This provision would make conforming amendments to the PHS Act, IRC, and the Employee Retirement Income Security Act of 1974 in order to apply the new health insurance rules to those statutes.

### **Sec. 134. Effective Dates.**

This provision would make effective the new rating requirements on group and individual coverage in a state by either the date on which a state enacts conforming legislation or 4 years after enactment, whichever is earlier. It would make effective all of the other new health insurance requirements on group and individual coverage on date of enactment.

## **Subtitle B – Available Coverage for All Americans**

### **Sec. 141. Assumptions Regarding Medicaid**

#### *Current Law*

There are many eligibility pathways into Medicaid specified in federal statute, some of which states are required to cover, and others that are optional. Eligibility for Medicaid is determined not only based on financial requirements, but also on categorical requirements – that is, to be eligible for traditional Medicaid, one must be a member of a covered group, such as children, pregnant women, parents with dependent children, persons who are elderly, and individuals with disabilities. Childless adults (nonelderly adults who are not disabled, not pregnant and not parents of dependent children) are generally not eligible for Medicaid, regardless of their income. Financial criteria vary by eligibility category and may be expressed as a percentage of the federal poverty level (e.g., children under age 6 in families with income up to 133% of the federal poverty level or FPL) or based on the low income, financial criteria used under federal welfare-related cash assistance programs (i.e., the former Aid to Families with Dependent Children program and the federal Supplemental Security Income program for persons who are elderly and persons with disabilities).

The federal government's share of most Medicaid services is determined by the federal Medical Assistance Percentage (FMAP), which varies by state and is determined by a formula set in statute. FMAP has a statutory floor of 50% and a statutory maximum of 83%. Certain Medicaid services receive a higher federal match, including those provided through an the Indian Health Service facility, to certain women with breast or cervical cancer, for family planning, or under the Qualifying Individuals program that pays Medicare Part B premiums on behalf of certain Medicaid beneficiaries.

An enhanced FMAP is provided for both services and administration under the Children's Health Insurance Program (CHIP), subject to the availability of funds from a state's federal allotment under CHIP. This enhanced FMAP means a state's share of expenditures is 30% lower than under the regular Medicaid FMAP. When a state expands its Medicaid program using CHIP funds (rather than Medicaid funds), the enhanced FMAP applies and is paid out of the state's federal CHIP allotment.

### *Proposed Options*

The proposed legislation assumes that the law authorizing the Medicaid program would be amended to implement the following policies (a) individuals currently eligible for Medicaid will remain eligible, (b) all individuals with income less than 150% of FPL will be eligible for Medicaid, (c) improvements to facilitate Medicaid enrollment will be made, (d) states will be required to maintain current levels of eligibility for those currently enrolled, (e) income criteria used to determine premium credits in the Gateway will also be used in Medicare, Medicaid, and CHIP, (f) until 2015, the FMAP will equal 100% for individuals eligible up to 150% of FPL and those currently enrolled using existing eligibility levels, (g) beginning in 2015, the 100% FMAP will be phased down to current law amounts by 2020, and (h) the increased FMAP will be applicable to states that have increased eligibility for individuals defined in (b) and (d) prior to the date of enactment.

## **Sec. 142. Building on the Success of the Federal Employees Health Benefit Program So All Americans Have Affordable Health Benefit Choices**

### *Current Law*

The Federal Employees Health Benefits Program (FEHBP) covers about 8 million current workers, Members of Congress, annuitants, and their families. FEHBP offers enrollees a choice of five fee-for-service plans available government-wide and another five plans available to employees of certain small federal agencies (such as the Foreign Service). In total, there are about 300 different plan choices, including all regionally available options, as well as choices offered by plans for standard option, high option, and high-deductible plans. As a practical matter, depending on where an enrollee resides, his or her choice of plans is limited to about five to 15 different plans.

Although there is no core or standard benefit package required for FEHBP, all plans cover basic hospital, surgical, physician, and emergency care. Plans are required to cover certain special benefits including prescription drugs (which may have separate deductibles and coinsurance); mental health care with parity of coverage for mental health and general medical care coverage; child immunizations; and limits on an enrollee's total out-of-pocket costs for a year, called the catastrophic limit. Plans must also include certain cost-containment provisions, such as offering preferred provider organization (PPO) networks in fee-for-service plans and hospital pre-admission certification.

### *Proposed Law*

It is the sense of the Senate that Congress should establish a means for all Americans to have affordable choices in health benefit plans in the same manner that Members of Congress have through the Federal Employees Health Benefits Program.

## **Sec. 143. Affordable Health Choices for All Americans**

### **“Title XXXI – Affordable Health Choices for All Americans”**

#### **“Subtitle A – Affordable Choices”**

### *Current Law*

No specific provision in federal law. However, the Gateway proposal has some components that are similar to the Massachusetts Connector, as described below for illustrative purposes.

In 2006, in tandem with substantial private health insurance market reforms, Massachusetts created the Health Insurance Connector Authority, governed by a Board of Directors, to serve as an intermediary that assists individuals in acquiring health insurance. In this role, the Health Connector manages two programs; the first is Commonwealth Care, which offers a government-subsidized plan at three benefit levels

from a handful of health insurers to individuals up to 300% FPL who are not otherwise eligible for traditional Medicaid or other coverage (e.g., Medicare, job-based coverage). The second is Commonwealth Choice, which offers an unsubsidized selection of four benefit tiers (gold, silver, bronze, and young adult) from six insurers to individuals and small groups. Under state law, the Board of Directors, with its 11 board members, has numerous responsibilities, including: determining eligibility for and administering subsidies through the Commonwealth Care program, awarding a seal of approval to qualified health plans offered through the Connector's Commonwealth Choice program, developing regulations defining what constitutes "creditable coverage," constructing an affordability schedule to determine if residents have access to "affordable" coverage and may therefore be subject to tax penalties if they are uninsured, and developing a system for processing appeals related to eligibility decisions for the Commonwealth Care program and the individual mandate.

### *Proposed Law*

#### ***Sec. 3101. Affordable Choices of Health Benefit Plans***

This section of the proposal establishes a new title to the Public Health Services Act, Title XXXI, *Affordable Health Choices for All Americans*. The title provides a means to establish health benefit Gateways in each state. States have some flexibility in establishing and administering the Gateway.

This section establishes health Gateways and provides start-up grants for the establishment of the Gateways. An American Health Benefit Gateway is a mechanism that facilitates the purchase of health insurance coverage and related insurance products for qualified individuals and employer groups.

The section would provide planning and establishment grants to the states for the establishment of Gateways. Each state would be awarded a grant based on a formula developed by the Secretary that includes two components: a minimum amount for each state, and an additional amount based on population. State grants would be renewed if the Secretary determines that the State is making progress toward the establishment of a Gateway and is implementing the individual and group market reforms of this legislation. States shall not be eligible for grant renewal as of the second fiscal year following the state being deemed as having a Gateway. There are authorized such sums as necessary to provide these grants in each of fiscal years 2009 through 2014.

There are 10 requirements associated with the Gateway mechanism (for which the Secretary would develop guidance):

- Individuals would have the choice to enroll or not enroll in a Gateway. No individual would be compelled to enroll in a Gateway.
- A state or the Secretary can establish Gateways.
- A Gateway must make qualified health plans available to individuals and employers and must include a public health insurance option. A Gateway

may make available a qualified health plan notwithstanding any provision of law that may require benefits other than the essential health benefits delineated in this proposal.

- Gateways must perform at least the following functions:
  - Establish procedures for certification, recertification and decertification of health plans, consistent with guidelines developed by the Secretary;
  - Develop and provide consumers with information on expected premiums and out of pocket expenses, the availability of in-network and out-of-network providers, administrative and operational surcharges assessed by the Gateway in offering plans, comparative information (as specified) about the utilization of services recommended by the U.S. Preventive Services Task Force, and other consumer information as determined by the Gateway relating to individuals' costs and expected experience.
  - Use administrative simplification measures and standards (described in Sec. 222).
  - Enter into agreements with other entities (navigators) to provide education about the Gateway, information on enrollment and the insurance credits (described below for the new Sec. 3111 of the Public Health Service Act) available, and assistance with plan enrollment.
  - Facilitate the purchase of coverage for long-term care services and supports.
  - Collect, analyze, and respond to enrollee complaints and concerns regarding the insurance coverage purchase through the Gateway.
- A Gateway may assess a surcharge on all health insurance issuers offering qualified health plans to pay for the Gateway's administrative and operational expenses. The surcharge may not exceed 3% of a plan's premium.
- States must develop a risk adjustment plan so that health plans or insurance issuers with enrollees with low actuarial risk will be assessed a charge and health plans or insurance issuers with high risk enrollees would receive a payment. Low or high risk is based on the average risk of all enrollees in all plans or coverage in the State for the year excluding self-insured group health plans. The Secretary in consultation with the States will develop the risk adjustment methodology. The Secretary may utilize methods similar to the risk adjustment methods used in Medicare's Part D (drug coverage) plans.
- A Gateway (through, to the extent practicable, the use of information technology) would establish policies and procedures to identify individuals who lack qualifying coverage and assist with the individual's enrollment in a qualified individual health plan that is affordable, the Medicaid program, the State Children's Health Insurance Program (CHIP), or other Federal programs for which individuals may be eligible. A qualified individual who is eligible for CHIP may elect to enroll in

CHIP or a qualified insurance plan. A parent or guardian would make election for minors. The Secretary would provide oversight to be sure that individuals were directed to the most appropriate program or plan. Enrollment materials should be prepared for enrollees who would qualify for these plans and should take into account language barriers and an individual's disabilities.

- For carrying out their activities, Gateways would consult with consumers who are enrolled in qualified health plans, individuals and entities with experience in facilitating enrollment in qualified health plans, state Medicaid offices, and advocates for enrolling hard to reach populations.
- The Secretary, in consultation with the Office of the National Coordinator for Health Information Technology, would develop interoperable, secure, scalable and reusable standards that facilitate enrollment of individuals in federal and state health and human services programs. The Secretary would facilitate the enrollment through methods that would include electronic matching against existing federal and state data to serve as evidence of eligibility and digital documentation in lieu of paper documentation, the ability of individuals to apply, recertify and manage eligibility information on-line (including conducting real-time queries against databases for existing eligibility prior to submitting applications), and other methods to streamline enrollment. The Secretary may award grants to enhance "community-based enrollment." The grants would be (1) to states in contracting with qualified technology vendors to develop electronic enrollment software systems, establishing statewide helplines for enrollment assistance and referrals, and establishing public education campaigns; and (2) to community-based organizations for infrastructure and training to establish electronic assistance programs.
- The Secretary would notify states of the established enrollment standards and protocols and may require that the states or other entities incorporate the protocols in order to receive federal funds.

A Gateway may certify a health plan (1) if it meets the criteria for certification discussed below, and (2) if the Gateway determines that making the plan available through the Gateway is in the best interest of qualified individuals or qualified employers.

The criteria for certification of qualified health plans would be established by the Secretary in regulation. Plans would be required to do the following:

- not employ marketing practices that have the effect of discouraging the enrollment in such plan by individuals with significant health needs;
- employ methods to ensure that insurance products are simple, comparable, and structured for ease of consumer choice;
- ensure a wide choice of providers;
- make available to individuals enrolled in, or seeking to enroll in, such plan a detailed description of the plan's covered benefits, service area, required premiums, cost-sharing requirements, the manner in which enrollees access providers, and the grievance and appeals procedures;

- cover at least the “essential health care benefits” described in Sec. 3103;
- obtain accreditation by the National Committee for Quality Assurance (NCQA) or by any other entity recognized by the Secretary — within a period established by the Gateway for such accreditation and applicable to all qualified health plans;
- implement a quality improvement strategy to improve health outcomes through quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives;
- have adequate procedures in place for appeals of coverage determinations; and
- not establish a benefit design that is likely to substantially discourage enrollment by certain qualified individuals in such plan.

A Gateway may operate in more than one state, provided that each state in which the Gateway would operate permits the operation. A state may establish one or more subsidiary Gateways. These subsidiary Gateways must serve a distinct geographic area be at least as large as a community rating area (as described above, in Sec. 2701).

The Secretary would establish a mechanism, including an Internet website to allow a state resident to identify any Gateway operating in the state.

A qualified individual could enroll in any qualified health plan made available to the individual. A qualified employer could choose a specific cost-sharing tier (described below in Sec. 3111) for its employees, from which employees could select the plan of their choice in that tier. A self-employed individual would be deemed to be a qualified *employer* unless the individual notifies the Gateway that the individual elects to be considered a qualified *individual*. If the self-employed individual elects to be a qualified individual, then the income used to determine eligibility for insurance support would be the total business income and, for income tax purposes, premium payments would not be counted as employer contributions to employer-provided coverage.

A qualified individual enrolled in a qualified health plan may pay the premium to health insurance issuer.

A health insurance issuer would consider each enrollee in a qualified health plan to be a member of a single risk pool.

Health insurance issuers would still be able to offer a health insurance policy or provide coverage to a qualified individual when such a policy is not considered a qualified health plan. This title does not prohibit an individual from purchasing a health insurance plan where such plan is not a qualified plan. This title does not terminate, abridge, or limit the operation of any state laws with respect to health plans that are not qualified health plans.

In consultation with experts in health care quality and stakeholders, the Secretary would develop guidelines on plan payment structures to increase reimbursement or other incentives for the following activities, for which plans would be required to report periodically to its Gateway:

- improving health outcomes through activities that include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model (described below in Sec. 212);
- prevention of hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post-discharge reinforcement by an appropriate health care professional; and
- the implementation of wellness and health promotion activities.

This title does not preempt any state law regarding market conduct or related consumer protections.

This option delineates certain quality-related criteria that hospitals and providers must meet in order to be eligible to contract with qualified health plans. Beginning on January 1, 2012, hospitals that have more than 50 beds (the Secretary may adjust this number through regulation) and that contract with qualified health plans would have to (1) use a “patient safety evaluation system” (as defined in current law in part C of Title IX of the Public Health Service Act) and (2) implement a mechanism to ensure that each patient receives a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post-discharge reinforcement by an appropriate health care professional. By that same date, qualified health plans could contract with a health care provider only if the provider implemented such mechanisms to improve health care quality as the Secretary may require through regulation. The Secretary is authorized to establish reasonable exceptions to these requirements.

***Sec. 3102. Financial Integrity***

This section describes the responsibilities of the Secretary, the Government Accountability Office (GAO) and the state with respect to financial integrity of the Gateway. States would keep accurate accounting of all Gateway activities, receipts and expenditures and submit annual reports to the Secretary. The Secretary may investigate the affairs of a Gateway, examine the properties and records of a Gateway, and may require periodical reports on Gateway activities. A Gateway shall fully cooperate in any investigation initiated by the Secretary. A Gateway is subject to annual audits by the Secretary.

If the Secretary determines that a Gateway or a state has engaged in serious misconduct the Secretary may rescind from payment due to the State an amount not to exceed 1 percent of the payment per year until corrective actions are taken by the State.

The Secretary would implement any procedure that is appropriate to reduce fraud, waste and abuse in the administration of the Gateways,

Not later than five years after the date of enactment, GAO will conduct an ongoing study of Gateway activities and enrollees. The study would review (a) the operations and

administration of the Gateway including surveys and reports of qualified health plans offered through Gateways and experience of such plans, Gateway expenses, qualified health plan claims statistics, plan complaints, and the manner in which Gateways meet their goals, (b) observations regarding the utilization and adoption of Gateways, and (c) any recommendations for improvements in Gateway operations or policies.

***Sec. 3103. Seeking the Best Medical Advice.***

The Secretary would be required to establish a Medical Advisory Council. In establishing the Council, the Secretary would be required either to consult with medical experts at the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), and other centers of excellence, or to contract with the Institutes of Medicine to establish the Council. The “Council” would be required to make recommendations to the Secretary, subject to limitations and other specification required in statute, on: (1) essential health care benefits eligible for credits under section 3111; (2) criteria for determining “minimum qualifying coverage”; and (3) conditions under which coverage would be considered affordable and available coverage for individuals and families at different income levels.

The provision describes required aspects of membership of the Council (including the need for appropriate expertise), terms of service, and other administrative matters including staffing, hearings, length of service, and expenses. Members of the Council would be appointed by the Secretary. The Council would report its recommendations to the Secretary not later than 180 days after the date of enactment of this title, and annually thereafter. The Secretary would review such reports for scientific and medical validity and seek revisions as necessary, within specified time frames and in consultation with medical experts at the NIH and CDC. The Secretary would submit reports (upon review, and any required revision) to Congress within 30 days of final receipt. Recommendations in these reports would be considered applicable unless Congress, within 90 calendar days of receipt, enacts a joint resolution, in specified language, disapproving such report in its entirety. For reports issued prior to June 30, the recommendations would apply for the following year. For recommendations issued after June 30, the recommendations would apply the second year, after the report was received. In the event that Congress disapproved a report, recommendations included in any prior reports that were not disapproved would remain applicable. If Congress disapproved the initial report reflecting the Council’s recommendation, the Council would issue a revised report, also subject to the Secretary’s review and Congressional disapproval.

The report of the Council would contain recommendations regarding the determination of essential health care benefits eligible for credits under section 3111, including items and services in at least the following categories: (A) ambulatory patient services; (B) emergency services; (C) hospitalization; (D) maternity and newborn care; (E) medical and surgical care; (F) mental health and substance abuse services; (G) prescription drugs; (H) rehabilitative, habilitative, and laboratory services; (I) preventive and wellness services; and (J) pediatric services, including oral and vision care. The Council would assure that its recommendations reflected a balance among these categories, and would

consider the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups.

The Council would establish the criteria that coverage must meet to be considered “minimum qualifying coverage” and the conditions under which coverage would be considered affordable and available coverage for individuals and families at different income levels. In establishing the items and services that comprise essential health care benefits, the Council would be required to ensure that the actuarial gross value of the benefits is equal to those provided under a typical employer plan, as determined by the Secretary. The inclusion of any other items and services, in addition to those listed in statute, would not effect the calculation of this limitation.

In establishing minimum qualifying coverage, the Council (1) would be required to exclude any coverage that provided reimbursement for the treatment or mitigation of a single disease or condition, or an unreasonably limited set of diseases or conditions; or that had an out-of-pocket limit that exceeded the amount described in Section 223 of the Internal Revenue Code of 1986 (re: Health Savings Accounts) for the year involved; (2) would establish the criteria in a manner that resulted in the least practicable disruption of the health care marketplace, consistent with the goals and activists under this title, and (3) could apply different criteria for young adults.

#### ***Sec. 3104. Allowing State Flexibility***

During the four-year period following enactment, a State may do the following: (1) establish a Gateway, adopt the reform provisions in Title I of the legislation (and subsequent amendments), discussed above, and agree to make state or local governments subject to employer responsibility requirements and free-rider penalties; (2) request the Secretary to operate a Gateway in the state (for a minimum of five years), adopt the individual and group market reform provisions in Subtitle A of Title I of the legislation (and subsequent amendments), and agree to make state or local governments subject to employer responsibility requirements and free-rider penalties, or (3) elect not to take these actions. If a state meets the requirements under option (1) any resident of the deemed “establishing state” would be eligible for a premium credit (described below for the new Sec. 3111 of the Public Health Service Act) beginning 60 days after the date that the Secretary has determined the state meets the requirements. The Secretary would establish procedures for continual review to ensure states comply with the requirements, and the Secretary would have the authority to revoke the determination.

If the state requests that the Secretary operate the Gateway, the Secretary would determine if the State is in compliance with the individual and group market reform provisions in Subtitle A of Title I of the legislation. If the state were determined to meet the requirements, the Secretary would establish a Gateway as soon as practicable; if the state did *not* meet the requirements, the Secretary would establish a Gateway as soon as practicable *after* the Secretary determines that the insurance reforms have been enacted by the state. The state would be deemed a “participating” state on the date on which the Gateway is established. Residents in these states would be eligible for premium credits 60 days after the Gateway in established.

If four years after the date of enactment a state is not an “establishing state” or a “participating state,” the Secretary would establish and operate a Gateway in the state, the individual and group market insurance provisions described above would become effective, the state would be deemed a participating state and, if the state agrees to make state or local governments subject to employer responsibility requirements and free-rider penalties, residents would be eligible for premium credits 60 days after the Gateway is established.

### ***Sec. 3105. Navigators***

The Secretary would award grants to ‘establishing states’ to enable state Gateway(s) to contract with private and public ‘navigator’ entities. A navigator would (a) conduct public education activities regarding the Gateway, (b) distribute fair and impartial enrollment and premium credit information, (c) assist with enrollment in a qualified plan, and (d) provide this information in culturally and linguistically appropriate manner.

To be eligible to be a navigator the entity must demonstrate existing relationships with or the establishment of relationships with employers and employees and self-employed individuals likely to be eligible to participate in the Gateway. These entities may include

- Trade, industry, and professional associations
- Commercial fishing industry organizations
- Ranching and farming organizations
- Chambers of commerce
- Unions
- Small business development centers
- And other entities determined by the Secretary

The Secretary would establish standards to avoid conflicts of interest. Under the standards, a navigator could not be a health insurance issuer or receive any direct or indirect consideration from any health insurance issuer in connection with an employer or employee in the Gateway. The Secretary, in collaboration with the states, would develop guidelines detailing a navigator’s duties.

Within one year of the date of enactment, states would be required to amend their Medicaid state plans so that in cases where an individual who applies for Medicaid or CHIP and is eligible for either, the state must establish procedures to (a) advise the individual of their option under a qualified health plan, (b) determine whether the individual is eligible for a health insurance premium credit and the amount of the credit, and (c) submit the necessary information to the qualified health plan to enroll the individual.

## **Subtitle C – Affordable Coverage for All Americans**

### **Sec. 151. Support for Affordable Health Coverage**

*Current Law*

***Pertaining to Sec. 3111***

None.

(See Current law Sec. 143 for the Massachusetts' example).

***Pertaining to Sec. 3112***

Over half of states provide assistance to small business to obtain health insurance coverage. This assistance can be in the form of subsidies to offset the cost of insurance, a small business tax credit, or a state-subsidized health insurance program.

*Proposed Law*

This section would amend the Public Health Service Act by adding a new subtitle B to the new Title XXXI.

**“Subtitle B – Making Coverage Affordable”**

***Sec. 3111. Support for Affordable Health Coverage.***

Under this section, the Secretary would establish the three minimum required cost-sharing tiers for qualified health plans as well as payment and eligibility for credits to help certain individuals pay for their coverage.

Plan Cost-Sharing Tiers. The Secretary would establish the three minimum required cost-sharing tiers, as shown in the table below. No more than once a year, the Secretary may redetermine the benefit value percentage or the out-of-pocket limitation. Expenditures considered “out of pocket” would be defined as those considered “qualified medical expenses” in the Internal Revenue Code for Health Savings Accounts (HSAs).

<b>Cost-sharing tiers</b>	<b>Plan would pay for the following % of total allowed costs</b>	<b>Enrollees' maximum out-of-pocket</b>
<b>Tier A (basic plan)</b>	76% ( $\pm 2$ percentage points)	Same amount set for Health Savings Accounts (HSAs) under current law ( $\pm 5\%$ )
<b>Tier B</b>	Tier A benefit value plus 8 percentage points ( $\pm 2$ percentage points)	50% of the Tier A out-of-pocket maximum ( $\pm 5\%$ )
<b>Tier C</b>	Tier A benefit value plus 17 percentage points ( $\pm 2$ percentage points)	15% of the Tier A out-of-pocket maximum ( $\pm 5\%$ )

Premium Credits. The Secretary would pay a premium credit to each Gateway for qualified, enrolled individuals. The Gateway would remit the credit to the qualified health plan an individual is enrolled in.

The amount of the premium credit would be determined by the Secretary so that an eligible individual whose modified adjusted gross income (MAGI) is 500% of the federal

poverty level (FPL) would pay no more than 10% of income in premiums. For individuals below 500% FPL, the percentage an individual would be required to pay for premiums would be reduced ratably such that an eligible individual with an income of 150% FPL (or less) would pay no more than 1% of income in premiums. The Secretary could establish a schedule of premium credits in dollar amounts to simplify the administration of the credits, so long as the schedule does not significantly change the value of the premium credits as would otherwise be calculated.

However, the premium credit amount would also be limited based on a “reference premium.” For an individual whose family income is at or below 200% of poverty, the reference premium would be the weighted average annual premium of the three lowest-cost plans in Tier C offered in the individual’s community rating area. For an individual whose family income is above 200% of poverty but is not above 300% of poverty, the reference premium would be the weighted average annual premium of the three lowest-cost plans in Tier B offered in the individual’s community rating area. For an individual whose family income is above 300% of poverty but is not above 500% of poverty, the reference premium would be the weighted average annual premium of the three lowest-cost plans in Tier A (basic plan) offered in the individual’s community rating area.

Regardless of their credit amount, individuals could enroll in any qualified health plan, but would have to pay the difference between the premium and the credit, if any.

The reference premium is based on items and services that are based on the category of services that define essential health services (described in Sec. 3103 of the bill). Other services or items that may be reimbursed by a plan are excluded from the reference premium calculation. Reference premium calculations would be determined for a standard population. If fewer than three qualified health plans were offered in a community rating area, the reference premium would be based on the premiums associated with the actual plans offered in the area. There would be an annual adjustment of the premium credit percentage based on the change in the medical care component of the consumer price index. A state may make payments to or on behalf of an eligible individual that are greater than the premium credit amounts or are intended to defray the costs of items or services that are not on the list of essential health care benefits defined earlier.

The Secretary, through regulation will establish rules and procedures for the submission of applications for payments (including the electronic submission and documents necessary for application), making eligibility determinations, resolving determination appeals, re-determining eligibility, and making payments. Eligibility determination rules would permit eligibility to be calculated based on (a) an applicant’s previous tax year income, or (b) in the case of an individual seeking a credit based on claiming a significant decrease in income, the applicant’s income for the most recent period otherwise practicable or the applicant’s declaration of estimated annual income for the year involved.

The Secretary has the authority to make these determinations regarding eligibility for premium credits to individuals based on income; the secretary will delegate to a Gateway (or upon request of the state or states which a Gateway operates in) the authority to carryout these activities. The Gateway must carry out the activities so that they are consistent with the regulations. After notice and providing the opportunity for a hearing, the Secretary has the right to revoke this authority in situations where the Gateway is not operating in accordance with the regulations.

An individual that has been determined to be eligible for subsidies would be responsible to notify a Gateway of any changes that might affect their eligibility status. Upon an individual's notice the Gateway would promptly re-determine the individual's eligibility. The Gateway would terminate payments on behalf of the individual, if the individual fails to provide the status change information in a timely basis or the Gateway determines the individual is no longer eligible for the premium credits.

Applications for this process can be done in person, by mail, telephone, and the Internet. The Secretary would determine the form of the application, and the manner of submission. The application may require documentation. An application may be submitted to the Gateway or a state agency for determination. A Gateway or state agency shall assist an individual in filing these applications.

For individuals who would receive a premium credit payment on their behalf for a year and who claim a significant decrease in income in that year, the individual would file an income reconciliation statement. Based on the income reconciliation statement, the Secretary would determine the size of overpayments or underpayments. Individuals would be liable to the Secretary for overpayment amounts. The Secretary would pay to the individual any deficit associated with underpayments. The Secretary could establish methods to reconcile overpayments and underpayments using the next credit amount otherwise available to the individual. If an individual fails to file a reconciliation statement, the individual would not be eligible for premium credit payments until the statement is filed. The Secretary has the right to waive this requirement if there is good cause. The Gateway would conduct outreach activities to individual potentially eligible for these reconciliation payments. These Gateway activities would include information on the application process with respect to these reconciliation payments.

As a condition of its State Medicaid plan, a state shall assist in making eligibility determinations for these premium credits, cost sharing provisions and out-of-pocket expenditure limits.

Payments received in this section would not be considered income for purposes of determining eligibility for any other federal program.

A Gateway could not establish rules that conflict with or prevent the application of regulations promulgated by the Secretary under this title.

No payments could be made for individuals who are not lawfully present in the United States.

Out of any funds in the US Treasury not otherwise appropriated, funds may be appropriated to carry out the activities under this section.

***Sec. 3112. Small Business Credit.***

This provision would provide a credit to qualified small businesses based on a formula that considers tiers of coverage provided (\$1,000 for each employee with self-only coverage, \$2,000 for each employee with family coverage, and \$1,500 for each employee with coverage for either two adults, or one adult and one or more children), adjusted annually for inflation; share of employer contribution towards the premium; firm size; and a factor based on number of months during a taxable year for which an employer paid or incurred employee health insurance expenses.

**Sec. 152. Non-Discrimination in Health Care**

[policy under discussion]

**Subtitle D – Shared Responsibility for Health Care**

**Sec. 161. Individual Responsibility**

*Current Law*

Federal law does not require individuals to have health insurance. Only Massachusetts, through its statewide program requires that individuals have health insurance (although this has been considered in other states, such as California, Maryland, Maine, and Washington). All adult residents of Massachusetts are required to have health insurance that meets “minimum creditable coverage” standards if it is deemed "affordable" at their income level under a schedule set by the board of the Massachusetts Connector. Individuals report their insurance status on state income tax forms. Individuals can file hardship exemptions from the mandate; persons for whom there are no affordable insurance options available are not subject to the mandate.

Beginning with tax year 2007, adult residents of Massachusetts without insurance and who are not exempt from the mandate lose their state income tax personal exemption. Beginning with tax year 2008, a replacement penalty is levied for each month an individual is without insurance, equal to 50% of the lowest premium for which he or she would have qualified, to be collected through withholding of state income tax refunds. If no refund is due or the penalty exceeds the refund amount, the state notifies the taxpayer and may use existing state income tax enforcement and collection procedures to obtain the balance owed.

*Proposed Law*

***Sec. 59B. Shared Responsibility Payments.***

The bill would amend Subchapter A of chapter 1 of Internal Revenue Code (IRC) by adding a new Part VIII -shared responsibility payments. Any individual who did not have qualifying coverage, as defined by statute, for any month during the taxable year, would be required to pay (in addition to any other amount required under this subtitle) an amount established by the Secretary, in consultation with the Secretary of Health and Human Services (HHS) and the states, effective for the taxable year following the date on which the amount was established. In establishing the amount the Secretary would be required to seek the minimum practicable amount that would enhance participation in qualified coverage. Exemptions would be allowed for any individual (1) for any month in which the individual did not have qualifying coverage for less than [--] days, (2) who was a resident of a state that was not a participating State or an establishing State (as defined by statute), (3) for whom affordable health care coverage was not available (as defined by the Medical Advisory Council), or (4) for whom a payment would otherwise present an exceptional financial hardship, as determined by the Secretary.

The amount imposed by this section would not be treated as a tax imposed by this chapter of the IRC for purposes of determining the amount of any credit allowable under this chapter, or the amount of minimum tax imposed by section 55 {IRC section 55 relates to the alternative minimum tax}. For purposes of subtitle F of the IRC (procedures and administration, the amount imposed by this section would be treated as if it were a tax imposed by section 1 (section 1 of the IRC relates to determination of tax liability)}. Section 15 would not apply to the amount imposed by this section (section 15 of the IRC relates to changes in tax rates during a year). This section would also not apply for purpose of determining the liability to any possession of the United states. For purpose of section 932 and section 7654 the amount would not be treated as a tax imposed by this chapter (section 932 of the IRC relates to the coordination of the U.S. and the Virgin Islands section 7654 of the IRC relates to coordination of the U.S. and certain possessions of individual income tax – “special possession” are defined as Guam, American Samoa, the Northern Marianas, and the Virgin Islands). The Secretary could prescribe regulations, as appropriate to carry out this section of the Act. This section would apply to taxable years beginning after December 31, 20[--].

***Sec. 6055. Reporting of Health Insurance Coverage.***

Every person who provides health insurance that is qualifying coverage would be required to make a return, in such form as prescribed by the Secretary that (1) contained the name, address, and taxpayer identification number of each individual who is covered under the health insurance that is qualifying coverage provided by such person, (2) the number of months during the calendar year during which each such individual was covered under the qualifying health insurance plan, and (3) other information as prescribed by the Secretary. Every person required to make a return described above, would also be required to provide, in writing, to each individual whose name was required on that return, the following information (1) the name, address and phone number of the person required to make such return, and (2) the number of months during the calendar year that such individual was covered under qualifying health insurance

provided by such person. The written statement would be required to be furnished on or before January 31 of the year following the calendar year for which the return was required to be made. Qualifying coverage would have the same meaning as established in Section 31[--] of the PHS Act. This would apply to taxable years beginning after December 31, 20[--].

No later than [--] of each year, the Secretary of the Treasury, in consultation with the Secretary of HHS, would send a notification to each individual who files an individual income tax return and who was not enrolled in qualifying coverage with information on the services available through the Gateway operating the State in which the individual resides.

## **Sec. 162. Notification on the Availability of Affordable Health Choices**

### *Current Law*

There is no federal requirement that employers offer health insurance. While the Employee Retirement Income Security Act of 1974 (ERISA) does not require an employer to offer health benefits, it does mandate compliance if an employer chooses to offer health benefits, such as compliance with plan fiduciary standards, reporting and disclosure requirements, and procedures for appealing denied benefit claims. ERISA was amended (as well as the Public Health Service Act and the Internal Revenue Code) in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, P.L. 99-272) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191), adding other federal requirements for health plans, including rules for health care continuation coverage, limitations on exclusions from coverage based on preexisting conditions, and a few benefit requirements such as minimum hospital stay requirements for mothers following the birth of a child.

### *Proposed Law*

#### ***Sec. 18A. Notice to Employees.***

The Fair Labor Standards Act of 1938 would be amended requiring each employer to which this bill applies to provide to each employee at the time of hiring (or for current employees, within [--] days of the enactment of this section), written notice informing them of the American Health Benefits Gateway, including a description of the services provided by the Gateway and contact information.

## **Sec. 163. Shared Responsibility of Employers**

### *Current Law*

There is no federal requirement that employers offer health insurance. While the Employee Retirement Income Security Act of 1974 (ERISA) does not require an employer to offer health benefits, it does mandate compliance if an employer chooses to offer health benefits, such as compliance with plan fiduciary standards, reporting and

disclosure requirements, and procedures for appealing denied benefit claims. ERISA was amended (as well as the Public Health Service Act and the Internal Revenue Code) in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, P.L. 99-272) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191), adding other federal requirements for health plans, including rules for health care continuation coverage, limitations on exclusions from coverage based on preexisting conditions, and a few benefit requirements such as minimum hospital stay requirements for mothers following the birth of a child.

*Proposed Law*

***Sec. 3115. Share Responsibility of Employers.***

[policy under discussion]

***Sec. 3116. Definitions.***

*Current Law*

Medicare is an example of a federal public health insurance option for the aged and disabled. Under Medicare, Congress and the Centers for Medicare and Medicaid Services (CMS) in the Department of Health and Human Services (HHS) determine many parameters of the program including eligibility rules, financing (including determination of payroll taxes, and premiums), required benefits, payments to health care providers, and cost sharing amounts. However, even within this public plan, CMS subcontracts with private companies to carry out much of the administration of the program.

*Proposed Law*

This provision would add the following definitions to the Public Health Service Act.

A public health insurance option would mean [policy under discussion]

An eligible individual would mean an individual with the following characteristics: (a) the individual is a citizen or national of the US, or an alien lawfully admitted to the US for permanent residence or an alien lawfully present in the US, (b) the individual is a qualified individual (as defined below), (c) the individual is enrolled in a qualified health plan, and (d) the individual is not receiving coverage under a State Children's Health Insurance Program.

A qualified employer would mean an employer that elects to make all full-time employees eligible for a qualified health plan and that meets specified criteria, including employer size.

In the case of an employer who elects to enroll in a qualified plan available through a Gateway in an establishing state, the criteria for qualified employers, including employer size, would be established by the state. In a participating state, criteria for qualified employers would be established by the Secretary. The criterion for employer size could be established by the Secretary through regulations, but if the Secretary did not establish criteria on employer size, the maximum employer size would be deemed to be 10.

A qualified health plan would mean a plan health plan that meets the following criteria. First, the plan would be required to have in effect a certification (which may include a seal or some other indication of approval) issued by each Gateway through which the plan is offered. Second, the plan would be offered by a health insurance issuer that (a) is licensed and in good standing in each state in which it offers insurance through this title, (b) agrees to offer at least one qualified health plan at each of two levels of cost sharing established by the Secretary, (c) complies with regulations established by the Secretary and other requirements as established by the Gateway, and (d) agrees to pay any surcharge assessed as part of the certification process.

A qualified individual would mean an individual who is (a) residing in a participating or establishing state, (b) not incarcerated, (c) not entitled to Medicare Part A, or enrolled in Medicare Part B, and (d) not eligible for coverage under Medicaid (or a Medicaid waiver), TRICARE, the Federal Employees Health Benefits Program, or, in some cases, employer sponsored insurance.

An individual who is eligible for employer-sponsored coverage would be deemed to be a qualified individual if the coverage offered by their employer did not meet criteria for minimum qualifying coverage, or the coverage was not affordable for the employee, as defined under the recommendations of the Medical Advisory Counsel.

An individual with an adjusted gross income that did not exceed 150 percent of the poverty line for a family size involved would be assumed to be eligible to participate in the Medicaid program, and would not be considered a qualified individual.

Qualifying coverage would mean (a) a group health plan or health coverage that an individual was enrolled in on the date of enactment, or that same coverage that was later renewed by an enrollee, (b) a group health plan or health coverage that an enrollee was not enrolled in on the date of enactment but that met or exceeded the criteria for minimum qualifying coverage, or (c) any of the following insurance or health coverage: Medicare coverage under Parts A and B, or Part C; Medicaid coverage, or coverage under a Medicaid Section 1115 waiver, but not coverage consisting solely of the Program for Distribution of Pediatric Vaccines; coverage under the State Children's Health Insurance Program; coverage under TRICARE; coverage under the veteran's health program, but only if the coverage is determined by the Secretary to be not less than the coverage provided under a qualified health plan, based on the individual's priority for services; the Federal Employees Health Benefits Program (FEHBP); State health benefits high risk pool; a health benefit plan for Peace Corps volunteers; or coverage under a qualified health plan. Individuals would be deemed to have qualifying coverage if the

individual was described in Section 1402(e) and (g) of the Internal Revenue Code of 1986 which pertains to ministers, members of religious orders, and Christian Science practitioners.

Unless otherwise specified, the definitions contained in Section 2791 of the Public Health Service (PHS) Act would apply to this title.

## **Subtitle E – Improving Access to Health Care Services**

### **Sec. 171. Spending for Federally Qualified Health Centers (FQHCs).**

#### *Current Law*

Section 330 of the PHS Act authorizes the Secretary, acting through the Health Resources and Services Administration (HRSA), to create a grant program to award funds to allow entities to establish health centers that serve medically underserved populations. These health centers may be community health centers, rural health centers, migrant health centers, and health centers for residents of public housing. The PHS Act authorizes \$2,065,000,000 for FY2008; \$2,313,000,000 for FY2009; \$2,602,000,000 for FY2010; \$2,940,000,000 for FY2011; and \$3,337,000,000 for FY2012. In FY2009, Congress appropriated \$4,190,022,000 for the Health Center program administered by HRSA. This amount includes \$44,055,000 appropriated for Health Center Tort Claims and \$2 billion appropriated under the American Recovery and Reinvestment Act (ARRA, P.L. 111-5).

#### *Proposed Law*

The bill would amend Section 330(r) of the PHS Act by authorizing the following amounts for grants to health centers: \$2,988,821,592 for FY2010; \$3,862,107,440 for FY2011; \$4,990,553,440 for FY2012; \$6,448,713,307 for FY2013; \$7,332,924,155 for FY2014; and \$8,332,924,155 for FY2015. For FY2016 and subsequent years, the amount authorized to appropriate for that year would be based on the amount authorized to appropriate for the preceding fiscal year, adjusted by the product of one plus the average percentage increase in costs incurred per patient served and one plus the average percentage increase in the total number of patients served.

### **Sec. 172. Other provisions.**

#### *Current Law*

Health centers, authorized under Section 330 of the PHS Act, are required to offer primary care services including: health services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology; diagnostic laboratory and radiologic services; preventive health services, including screenings; voluntary family planning services; preventive dental services; and emergency medical services. The PHS Act allows health centers to offer services additional to primary health care if these services are appropriate to meet the needs of the population served. The Act provides that centers must serve a

medically underserved population but does not specify that the center be located in a medically underserved area. The Act requires the center to evaluate whether its location is appropriate to best meet the needs of its clients. Current law does not specify a limit on the number of centers that can be located within a catchment area.

The PHSA also requires the Secretary to take into account the linkages of a health center with other providers in the area when making grant funding decisions. Additionally, the Secretary is authorized to make grants to health centers to enable the centers to plan and develop networks to improve access and availability of health services to individuals served by the health center. Under current law, health centers are required to have a governing board that is composed of a majority of individuals served by the center. The board must meet monthly, approve the center's budget and director, and approve general policies for the center.

### *Proposed Law*

The bill would amend Section 330 of the PHSA to do the following:

In defining a "health center," the bill would authorize the provision of required primary health services and additional health services either at facilities directly operated by the center or at other inpatient or outpatient settings. It would also add considerations for the location of service delivery sites, whereby a center would not be required to locate its facility within a designated medically underserved area if the center determines their current location to be reasonably accessible and appropriate to meet the needs of the residents and or special medically underserved population.

The bill would authorize the Secretary to permit grant applicants to propose the location of a service delivery site within another center's catchment area if the applicant demonstrates sufficient unmet need and justifies the need for additional federal resources. In determining whether to approve such proposal, the Secretary would be required to take into consideration collaboration between centers and consider any comments by the affected center concerning the proposal's impact.

With respect to grant application requirements, the bill would require that the center include contractual arrangements, as appropriate, when making reasonable efforts to establish and maintain collaborative relationships with other health care providers in the catchment area.

Regarding application requirements for the center's governing board, the bill would authorize, in the case of an application for a public center, a public entity to retain authority to establish financial and personnel policies for the center. The bill would also require, in the case of an application with co-applicant with a public entity, that the center has established a governing board that meets the current requirements with respect to composition, meeting, and duties.

The bill would provide for the modification of the center's overall plan and budget at any time during the fiscal year, provided that such modifications do not require additional grant funds, do not compromise the accessibility or availability of services, and otherwise meet the conditions of the location of a service delivery site within another center's catchment area. Modifications that do not meet these conditions, as determined by the health center, would be submitted for the Secretary's approval.

The bill would authorize the Secretary to carry out projects to establish and administer arrangements under which the costs of providing supplies and services for the operation of federally qualified health centers are reduced through collaborative efforts of the centers. This could be arranged through purchases that apply to multiple centers or through such other methods as determined appropriate by the Secretary.

With respect to health center operating grants, the bill would provide the center with an opportunity to correct material failures regarding grant conditions. Specifically, if the Secretary finds that the center materially fails to meet any requirements, the Secretary would be required to provide the center with an opportunity to achieve compliance before terminating the center's grant. A center may appeal and obtain an impartial review or fair hearing on any Secretarial determination.

### **Sec. 173. Funding for National Health Service Corps.**

#### *Current Law*

Sections 331, 338A, 338B, and 338I of the PHS Act authorize the National Health Service Corps (NHSC), administered by HRSA. The NHSC provides scholarship and loan repayment programs for medical school students, nurse practitioners, nurse midwives, physician assistants, dental school students, and allied health professionals who enter primary care in health professional shortage areas (HPSA). NHSC clinicians may fulfill their service commitments in health centers, rural health clinics, public or nonprofit medical facilities, federal or state correctional facilities, or within other community-based systems of care. The PHS Act authorizes the following amounts for the NHSC scholarship and loan repayment programs: \$131,500,000 for FY2008; \$143,335,000 for FY2009; \$156,235,150 for FY2010, \$170,296,310 for FY2011, and \$185,622,980 for FY2012.

#### *Proposed Law*

The bill would amend Section 338H of the PHS Act to authorize the following: \$320,461,632 for FY2010; \$414,095,394 for FY2011; \$535,087,442 for FY2012; \$691,431,432 for FY2013; \$893,456,433 for FY2014; and \$1,154,510,336 for FY2015. For FY2016 and subsequent years, the amount authorized to appropriate for that year would be based on the amount appropriated for the preceding fiscal year adjusted by the product of one plus the average percentage increase in the costs of health professions education during the prior fiscal year; and one plus the average percent change in the number of individuals residing in a health professions shortage area during the prior

fiscal year relative to the number of individuals residing in health professions shortage areas during the previous fiscal year.

**Sec. 174. Negotiated rulemaking for development of methodology and criteria for designating medically underserved populations and health professions shortage areas.**

*Current Law*

Section 330(b) of the PHS Act requires the Secretary to establish criteria to designate an area as being medically underserved and, under Section 332 of the PHS Act, the Secretary designates an area as having a shortage of health professionals. When designating a medically underserved population (MUP), the Secretary must prescribe criteria for determining the specific shortage of personal health services for an area or group. Designation of MUPs has been carried out under the Grants for Community Health Services regulations codified at 42CFR Part 51c.102(e), and implementing Federal Registrar notices. The criteria used by the Secretary to determine whether an area is a health professional shortage area are codified at 42 CFR Part 5. These criteria must take into account comments received from state and local officials and include factors indicative of the health and economic status of the population group or residents of the area. The administrative rule making process requires a comment period for stakeholders to comment on proposed rules; and, under current law, the Secretary must consult with relevant stakeholders when determining if an area no longer meets the conditions of being medically underserved or as having a shortage of health professionals.

*Proposed Law*

The Secretary, through a negotiated rule making process, would be required to establish a comprehensive methodology and criteria for designating a medically underserved population and a health professional shortage area. In establishing this methodology and criteria, the Secretary would consult with relevant stakeholders and other specified entities who would be affected by the rule. The Secretary would be required to take into account the availability, timeliness, and appropriateness of data necessary to make the designation; the impact of the methodology and criteria on communities, health centers, and other safety net providers; the availability of data for applicants applying for the designation; and the extent to which the methodology accurately measures various barriers that individuals and populations confront when seeking health care services.

The Secretary would be required to publish a notice of the rulemaking process no later than 45 days after enactment, and make progress towards publishing a rule by the target date of July 10, 2010. The Secretary would also be required to appoint a negotiated rulemaking committee by no later than 30 days after the end of the comment period and appoint a facilitator of the committee no later than 10 days after the committee is appointed.

The committee would be required to report to the Secretary no later than April 1, 2010 regarding its progress on reaching a consensus on the rulemaking proceedings and whether there will be consensus by one month before the target date of publishing the rule (i.e. June 2010). If the committee reports that it has not made progress towards reaching a consensus or is unlikely to reach a consensus before June 2010, the Secretary may terminate the committee and provide an alternative method for publishing the rule. If the committee is not terminated, the committee must submit a report containing a proposed rule no later than one month before the target publication date (i.e. June 2010). The Secretary would be required to publish a rule in the Federal Register no later than the target publication date. The rule would be effective and final immediately on an interim basis, but subject to changes and revision following a public comment period of no less than 90 days. In connection with the rule, the Secretary must specify the process for the timely review and approval of applications for the designation of a “medically underserved population” or the designation as a “health professional shortage area.” The Secretary would provide for consideration of public comments and must republish the rule no later than one year after the target publication date.

## **Sec. 175. Equity for Certain Eligible Survivors**

### *Current Law*

Section 411(c)(4) of the Black Lung Benefits Act provides for a rebuttable presumption of eligibility for Black Lung Benefits for a miner and his or her survivors in the case of a miner who had worked in underground coal mines for at least 15 years, had a negative chest roentgenogram, and had other evidence of a totally disabling respiratory or pulmonary impairment. This rebuttable presumption does not apply to claims filed by miners or survivors on or after the effective date of the Black Lung Amendments of 1981 (January 1, 1982).

Section 422(l) of the Black Lung Benefits Act provides that the survivors of a miner who was eligible for Part C Black Lung Benefits at the time of his or her death are not required to submit a new claim in order to receive survivors benefits. This provision does not apply to claims for Part C benefits originally filed on or after the effective date of the Black Lung Amendments of 1981 (January 1, 1982).

### *Proposed Law*

Section 175 of the proposed law would eliminate the provisions limiting the rebuttable presumption of eligibility provided in Section 411(c)(4) and the continuation of benefits for survivors provided in Section 422(l) of the Black Lung Benefits Act to claims filed before January 1, 1982. The elimination of these provisions would only apply to claims for Part B or C Black Lung Benefits filed after January 1, 2005 and that are pending on or after the date of enactment of the proposed law.

## **Sec. 176. Reauthorization for Emergency Medical Services for Children Program**

### *Current Law*

Section 1910 of the PHSA authorizes the Secretary to make grants to states or accredited schools of medicine to support demonstration programs that expand and improve emergency medical services for children who need treatment for trauma or critical care. The program is administered by the Maternal and Child Health Bureau under HRSA. Grants made are for no more than a 3-year period (with an optional 4th year based on performance), and subject to annual evaluation by the Secretary. In any fiscal year, only three grants may be made within a state.

The Act authorized \$2 million for FY1985 and for each of the two succeeding fiscal years, \$3 million for FY1989, \$4 million for FY1990, \$5 million each of FYs 1991 and 1992, and such sums as necessary for each of FYs 1993 through 2005. While current authorization has expired, these programs continue to receive federal funding. In FY2009, Congress appropriated \$20 million.

### *Proposed Law*

The bill would amend Section 1910 of the PHSA by expanding the grant year period to a 4-year period (with an optional 5th year). It would also authorize funding for FYs 2010 through 2014 in the following amounts: \$25,000,000 for FY2010; \$26,250,000 for FY2011; \$27,562,500 for FY2012; \$28,940,625 for FY2013; and \$30,387,656 for FY2014.

## **Subtitle F –Making Health Care More Affordable for Retirees**

### **Sec. 181. Reinsurance for Retirees**

#### *Current Law*

No current law. Average per capita health spending among the near elderly in 2004 (\$7,787) was 50% more than among 45-to 54-year-olds (\$5,210) and more than double that of 19- to 44-year olds (\$3,370). These spending levels carry over into their health insurance costs. In the non-group market, average premiums for the near elderly were nearly \$1,200 more than 45- to 54-year-olds and triple that for 25- to 34-year olds. The near elderly were more likely than their younger adult counterparts to spend more than 10% of their after-tax income on health care and health insurance premiums.

#### *Proposed Law*

This section provides for a temporary “reinsurance program” for selected employers who are in a state that does not have a Gateway (i.e., either an establishing state that has a

Gateway that it administers or a participating state that has a Gateway that is administered by the Secretary of HHS).

Within 90 days of enactment, employers in non-Gateway operating states would be eligible for reimbursement to offset the high costs of retirees between 55 and 65 who are provided employer-based health insurance. This federal reimbursement would cease when the state is deemed to have an active Gateway.

To be eligible, an employer must provide health insurance for retirees who are between 55 and 64 years old (and their dependants) and are not eligible for Medicare. The health insurance plans can take many forms, including

- traditional plans,
- self-insuring plans,
- plans negotiated during the process of collective bargaining,
- plans funded through a Voluntary Beneficiary Employee Association (a type of trust fund), and
- multiple employer plans.

The employer must submit an application to participate in the program. A collective bargaining organization that provides health insurance for its members would be treated as an employer.

The employer's health insurer must

- provide a plan that meets the minimum gross actuarial value of essential benefits that are detailed earlier in this title,
- implement cost-saving measures for enrollees with chronic and high-cost conditions,
- provide documentation for costs and claims, and
- be certified by HHS.

The employer would submit claims for reimbursement to the Secretary. The claims must document the services received, and the actual price paid for the services (i.e., the employer would take into account any negotiated price concessions). HHS would then reimburse the employer for 80% of the costs above \$15,000 associated with any valid claim. To be eligible for reimbursement, the claim must be between \$15,000 and \$90,000. These amounts would be adjusted annually using the Medical Care Component of the Consumer Price Index (rounded to the nearest multiple of \$1,000). The employer would use the reimbursed money to lower the insurance premiums it charges enrollees.. The reimbursed money could not be used for administrative costs or to increase the employer's profit. The Secretary would develop a monitoring mechanism to ensure the appropriate use of these payments to employers. The reimbursed money would not be included in determining employer gross income. The Secretary would establish an appeals process for employers' appeals of claim determinations. In addition, the Secretary would be required to develop procedures against fraud, waste and abuse under

the program. HHS would conduct annual audits of participating employers to ensure compliance with this program.

The Treasury of the United States would establish a “Retiree Reserve Trust Fund” (the “Trust Fund”). The Trust Fund would consist of appropriated amounts or credits. All trust fund amounts would remain available until expended. There is appropriated to the Trust Fund, out of any moneys in the treasury not otherwise appropriated, an amount requested by the Secretary, except that the total of all requests could not exceed \$10 billion. Trust Fund amounts may be appropriated to carry out the program. Trust Fund amount appropriated for the program would not be factored into any budget enforcement procedure including those associated with the Balanced Budget and Emergency Deficit Control Act. HHS may close employer applications to the program after reaching the limit of \$10 billion.

## **Subtitle G – Improving the Use of Health Information Technology for Enrollment; Miscellaneous Provisions**

### **Sec. 185. Health Information Technology Enrollment Standards and Protocols**

#### *Current Law*

The Health Information Technology for Economic and Clinical Health (HITECH) Act, which was incorporated into the American Recovery and Reinvestment Act of 2009 (P.L. 111-5), created a new Title XXX in the PHS Act to promote the widespread adoption of health information technology (HIT). Among its provisions, the HITECH Act codified the existing Office of the National Coordinator for HIT (ONCHIT) and established a process for the development of interoperability standards that support the nationwide electronic exchange of health information among doctors, hospitals, patients, health plans, the federal government, and other health care stakeholders. The Act established an HIT Policy Committee to make policy recommendations to the National Coordinator relating to the implementation of a nationwide HIT infrastructure, including recommending areas in which standards are needed for the electronic exchange and use of health information. It also established an HIT Standards Committee to develop, harmonize, and pilot test standards, implementation specifications, and certification criteria for the electronic exchange of health information, based on the recommendations of the HIT Policy Committee.

The HITECH Act created several grant programs, including a state loan program, to support HIT infrastructure and to help health care practitioners finance HIT. In addition, the legislation provided financial incentives through the Medicare and Medicaid programs to encourage doctors, hospitals, health clinics, and other entities to adopt and use certified electronic health records (EHRs). Medicare incentive payments are phased out over time and replaced with financial penalties for providers that are not using EHRs. Finally, the HITECH Act expanded and strengthened the HIPAA privacy and security standards.

*Proposed Law*

**Sec. 3021. Health Information Technology Enrollment Standards and Protocols.**

The proposal would add a new Subtitle C to PHS Act Title XXX. The Secretary, within 180 days of enactment and in consultation with the HIT Policy Committee and the HIT Standards Committee, would be required to develop interoperable and secure standards that facilitate enrollment of individuals in federal and state health and human services programs. The standards and protocols would have to allow for the following functions: (1) electronic matching against existing federal and state data that provide evidence of eligibility, including vital records, employment history, and tax records; (2) simplification and submission of electronic documentation, digitization of documents, and systems verification of eligibility; (3) reuse of stored eligibility information; (4) capability of individuals to apply, recertify, and manage their eligibility information online; (5) ability to expand the enrollment system to integrate new programs, rule, and functionalities; (6) notification, including by email and phone, of eligibility, recertification, and other information regarding eligibility; and (7) other functionalities to streamline the enrollment process. The Secretary would be required to notify states upon approval of the standards and protocols and would be authorized to require that states and other entities incorporate such standards and protocols as a condition of receiving federal HIT funds.

The Secretary would be required to award grants to states and localities to develop new or upgrade existing IT systems to implement the enrollment standards and protocols. Eligible grantees would be required to submit an adoption and implementation plan that includes, among other things, demonstrated collaboration with other grantees. The Secretary also would be required to ensure that the enrollment IT adopted by grantees be made available at no cost to other qualified states, localities, and other entities, as determined by the Secretary.

**Sec. 186. Rule of Construction Regarding Hawaii's Prepaid Health Care Act**

*Current Law*

The Hawaii Prepaid Health Care Act (PHCA) was originally enacted in 1974 to set minimum standards of health care benefits for workers. As defined in statute, employers (excluding Federal, State and City government and other categories specifically excluded by the law ) are required to provide Hawaii employees with a qualified prepaid group health care plan. Unless specifically excluded under the law or a Notice to Employer to waive coverage is filed with the employers, all employees who meet the eligibility requirements are entitled to health care coverage through employer-based group policies. The Employee Retirement Income Security Act (ERISA) includes an exemption for Hawaii's PHCA, allowing it to operate.

*Proposed Law*

This would not modify or limit the application of the exemption for Hawaii's Prepaid Health Care Act, as provided under ERISA.

### **Sec. 187. Key National Indicators**

#### *Current Law*

None

#### *Proposed Law*

The section would establish the Commission on Key National Indicators, the "Commission". The processes sets forth the required aspects of Commission membership, qualifications, and other specifications.

The Commission would have the following responsibilities:

- Conducting comprehensive oversight of the newly established key national indicator system
- Making recommendations on how to improve the key national indicator system
- Coordinating with Federal Government users and information providers to assure access to relevant and quality data
- Entering into contracts with the National Academy of Sciences, the "Academy"

This bill would mandate two annual reports; one to Congress and the President (Not later than 1 year after the selection of the 2 Co-Chairpersons of the Commission, and each subsequent year thereafter) and the other to the Academy (Not later than 6 months after the selection of the 2 Co-Chairpersons of the Commission, and each subsequent year thereafter). The report to Congress would be a detailed statement of recommendations, findings, and conclusions of the Commission on the activities of the Academy and a designated Institute (non-profit entity) related to the establishment of a Key National Indicator System. The report for the Academy would also be submitted to a designate Institute, detailing recommendations concerning potential issue areas and key indicators in the Key National Indicators.

The Commission would not have authority to direct the Academy, or, if established, the Institute, to adopt, modify, or delete any key indicators.

As soon as practical, the Commission shall enter into an arrangement with the Academy to review available public and private sector research on key national indicator set selection, determine how to best establish a key national indicator system for the United States, and other provisions. Concurrently, the Academy shall convene a multi-sector, multi-disciplinary process to define major scientific and technical issues associated with developing, maintaining, and evolving a Key National Indicator System.

The Academy would establish the key national indicator system by either creating its own institutional capability, or partnering with an independent, private, non-profit organization as an Institute. The Academy, through its capability or partnership with an appropriate Institute, shall identify and select all criterion and methodologies to establish and operate the key national indicator system. This entails issues to be represented, measures to utilize, and data to populate the system. The Academy would be required to design, publish, and maintain a public website for public access to key national indicators. Also, the Academy would develop a quality assurance framework to ensure rigorous and independent processes and quality data selection.

Upon establishing a Key National Indicator System, the Academy shall create an appropriate governance mechanism that incorporates advisory and control functions, if applicable, balance appropriate Academy involvement with the independence of the Institute, and submit to the Commission a report detailing the findings and recommendations of the Academy (not later than 270 days after the date of enactment of this Act). The Academy would exercise the option, at any time, to alter the establishment the key national indicator system (including new aspects of its relationships with the Institute, if applicable, and designating a different non-profit entity to serve as the Institute).

The Academy (or Institute if established) would exercise sole discretion, at any time, to alter its approach to the establishment of a key national indicator system.

The Government Accountability Office (GAO) would conduct a study for Congress of previous work (from all public, private agencies in the United States and abroad) on the best practices of establishing a key national indicator system. GAO would also conduct a financial audit and programmatic assessments of the Institute (if established) reporting the results to the Commission as well as appropriate authorizing committees of Congress.

### *Appropriations*

In order to carry out the purposes of establishing the Commission and contracting Academy, there would be an authorization to appropriate \$10 million for fiscal year 2010, and \$7.5 million for each fiscal year 2011 through 2018. It would be the responsibility of the Academy to devise a budget for the construction and management of a sustainable, adaptable, and evolving key national indicator system that reflects all Commission funding and (if applicable) Institute activities.

## **Subtitle H – CLASS Act**

### **Sec. 190. Short title of Subtitle**

#### **PART I – Community Living Assistance Services and Supports**

**Sec. 191. Establishment of National Voluntary Insurance Program for Purchasing Community Living Assistance Services and Support**

**“Title XXXII – Community Living Assistance Services and Supports”**

*Current Law*

No provision.

*Proposed Law*

Amend the Public Health Service Act to include the following: Title XXXII – Community Living Assistance Services and Supports

**Sec. 3201. Purpose.**

The provision would state as the purpose of this title the establishment of a national voluntary insurance program for purchasing community living assistance services and supports in order to: (1) provide individuals with functional limitations tools that allow them to maintain their personal and financial independence and live in the community through a new financing strategy for community living assistance services and supports; (2) establish an infrastructure to help address the Nation’s community living assistance services and supports needs; (3) alleviate burdens on family caregivers; and (4) address institutional bias by providing a financing mechanism that supports personal choice and independence to live in the community.

**Sec. 3202. Definitions.**

The provision would define the following terms:

(1) ACTIVE ENROLLEE to mean an individual who is enrolled in the CLASS program in accordance with section 3204 and who has paid any premiums due to maintain such enrollment.

(2) ACTIVELY EMPLOYED to mean an individual who is (1) reporting for work at the individual’s usual place of employment or at another location to which individual is required to travel because of the individual’s employment (or in the case of an individual who is a member of the uniformed services, is on active duty and is physically able to perform the duties of the individual’s position); and (2) is able to perform all the usual and customary duties of the individual’s employment on the individual’s regular work schedule.

(3) ACTIVITIES OF DAILY LIVING to mean each of the following activities specified in section 7702B(e)(2)(B) of the IRC of 1986: eating, toileting, transferring, bathing, dressing, and continence.

(4) CLASS PROGRAM to mean the program established under this title.

(5) DISABILITY DETERMINATION SERVICE to mean, with respect to each State, the entity that has an agreement with the Commissioner of Social Security to make disability determinations for purposes of title II or XVI of the Social Security Act.

(6) ELIGIBLE BENEFICIARY to mean any individual who is an active enrollee in the CLASS program and, as of the date described: (1) has paid premiums for enrollment in such program for at least 60 months; and (2) has paid premiums for enrollment in such program for a least 12 consecutive months, if a lapse in premium payments of more than 3 months has occurred during the period that begins on the date of the individual's enrollment and ends on the date of such determination.

For the purpose of determining an eligible beneficiary, the date described is the date on which the individual is determined to have a functional limitation described in section 3203(a)(1)(C) that is expected to last for a continuous period of more than 90 days.

(7) HOSPITAL, NURSING FACILITY, INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED, INSTITUTION FOR MENTAL DISEASES to have the meanings given such terms for purposes of Medicaid.

(9) CLASS INDEPENDENCE ADVISORY COUNCIL or COUNCIL to mean the Advisory Council established under section 3207 to advise the Secretary.

(10) CLASS INDEPENDENCE BENEFIT PLAN to mean the benefit plan developed and designated by the Secretary in accordance with section 3203.

(11) CLASS INDEPENDENCE FUND to mean the fund established under section 3206.

(12) MEDICAID to mean the program established under title XIX of the Social Security Act.

(13) POVERTY LINE to have the meaning given the term in section 2110(c)(5) of the Social Security Act.

(14) PROTECTION AND ADVOCACY SYSTEM to mean the system for each State established under section 143 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000.

***Sec. 3203: Class Independence Benefit Plan***

*Process for Development.* The Secretary, in consultation with appropriate actuaries and other experts, would be required to develop at least 2 actuarially sound benefit plans as

alternatives for consideration for designation as the CLASS Independence Benefit Plan under which eligible beneficiaries would receive benefits. Each of the plan alternatives would be required to be designed to provide eligible beneficiaries with program benefits and be consistent with the following requirements:

Premiums. The maximum monthly premium for enrollment for all reasonably anticipated new and continuing enrollees during the year would be prohibited from exceeding the estimated average dollar amount of \$65, increased by the Consumer Price Index for all urban consumers (U.S. city average) for each year after 2009 and before such year. The maximum monthly premium could be lower for younger individuals than for older individuals, but the same premium would be required to be established for all such individuals of the same age.

Individuals with incomes that do not exceed the poverty line and individuals under age 22 who are actively employed during any period in which they are full-time students (as determined by the Secretary) would be required to pay a nominal premium that would not exceed \$5, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for each year after 2009 and before such year. Beginning with the first month following the month in which an individual ceases to fall into this category, individuals would be subject to the same monthly premium as the monthly premium that would apply to an individual of the same age who first enrolls in the program under the most similar circumstances (such as the first year of eligibility for enrollment in the program or in a subsequent year).

Benefit Trigger and Eligibility. There is a 5-year vesting period before becoming eligible for benefits. To trigger benefits based on a functional limitation that is expected to last for a continuous period of more than 90 days: (i) the individual would be determined to be unable to perform at least the minimum number (which may be 2 or 3) of activities of daily living as are required under the plan for the provision of benefits without substantial assistance (as defined by the Secretary) from another individual; (ii) the individual requires substantial supervision to protect the them from threats to health and safety due to substantial cognitive impairment; and (iii) the individual has a level of functional limitation similar the level of functional limitation described in previous clauses.

Cash Benefit. A cash benefit paid to an eligible beneficiary would not be less than an average of \$50 per day (as determined based on the reasonably expected distribution of beneficiaries receiving benefits at various benefit levels). The cash benefit amount would vary based on a scale of functional ability, with not less than 2, and not more than 6, benefit level amounts. Cash benefits would be paid on a daily or weekly basis and no lifetime or aggregate limit would be applied. The benefits would allow for coordination with any supplemental coverage purchased from a health insurance issuer through a Gateway established under section 3101.

The CLASS Independence Advisory Council would be required to evaluate the alternative benefit plans and recommend for designation as the CLASS Independence Benefit Plan for offering to the public the plan that the Council determines would best balance price and benefits to meet enrollees' needs in an actuarially sound manner, while optimizing the probability of the long-term sustainability of the CLASS program. Taking into consideration the recommendation of the CLASS Independence Advisory Council, the Secretary would be required to designate a benefit plan as the CLASS Independence Plan no later than October 1, 2012. The Secretary would be required to publish such designation, along with details of the plan and the reasons for its selection, in an interim final rule that would allow for a period of public comment and subsequent response by the Secretary before being finalized.

*Additional Premium Requirements.* The Secretary would be required to annually establish the monthly premium for new enrollees in the CLASS program during any year after the first effective year of the program. The Secretary would be required to determine these annual monthly premiums based on: (A) the most recent report of the CLASS Independence Fund Board of Trustees; (B) the advice and recommendations of the CLASS Independence Advisory Council; (C) the projected distribution and amounts of benefits under the CLASS program; and such other factors as the Secretary would determine appropriate.

The amount of the monthly premium for an individual upon enrollment would be required to remain the same for as long as the individual would be an active enrollee. Certain exceptions would apply. If the Secretary determines, based on the most recent Board of Trustees of the CLASS Independence Fund, the advice of the CLASS Independence Advisory Council, or such other information as the Secretary determines appropriate, that the monthly premiums and income to the CLASS Independence Fund for a year are projected to be insufficient with respect to the 20-year period that would begin with that year. The Secretary would be required to adjust the monthly premium for individuals as necessary (but maintaining a nominal premium for enrollees whose income is below the poverty line or who are full-time students actively employed). An exemption from an increase would also be required for monthly premiums of active enrollees who have attained age 65, paid enrollment premiums for at least 20 years, and are not actively at work.

Individuals who re-enroll after 90 days during which the individual failed to pay the monthly premium would be required to be treated as an initial enrollment for purposes of age-adjusting the premium for enrollment in the program. If re-enrolled in 5 years, these individuals would be required to be credited with any months of paid premiums that accrued prior the lapse and would be required to pay premiums for enrollment for at least 12 consecutive months before being eligible to receive benefits.

There would be a penalty imposed for re-enrollment after a 5-year lapse. The monthly premium for these individuals would be required to be the age-adjusted premium that would be applicable to an initially enrolling individual who is of the same age and increased by the greater of: (i) the amount the Secretary determines is actuarially sound

for the period over which the individual lapsed to maintain the individual's enrollment in the CLASS program, or (ii) 1 percent of the applicable age-adjusted premium for each where a lapse of paying the premium occurred.

In determining the monthly premiums for the CLASS program, the Secretary is authorized to factor in the costs for administering the program. For the first 5 years of the program, such costs could not exceed 3% of all premiums paid during each year. For subsequent years, such costs could not exceed 5% of the total amount of all expenditures (including benefits paid) with respect to that year.

Underwriting, other than on the basis of age, would be prohibited from being used to determine monthly premiums for enrollment in the CLASS program or preventing an individual from enrolling in the program.

*Self-Attestation and Verification of Income.* The Secretary would be required to establish procedures to: (1) permit an individual who is eligible for the nominal premium to self-attest to their status; (2) verify using procedures similar to the procedures used by the Commissioner of Social Security and request information from a financial institution with the beneficiary's permission and consistent with the requirements applicable to the conveyance of data and information under section 1942 of such Act; and (3) require an individual to confirm on at least an annual basis, that their income does not exceed the poverty line or that they continue to maintain such status.

***Sec. 3204: Enrollment and Disenrollment Requirements***

*Enrollment, Opt-Out, and Disenrollment.* The Secretary would be required to establish procedures for automatic enrollment for the CLASS Program by an employer. Automatic enrollment would be similar to how employers may elect to automatically enroll employees in 401(k), 403(b), or 457 retirement plans. Such procedures would provide for an alternative enrollment process for an individual: who is self-employed; has more than 1 employer; whose employer does not elect to participate in the automatic enrollment process, or is a spouse of an eligible individual not subject to automatic enrollment.

The Secretary would be required to establish by regulation procedures to ensure that an individual is not automatically enrolled by the CLASS Program by more than one employer, and to allow for an individual's employer to deduct a premium for spouse who is not subject to automatic enrollment. Program enrollment would be required to be made in such manner as the Secretary may describe to ensure ease of administration.

An eligible individual could elect to waive enrollment in the CLASS program at any time in such form or manner as the Secretary would be required to prescribe.

The Secretary would be required to establish procedures under which:

- (1) an individual who, in the year of the individual's initial eligibility to enroll in the CLASS program, has elected to waive enrollment and is eligible to elect to enroll in the program (in such form and manner as the Secretary would be

required to establish) only during an open enrollment period. Such period would be established by the Secretary, specific to the individual, and may not occur more frequently than biennially after the date on which the individual first elected to waive enrollment in the program; and

(2) an individual would only be permitted to disenroll from the program during an annual disenrollment period established by the Secretary and in such form and manner as the Secretary would be required to establish.

For purposes of enrolling in the CLASS program, an individual is defined as: (1) having attained at least age 18; (2) who receives taxable wages or taxable self-employment income, and (3) who is actively at work; (4) who is not a patient in a hospital or nursing facility, an intermediate care facility for the mentally retarded, or an institution for mental diseases and receiving Medicaid, or confined to jail, prison, other penal institution or correctional facility, or by court order pursuant to conviction of a criminal offense or in connection with a verdict or finding related to insanity, mental disease, a mental defect, or mental incompetence. A spouse of an individual meeting the above criteria would be eligible if they are not actively at work or are not receiving taxable wages or taxable self-employment income. Nothing in this section should be construed as requiring an active enrollee to continue to receive wages and/or be self-employed in order to maintain enrollment in the CLASS program.

*Payment.* An amount equal to the monthly premium for the enrollment in the CLASS program would be required to be deducted from the wages or self-employment income of eligible individuals. The procedures for employers who elect this deduction would be established by the Secretary, in consultation with the Secretary of Treasury, for employers who elect to deduct or withhold such premiums on behalf of enrolled employees. The Secretary would be required to establish alternative procedures for the payment of monthly premiums by an individual enrolled in the CLASS Program who does not: 1) have an employer who elects to deduct and withhold premiums, or 2) earn wages or derive self-employment income.

*Transfer of Premium Collected.* During each calendar year, the Secretary of Treasury would be required to deposit into the CLASS Independence Fund a total amount equal (in the aggregate) to 100% of the premiums collected during that year. The amount deposited would be transferred in at least monthly payments to the CLASS Independence Fund on the basis of estimates by the Secretary and certified to the Secretary of Treasury of amounts collected in accordance to certain requirements. Proper adjustments would be required to be made in amounts subsequently transferred to the fund to the extent prior estimates were in excess of, or were less than, actual amounts collected.

### ***Sec. 3205. Benefits.***

*Determination of Eligibility.* The Secretary would be required to establish procedures for active enrollees to apply for benefits under the CLASS Independence Benefit Plan. In regards to eligibility assessments, no later than January 1, 2012, the Secretary would be required to enter into agreements with (i) each state's Disability Determination Service to

provide for eligibility assessments of active enrollees applying for benefits; (ii) each state's Protection and Advocacy System to provide advocacy services (as specified below); and (iii) public and private entities to provide advice and assistance counseling (as specified below). Such agreements would require that a Disability Determination Service make its eligibility determination for a cash benefit and the amount of such benefit (in accordance with the sliding scale established under the plan) within 30 days of receipt of a benefits application. Applications pending after 45 days would be required to be deemed approved.

An agreement entered into for advice and assistance counseling would be required to assign, as requested by an eligible beneficiary, a counselor to provide information regarding: (1) accessing and coordinating long-term care services and supports in the most integrated setting; (2) possible eligibility for other benefits and services; (3) development of a service and support plan; (4) information about programs and services established under the Assistive Technology Act of 1998; and (5) such other services as the Secretary, by regulation, may require.

An agreement entered into with public and private entities would require the Protection and Advocacy System for the state to assign, as needed, an advocacy counselor to each eligible beneficiary that is covered by such agreement and who would be required to provide an eligible beneficiary with: (A) information regarding how to access the appeals process; (B) assistance with respect to the annual recertification and notification required for such recertification; and (C) such other services as the Secretary, by regulation, would require. The agreement would also require that the Protection and Advocacy System to ensure that the System and such counselors comply with the requirements of each state's Disability Determination Service.

Active enrollees would be required to be deemed presumptively eligible if the enrollee: (i) applied for, and attests to being eligible for, the maximum cash benefit available under the sliding scale established under the CLASS Independence Benefit Plan; (ii) is a patient in a hospital (but only if the hospitalization is for long-term care), nursing facility, intermediate care facility for the mentally retarded (ICF/MR), or an institution for mental diseases; and (iii) is in the process of, or about to being in the process of, planning to discharge from the hospital, facility or institution; or within 60 days from the date of discharge from the hospital, facility or institution.

As determined by the Secretary, an eligible beneficiary would be required to periodically, recertify by submission of medical evidence the beneficiary's continued eligibility for benefits; and submit records of expenditures attributed to the aggregate cash benefit received by the beneficiary during the preceding year.

The Secretary would be required to establish procedures for applicants of benefits under the CLASS Independence Benefit Plan to be guaranteed the right to appeal an adverse determination.

*Benefits.* An eligible beneficiary would receive the following required benefits: (1) a cash benefit established by the Secretary that, in the first year, is not less than the average of \$50 per day (as determined based on the reasonably expected distribution of beneficiaries receiving benefits at various benefit levels); and for subsequent years, is not less than the average per day dollar limit applicable for the preceding year, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) over the previous year; (2) advocacy services; and (3) advice and assistance counseling.

The Secretary would be required to establish procedures for administering the provision of benefits to eligible beneficiaries, including payment of cash benefits for the beneficiaries into a Life Independence Account established by the Secretary on behalf of each eligible beneficiary. Cash benefits paid into a Life Independence Account would be required to be used to purchase nonmedical services and supports that beneficiaries would need to maintain their independence at home or in another residential setting of their choice in the community, including, but not limited to, home modifications, assistive technology, accessible transportation, home-maker services, respite care, personal assistance services, home care aides, and nursing support. The Secretary would be required to establish procedures for crediting an account established on behalf of a beneficiary with the beneficiary's cash daily benefit; allowing the beneficiary to access such account through debit cards; and accounting for the beneficiary's withdrawals.

The Secretary would be required to establish procedures for allowing access to a beneficiary's cash benefits by an authorized representative of the eligible beneficiary. These procedures would be required to ensure that authorized representatives comply with standards of conduct established by the Secretary, including standards requiring that such representatives provide quality services on behalf of such beneficiaries, do not have conflicts of interest, and do not misuse benefits paid on behalf of such beneficiaries or otherwise engage in fraud or abuse.

Benefits would be required to be paid to, or on behalf of, an eligible beneficiary beginning with the first month in which an application for such benefits is approved. An eligible beneficiary may elect to defer payment of their daily or weekly benefit and rollover the payment from month-to-month (but not from year-to-year); and receive a lump-sum payment in an amount that may not exceed the lesser of the total amount of the accrued deferred benefits or the applicable annual benefit. The applicable period for determining an eligible beneficiary's applicable annual benefit and the amount of accrued deferred benefits is the 12-month period commencing with the first month of receipt of such benefits and each 12-month period thereafter.

The Secretary would be required to recoup any accrued benefits in the event of a beneficiary's death or the beneficiary's failure to elect to receive a deferred lump-sum payment before the end of the 12-month period in which such benefits are accrued. Any benefits recouped would be required to be paid into the CLASS Independence Fund and used for investment on behalf of enrollees and for the payment of the Fund's administrative expenses and beneficiaries' cash benefits.

*Primary Payer Rules for Medicaid Beneficiaries.* If an eligible beneficiary is enrolled in Medicaid and is a patient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or an institution for mental diseases, then the beneficiary would be required to retain an amount equal to 5 percent of the beneficiary's daily or weekly applicable cash benefit (in addition to Medicaid's personal needs allowance), and the remainder of such benefit shall be applied toward the facility's cost of providing the beneficiary's care. Medicaid would be required to provide secondary coverage of such care.

If an eligible beneficiary is enrolled in Medicaid and receiving home and community-based services (as defined by sections 1915(c) and (d) and section 1115 of the Social Security Act and a state's Medicaid state plan services), then the beneficiary would retain 50% of the beneficiary's daily or weekly applicable cash benefit. The remainder of the cash benefit would be applied toward the cost to the state of providing such assistance (and shall not be used to claim Federal matching funds under Medicaid). Medicaid would provide secondary coverage for the remainder of any costs incurred. A state would be paid the 50% of a beneficiary's daily or weekly cash benefit only if: (1) the state's home and community-based waiver (under either sections 1915(c) or (d) or section 1115) or its related Medicaid state plan services do not include a waiver of statewideness or comparability; and (2) the state offers, at a minimum, case management services, personal care services, habilitation services, and respite care under its Medicaid program.

If an eligible beneficiary is enrolled in Programs of All-Inclusive Care for the Elderly (PACE) under Medicaid, then the beneficiary shall retain an amount equal to 50 percent of the beneficiary's daily or weekly cash benefit (as applicable). The remainder of the cash benefit would be applied toward the cost to the state of providing such assistance (and shall not be used to claim Federal matching funds under Medicaid). Medicaid would be required to provide secondary coverage for the remainder of any costs incurred in providing such assistance. A state would be paid the 50% of a beneficiary's daily or weekly cash benefit only if the Medicaid PACE beneficiary is a patient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or an institution for mental diseases.

Subject to these rules, benefits received would be required to supplement but not supplant other health care benefits for which the beneficiary is eligible under Medicaid or any other Federally funded program.

*Relationship to Other Programs.* Benefits paid to an eligible beneficiary under the CLASS program would be required to be disregarded for purposes of determining or continuing the beneficiary's eligibility for other Federal, State or locally funded assistance programs, including the Federal Old-Age, Survivors and Disability Insurance Benefit program, Supplemental Security Income Program, Medicare, Medicaid, the State Children's Health Insurance Program, programs administered by the Secretary of Veterans Affairs, low-income housing assistance programs, or the supplemental nutrition assistance program established under the Food and Nutrition Act of 2008.

*Other Requirements.* Nothing in this title would be construed as prohibiting benefits paid under the CLASS Independence Benefit Plan from being used to compensate a family caregiver for providing community living assistance services and supports to an eligible beneficiary.

The Secretary would be required to establish procedures to ensure that the Disability Determination Service and Protection and Advocacy System for a State, advocacy counselors for eligible beneficiaries, and any other entities that provide services to active enrollees and eligible beneficiaries under the CLASS program comply with the following:

- (1) if the entity provides counseling or planning services, such services are provided in a manner that fosters the best interests of the active enrollee or beneficiary;
- (2) if the entity has established operating procedures that are designed to avoid or minimize conflicts of interest between the entity and an active enrollee or beneficiary;
- (3) the entity provides information about all services and options available to the active enrollee or beneficiary, to the best of its knowledge, including services available through other entities or providers;
- (4) the entity assists the active enrollee or beneficiary to access desired services, regardless of the provider;
- (5) the entity reports the number of active enrollees and beneficiaries provided with assistance by age, disability, and whether such enrollees and beneficiaries received services from the entity or another entity;
- (6) if the entity provides counseling or planning services, the entity ensures that an active enrollee or beneficiary is informed of any financial interest that the entity has in a service provider; and
- (7) the entity provides an active enrollee or beneficiary with a list of available service providers that can meet the needs of the active enrollee or beneficiary.

***Sec. 3206. CLASS Independence Fund.***

*Establishment of CLASS Independence Fund.* A trust fund, entitled the ‘CLASS Independence Trust Fund,’ would be established within the U.S. Treasury. The Secretary of Treasury would be required to serve as Managing Trustee of the Fund. The Fund is required to consist of all amounts derived from payments into the Fund and remaining after investment of such amounts, including additional amounts derived as income from such investments. The amounts held in the CLASS Independence Trust Fund (hereinafter referred to as the Fund) are appropriated and are required to remain available without fiscal year limitation:

- (1) to be held for investment on behalf of individuals enrolled in the CLASS program;
- (2) to pay the administrative expenses related to the Fund and to investments specified below; and
- (3) to pay cash benefits to eligible beneficiaries under the CLASS Independence Benefit Plan.

*Investment of Fund Balance.* The Secretary of the Treasury would be required to invest and manage the CLASS Independence Fund in the same manner, and to the same extent, as the Federal Supplementary Medical Insurance Trust Fund ( Medicare Part B).

*Off-Budget Status; Lock-Box Protection.* Notwithstanding any other provision of the law, the amounts derived from payments into the Fund and payments from the fund would not be counted as new budget authority, outlays, receipts or deficit or surplus for the purposes of: the budget of the U.S. government, as submitted by the President; the congressional budget; or the Balanced Budget and Emergency Deficit Control Act of 1985.

Notwithstanding any other provision of law, the Senate or the House of Representatives would not consider any measure that would authorize the payment or use of amounts in the Fund for any purpose other than the purpose authorized under this title. However, this provision may be waived or suspended in the Senate only by an affirmative vote of 3/5 of the Members.

Appeals in the Senate from the decisions of the Chair relating to this waiver authority would be required to be limited to 1 hour, to be equally divided between, and controlled by, the mover and the manager of the measure that would authorize the payment or use of amounts in the Fund for a purpose other than that which was authorized under this title. An affirmative vote of 3/5 of the Members would be required in the Senate to sustain an appeal of the ruling of the Chair on a point of order raised in relation to this waiver authority.

The provision would require Congress to enact this section as an exercise of the rulemaking power of the Senate and House of Representatives. It is deemed to be a 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 a measure regarding off-budget status and lock-box protection. It also supersedes other rules only to the extent it is inconsistent with such rules and 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.

*Board of Trustees.* The provision would create a Board of Trustees of the Fund composed of the Commissioner of Social Security; the Secretary of the Treasury; the Secretary of Labor; and the Secretary of Health and Human Services, all ex-officio, and two members of the public (both of whom may be not be from the same political party). The President would be required to nominate the public members for a term of 4 years, subject to confirmation by the Senate. A public member of the Board of Trustees who is nominated and confirmed to fill a vacancy occurring during a term would be required to serve for the remainder of such term. Confirmed public members may continue to serve after the expiration of their term until the earlier of the time at which the member's successor takes office or the time at which a report of the Board is first issued following the expiration of the member's term. The Secretary of the Treasury would be required to be the Managing Trustee. The Board of Trustees would be required to meet no less than

once each calendar year. A person serving on the Board of Trustees would not be considered a fiduciary or personally liable for actions taken in such capacity with respect to the Trust Fund.

The Board of Trustees would be required to do the following duties:

- 1) hold the Fund;
- 2) report to Congress no later than April 1 of each year on the operation and status of the Fund during the preceding fiscal year and on its operation and status during the current fiscal year and next 2 fiscal years;
- 3) report immediately to the Congress whenever the Board is of the opinion that the amount of the Fund is unduly small; and
- 4) review the general policies followed in managing the Fund, and recommend changes in such policies, including necessary changes in the provisions of the law governing management of the Fund.

The Report to Congress would be required to include:

- 1) A statement of the assets of and the disbursements to from the Fund during the preceding fiscal year.
- 2) A statement of the actuarial status of the Fund for the current and 2 subsequent fiscal years, and projected over the 75-year period beginning with the current fiscal year, and
- 3) An actuarial opinion by the Chief Actuary of the Social Security Administration certifying that the techniques and methodologies used are generally accepted within the actuarial profession and that the assumptions and cost estimates used are reasonable.

In addition, the Report to Congress would be printed as a House document of the session of Congress to which it is made.

The Board of Trustees would be required to include in the report recommendations for appropriate legislative action if the Board determines that enrollment trends and expected future benefit claims on the Fund create expected financial problems that are unlikely to be resolved with reasonable premium increases or through other means. These recommendations for such legislative action can include whether to adjust monthly premiums or impose a temporary moratorium on new enrollment.

***Sec. 3207. Class Independence Advisory Council.***

*Membership.* The provision would create an Advisory Committee known as the CLASS Independence Advisory Council (hereinafter referred to as the Council). It would require the Council to be composed of no more than 15 individuals, not otherwise employed by the U.S. Government. Council members would also be required to be: (1) appointed by the President, without regard to the civil service laws and regulations, and (2) composed of a majority who represent individuals who participate, or are likely to participate, in the CLASS program. This would include representatives of older and younger workers,

individuals with disabilities, family caregivers of individuals who require services and supports at home or in the community, individuals with expertise in long-term care or disability insurance, actuarial science, economics, and other relevant disciplines, as determined by the Secretary.

Council members would be required to serve overlapping 3 year terms, but would not be eligible to serve for more than 2 consecutive terms. The President would be required to appoint one of the Council members to serve as Chair.

*Duties.* Council members would be required to advise the Secretary on matters of general policy in the administration of the CLASS program and in the formulation of regulations under this title including the development of the CLASS Independent Benefit Plan and the determination of monthly premiums under such plan.

The Federal Advisory Committee Act (FACA, 5 U.S.C. App.) will regulate activities of the CLASS Independence Advisory Council to improve transparency and excludes Section 14 of FACA, making it permanent.

The provision would authorize such sums as necessary for FY2011 and for each fiscal year thereafter for the purposes of carrying out the Council's duties. Any sums appropriated would be authorized to remain available, without fiscal year limitation, until expended.

***Sec. 3208. Regulations: Annual Report.***

*Regulations.* The provision would require the Secretary to promulgate regulations, as necessary, to carry out the CLASS program. It would require such regulations to include provisions to prevent fraud and abuse under the program.

*Annual Report.* Beginning January 1, 2014, the Secretary would be required to submit an annual report to Congress on the CLASS program that includes the following: total number of program enrollees; total number of eligible beneficiaries during the fiscal year; total amount of cash benefits provided during the fiscal year; a description of instances of fraud or abuse identified during the fiscal year; and recommendations for administrative or legislative action, as determined necessary by the Secretary, to improve the program or prevent fraud or abuse.

***Sec. 3209: Tax Treatment of the Program.***

*Tax Treatment of The CLASS Program.* For tax purposes, the CLASS Program would be required to be treated in the same manner as a qualified long-term care insurance contract for qualified long-term care services.

***Conforming Amendments to Medicaid.***

Title XIX, section 1902(a) of the Social Security Act would be amended to require a state plan for medical assistance to 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 Medicaid and are eligible beneficiaries under the CLASS program established under Title XXXII of the PHSA as established by the Secretary.

*Assurance of Adequate Infrastructure for the Provision of Personal Care Attendant Workers.* Amends Title XIX, section 1902(a)(2) of the Social Security Act to require a state plan for medical assistance to provide that, no later than 2 years after the date of enactment of the CLASS Act, each state would be required to assess the extent to which entities such as providers of home care, home health services, and home and community services; 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 services to individuals receiving benefits under the CLASS program, including rural and underserved areas.

It would also require each state to 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 workforce supply for individuals receiving benefits under the CLASS program, including in rural and underserved areas. The provisions would also ensure that the designation or creation of such entities would 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 based 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.

*Personal Care Attendant Workforce Advisory Panel.* The Secretary of Health and Human Services would be required to establish a Personal Care Attendants Workforce Advisory Panel (hereinafter referred to as an Advisory Panel) no later than 90 days after the enactment. The purpose of the Advisory Panel would be to examine and advise the Secretary and Congress on workforce issues related to personal care attendant workers, including the adequacy of the number of workers, their salaries, wages, and benefits, and access to the services they provide.

The Secretary would be required to appoint members to the Advisory Panel that include individuals with disabilities of all ages, individuals who are seniors, and individuals who are representatives of the following: individuals with disabilities, seniors, workforce and labor organizations, home and community-based service providers, and assisted living providers.

*National Clearinghouse for Long-Term Care Information.* Information regarding the CLASS program will be added to the National Clearinghouse for Long-Term Care

Information. Additional funding of \$3,000,000 annually is required to be appropriated for 2011 and 2015.

*Effective Date.* The provisions would require that the amendments made by this section take effect on January 1, 2011.

## **PART II – Amendments of the Internal Revenue Code of 1986**

### **Sec. 195. Credit for Costs of Employers Who Elect to Automatically Enroll Employees and Withhold Class Premiums from Wages**

#### *Current Law*

The Internal Revenue Code of 1986 includes a General Business Credit, the amount of which for the current year is the sum of more than 30 separate credits.

#### *Proposed Law*

The provision would amend the Internal Revenue Code of 1986 to add the following section:

#### ***Sec. 45R: Credit for Costs of Automatically Enrolling Employees and Withholding CLASS Premiums from Wages.***

*General Rule.* The CLASS automatic enrollment and premium withholding credit would be an amount equal to 25 percent of the total amount paid or incurred by the taxpayer during the taxable year to:

- (1) Automatically enroll employees in the CLASS program, and
- (2) Withhold monthly CLASS premiums on the behalf of an employee who is enrolled in that program.

*Denial of Double Benefit.* The provision would not allow a deduction to be taken for any amount taken into account when determining the credit under this section.

*Election Not to Claim Credit.* The taxpayer can elect not to claim the credit for any taxable year.

*Credit Made Part of General Business Credit.* The provision would add the CLASS automatic enrollment and premium withholding credit to the list of the credits that are part of the General Business Credit.

Effective Date. The effective date would apply to expenses paid or incurred after December 31, 2010 in taxable years ending after such date.

## **Sec. 196. Long-Term Care Insurance Includible in Cafeteria Plans**

### *Current Law*

Cafeteria plans are defined as a written plan under which all participants are employees, and the participants may choose among 2 or more benefits consisting of cash and qualified benefits. Qualified benefits mean any benefit which is not includible in the gross income of the employee solely because under the plan the employee can choose among the benefits of the plan. Qualified benefits are not includible in the gross income of the employee by reason of an express provision in Chapter 1 of the IRC (other than section 106(b), 117, 127, or 132). Qualified benefits include any group term life insurance which is includible in gross income only because it exceeds the dollar limitation of Section 79 and such term includes any other benefit permitted under regulation. Qualified benefits do not include any product which is advertised, marketed, or offered as long-term care insurance.

### *Proposed Law*

The Internal Revenue Code of 1986 would be amended to allow long-term care insurance to be included in cafeteria plans. The amendment would be effective for taxable years beginning after December 31, 2010.

## **Title II- Improving the Quality and Efficiency of Health Care**

### **Subtitle A- National Strategy to Improve Health Care Quality**

#### **Sec. 201. National Strategy**

##### *Current Law*

There are no provisions in current law that require the development of national quality priorities, strategy, strategic plans, or infrastructure (directed either at the Secretary of Health and Human Services or the Agency for Healthcare Research and Quality).

However, section 1890 of the Social Security Act requires the Secretary to identify and have in effect a contract with a consensus-based entity, such as the National Quality Forum, to perform the following duties: 1) synthesize evidence and convene stakeholders to make recommendations, with respect to activities conducted under this Act, on an integrated national strategy and priorities for health care performance measurement in all applicable settings; 2) provide for the endorsement of standardized health care performance measures; 3) establish and implement a process to ensure that endorsed measures are updated or retired based on new evidence; 4) promote the development of

electronic health records that facilitate the collection of performance measurement data; and 5) report annually to Congress.

The National Quality Forum has been awarded this contract and recently released its first report, *Improving Healthcare Performance: Setting Priorities and Enhancing Measurement Capacity*, in fulfillment of this statutory requirement.

Section 913(b)(2) of the PHS Act requires the Agency for Healthcare Research and Quality (AHRQ) to submit to Congress an annual report on national trends in the quality of health care provided to the American people. AHRQ developed the first National Healthcare Quality Report in 2003. In addition, Section 903(a)(6) of the PHS Act requires AHRQ to annually submit to Congress a report regarding prevailing disparities in health care delivery as it relates to racial factors and socioeconomic factors in priority populations.

### *Proposed Law*

This proposal would require the Secretary, through a new Part S, Section 399HH under Title III of the Public Health Service Act (PHS Act), to establish a national strategy for healthcare quality improvement. Specifically, it would require the Secretary to establish a national strategy to improve the delivery of health care services, outcomes and population health and to identify national priorities for quality improvement in developing a national strategy. The Secretary would also be required to periodically (at least triennially) update the national strategy and transmit the national strategy and updates to relevant Committees of Congress.

The national priorities would have to: 1) address health care provided to patients with high-cost chronic diseases; 2) improve the design, development, demonstration, dissemination and adoption of infrastructure and methodologies and strategies for quality improvement in the delivery of health care services that represent best practices to improve patient safety, preventable admissions and readmissions, and health care-associated infections; 3) have the greatest potential for improving health outcomes, efficiency, and patient-centeredness of care; 4) reduce health disparities; 5) address gaps in quality and health outcomes measures, comparative effectiveness information, and data aggregation techniques; 6) identify areas in the delivery of health care services that have the potential for rapid improvement in the quality of patient care; 7) improve Federal payment policy to emphasize quality; 8) enhance the use of health care data to improve quality, transparency, and outcomes; and 9) address other areas as determined by the Secretary.

In addition, this proposal would require the Secretary to create a comprehensive strategic plan as part of the national strategy to achieve the national priorities for quality improvement. This would include addressing, at a minimum: 1) coordination among agencies within the Department; 2) agency-specific strategic plans to achieve national priorities; 3) establishing annual benchmarks for each relevant agency to achieve national priorities; 4) a process for regular reporting by the agencies to the Secretary on the implementation of the strategic plan; 5) using common incentives among public and

private payers with regard to quality and patient safety efforts; and 6) incorporating quality improvement and measurement in the strategic plan for health information technology required by the American Recovery and Reinvestment Act of 2009 (P.L. 111-5).

The Secretary would also be required to publish an annual national health care quality report card and create a website to make public the national priorities, agency-specific strategic plans, the annual national health care quality report card, and other information the Secretary deemed appropriate. The annual national health care quality report card would include: 1) the considerations for national priorities; 2) an analysis of the progress of the agency-specific strategic plans in achieving the national priorities and any gaps in such strategic plans; 3) the extent to which private sector strategies have informed Federal quality improvement efforts; and 4) a summary of consumer and provider feedback regarding quality improvement practices.

Finally, this proposal would require all relevant agencies within the Department of Health and Human Services to review the statutory authority, regulations, policies, and procedures of such agency in order to determine if there are any deficiencies that prohibit full compliance with this title. Agencies would be required to submit a proposal to the Secretary outlining the measures that may be necessary to bring the authority, regulations, policies, and procedures of the agency into conformity with the intent, purposes and provisions of this title.

## **Sec. 202. Interagency Working Group on Health Care Quality**

### *Current Law*

No provisions.

### *Proposed Law*

This proposal would require the President to convene a working group to be known as the Interagency Working Group on Health Care Quality. The goals of this group would include achieving the following: 1) collaboration, cooperation and consultation between Federal departments and agencies with respect to developing and disseminating strategies, goals, models, and timetables that are consistent with the national priorities identified in Section 399HH; and 2) avoidance of duplication of quality improvement efforts and a streamlined process for quality reporting and compliance requirements.

The Working Group would be required to include senior level representatives of the Department of Health and Human Services, the Department of Labor, the United States Office of Personnel Management, the Department of Defense, the Department of Education, the Department of Veterans Affairs, and any other Federal agencies and department with activities relating to improving health care quality and safety, as determined by the President. The Secretary of Health and Human Services would serve

as the Chair, and Member of the Working Group would serve as Vice Chair, on a rotating basis.

Not later than December 10, 2010, and annually after that, the Working Group would be required to submit a report describing the progress and recommendations of the Group to relevant Committees of Congress and shall make this report publicly available on a website.

### **Sec. 203. Quality Measure Development**

#### *Current Law*

The Agency for Healthcare Research and Quality (AHRQ) has significant existing statutory authorities with respect to the development of quality measures. Specifically, the Agency's mission, among other things, is to promote healthcare quality improvement by conducting and supporting research that develops and presents scientific evidence regarding all aspects of health care, including methods for measuring quality and strategies for improving quality (Sec. 901 of the PHS Act).

Section 912 of the PHS Act requires AHRQ to provide support for public and private efforts to improve healthcare quality, and that the role of the Agency specifically include the ongoing development, testing, and dissemination of quality measures, including measures of health and functional outcomes and the compilation and dissemination of health care quality measures developed in the private and public sector. To comply with this last requirement, the Agency has established the National Quality Measures Clearinghouse, an online resource that compiles and catalogues quality measures.

Finally, Section 917 of the PHS Act requires AHRQ to coordinate all research, evaluations, and demonstrations related to health services research, quality measurement and quality improvement activities undertaken and supported by the Federal Government.

Section 1890 of the Social Security Act requires the Secretary to identify and have in effect a contract with a consensus-based entity, such as the National Quality Forum, to perform the following duties: 1) synthesize evidence and convene stakeholders to make recommendations, with respect to activities conducted under this Act, on an integrated national strategy and priorities for health care performance measurement in all applicable settings; 2) provide for the endorsement of standardized health care performance measures; 3) establish and implement a process to ensure that endorsed measures are updated or retired based on new evidence; 4) promote the development of electronic health records that facilitate the collection of performance measurement data; and 5) report annually to Congress.

The National Quality Forum has been awarded this contract and recently released its first report, *Improving Healthcare Performance: Setting Priorities and Enhancing Measurement Capacity*, in fulfillment of this statutory requirement.

#### *Proposed Law*

This proposal would add a new Part D under Title IX of the PHS Act entitled Health Care Quality Improvement, Subpart I- Quality Measure Development.

For purposes of this subpart, a quality measure would be defined as “a standard for measuring the performance and improvement of population health or of health plans, providers or services, and other clinicians in the delivery of health care services.”

This proposal would direct the Director of AHRQ to identify, not less often than biennially, gaps where no quality measures exist or where existing measures need improvement, updating or expansion. The Director would be required to make a report on any gaps identified, and the process used to identify the gaps, available to the public on a website.

This provision would require the Director to award grants, contracts, or intergovernmental agreements to eligible entities for purposes of developing, improving, updating, or expanding quality measures in areas identified as gaps areas. The Director would be required to give priority to the development of quality measures that allow the assessment of 1) health outcomes and functional status of patients; 2) the continuity, management, and coordination of health care and care transitions across the continuum of providers; 3) patient, caregiver, and authorized representative experience, quality and relevance of information provided to patients, caregivers, and authorized representatives to inform decision making; 4) the safety, effectiveness, and timeliness of care; 5) health disparities; 6) the appropriate use of health care resources and services or 7) the use of innovative strategies and methodologies.

To be eligible for grants or awards under this section, entities would have to 1) have demonstrated expertise and capacity in measure development and evaluation; 2) have adopted procedures to include the views of those whose performance would be assessed by the measure and the views of other parties who also would use the quality measures in the development process; 3) collaborate with a qualified consensus-based entity, as practicable, and the Secretary that measures will meet the requirements to be considered for endorsement by such qualified consensus-based entity; 4) have transparent policies regarding conflicts of interest; and 5) submit an application according to requirements of the Secretary.

An entity receiving funds under this section would be required to use the funds to develop quality measures that meet the following requirements: 1) such measures build upon measures developed under section 1139A of the Social Security Act; 2) to the extent practicable, data on measures is able to be collected using HIT; 3) each measure is free of charge to users; and 4) each quality measure is publicly available on a website.

The funds under this section would be able to be used by the Director to update and test quality measures endorsed by a qualified consensus-based entity.

An appropriation of \$75,000,000 per year from FY2010 through FY2014 would be authorized.

## **Sec. 204. Quality Measure Endorsement; Public Reporting; Data Collection.**

### *Current Law*

Section 1890 of the Social Security Act requires the Secretary to identify and have in effect a contract with a consensus-based entity, such as the National Quality Forum, to perform the following duties: 1) synthesize evidence and convene stakeholders to make recommendations, with respect to activities conducted under this Act, on an integrated national strategy and priorities for health care performance measurement in all applicable settings; 2) provide for the endorsement of standardized health care performance measures; 3) establish and implement a process to ensure that endorsed measures are updated or retired based on new evidence; 4) promote the development of electronic health records that facilitate the collection of performance measurement data; and 5) report annually to Congress.

The National Quality Forum has been awarded this contract and recently released its first report, *Improving Healthcare Performance: Setting Priorities and Enhancing Measurement Capacity*, in fulfillment of this statutory requirement.

With respect to public reporting of quality information, according to 1886(b)(3)(B)(viii)(VII) of the Social Security Act, the Secretary must establish procedures for making hospital quality data reported pursuant to CMS's Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program available to the public, and these procedures must ensure that a hospital has the opportunity to review the data prior to such data being made public.

Also according to section 1886(b)(3)(B)(viii)(VII) of the Social Security Act, 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.

Currently, individual hospital performance on specific quality measures and on certain conditions is available on CMS's Internet website, Hospital Compare.

### *Proposed Law*

This section would amend Title III of the PHS Act by adding three new sections: 1) 399JJ- Quality Measure Endorsement; 2) 399KK: Public Reporting of Performance Information; and 3) 399LL: Evaluation of Data Collection Process for Quality Measurement.

#### Section 399JJ

Section 399JJ would define the following terms: 1) qualified consensus-based entity: means an entity with a contract with the Secretary under section 1890 of the Social

Security Act; 2) quality measure: means a standard for measuring the performance and improvement of population health or of health plans, providers of services, and other clinicians in the delivery of health care services; and 3) multi-stakeholder group: means a voluntary collaborative of organizations representing a broad group of stakeholders interested in or affected by the use of such quality measure.

A qualified consensus-based entity would be permitted to receive a grant or contract to: 1) make recommendations to the Secretary for national priorities for performance improvement; 2) identify gaps in endorsed quality measures as specified; 3) identify and endorse quality measures, including measures that address gaps; 4) update endorsed measures; 5) make endorsed measures publicly available and have a plan for wide-spread dissemination; and 6) transmit endorsed measures to the Secretary.

A qualified consensus-based entity that received a grant under this section would be required to provide a report to the Secretary (no less than annually) 1) of where gaps exist and where measures are unavailable or inadequate to identify or address such gaps and 2) regarding areas in which evidence is insufficient to support endorsement of quality measures in priority areas identified by the Secretary under the national strategy. The required annual report regarding the economic and quality impact of the use of endorsed measures.

A qualified consensus-based entity that receives a grant under this section would be required to evaluate the evidence and convene multi-stakeholder groups to make recommendations for national priorities for performance improvement not less frequently than triennially. In making these recommendations, the qualified consensus-based entity would be required to ensure that priority is given to areas in the delivery of health care services for all populations, including children and other vulnerable populations that 1) address the health care provided to patients with prevalent, high-cost chronic diseases; 2) improve the design, development, demonstration, dissemination and adoption of infrastructure and methodologies and strategies for quality improvement in the delivery of health care services that represent best practices to improve patient safety, preventable admissions and readmissions, and health care-associated infections; 3) have the greatest potential for improving health outcomes, efficiency, and patient-centeredness of care; 4) reduce health disparities; 5) address gaps in quality and health outcomes measures, comparative effectiveness information, and data aggregation techniques; 6) identify areas in the delivery of health care services that have the potential for rapid improvement in the quality of patient care; and 8) address the appropriate use of health care technology.

This process would be required to be open and transparent, and the selection of organizations participating in the multi-stakeholder groups shall include provisions for public comment on and public nomination of members.

A qualified consensus-based entity that receives a grant under this section would be required to convene multi-stakeholder groups to provide guidance on the selection of individual or composite measures, for use in reporting performance information to the public or for use in Federal health programs from among 1) measures that have been

endorsed by the qualified consensus-based entity (under Section 1890(b) of the SSA); and 2) measures that have not been considered for endorsement by the qualified consensus-based entity but are used or proposed to be used by the Secretary under laws that require the collection or reporting of quality measures. The guidance of the multi-stakeholder groups would be required to be transmitted to the Secretary by the qualified consensus-based entity. This process would be required to be open and transparent, and the selection of organizations participating in the multi-stakeholder groups would be required to include provisions for public comment on and public nomination of members.

Under this section, the Secretary would be permitted to make a determination under regulation or otherwise to use a quality measure that has been endorsed by the qualified consensus-based entity (under Section 1890(b) of the SSA) only after taking into account the guidance of multi-stakeholder groups, as described above. The Secretary would be permitted to make a determination to use a quality measure that has not been endorsed provided that the Secretary 1) transmits the measure to the qualified consensus-based entity for consideration for endorsement and for the multi-stakeholder consultation process to provide guidance on the selection of individual or composite measures, for use in reporting performance information to the public or for use in Federal health programs; 2) publishes in the Federal Register the rationale for the use of the measures; and 3) phases out use of the measure upon a decision of the qualified consensus-based entity not to endorse the measure, contingent on the availability of an adequate alternative endorsed measure. If there is no adequate alternative, the Secretary would be required to support the development of such an alternative measure.

This section would require that the Secretary establish a process to notify the qualified consensus-based entity when its recommendations regarding quality measures would have to be submitted to the Secretary for consideration in development of a regulation. The notification would be required to occur at least 120 days prior to the date that recommendations were due.

In publishing specified regulations, the Secretary would be required to include a description of each recommendation of the qualified consensus-based entity and the Secretary's responses to each recommendation. Specified regulation would be defined to mean a notice of proposed rulemaking to implement the collection or reporting of data on quality measures. This subsection would apply with respect to determinations or requirements by the Secretary for the use of quality measures made on or after the date of enactment of the Affordable Health Choices Act.

This section would also require the Secretary to review quality measures used by the Secretary not less than once every three years, to determine whether to maintain the measure or phase it out. In conducting the review, the Secretary would be required to 1) seek to avoid duplication of measures; and 2) take into consideration current innovative methodologies and strategies for quality improvement practices in the delivery of health care services that represent best practices for such quality improvement and measures endorsed by a qualified consensus-based entity since the previous review.

The Secretary would also be required to establish a process, as specified, for disseminating quality measures used by the Secretary.

An appropriation of \$50,000,000 for each year from FY2010 to FY2014 would be authorized.

#### Section 399KK

This section would require the Secretary to implement, within 5 years of enactment, a system for the reporting on quality measures that protect patient privacy, and where appropriate: 1) assess health outcomes and functional status of patients; 2) assess the continuity and coordination of care and care transitions as specified; 3) assess patient experience and patient caregiver and family engagement; 4) assess the safety, effectiveness, and timeliness of care; and 5) assess health disparities as specified. These measures would be required to be: 1) risk-adjusted as specified; 2) valid, reliable, evidence-based, feasible to collect, and actionable by providers, payers, and consumers, as appropriate; 3) minimize the burden of collection and reporting such measures; and 4) be consistent with the national strategy.

This section would require the Secretary to make available to the public performance information summarizing data on quality measures collected under this section through a series of standardized websites, tailored as specified. Each website would be required to be designed to make the use and navigation of it readily available to individuals assessing it. Performance information on these websites would be required to be made available by clinical condition and where appropriate be provider-specific to meet the needs of patients with different clinical conditions. The Secretary would be required to carry out the development of performance websites in collaboration with a qualified consensus-based entity to determine the type of information that is useful to stakeholders and the format that best facilitates use of the reports and of performance reporting websites. The qualified consensus-based entity would be required to convene specified multi-stakeholder groups to review the design and format of each website and to transmit the views of such groups to the Secretary.

#### Section 399LL

This section would require the Comptroller General of the United States to conduct periodic evaluations of the implementation of the data collection processes for quality measures to be used by the Secretary.

In carrying out the evaluation, the Comptroller General would be required to determine 1) whether the system for the collection of data for quality measures provides for validation of data as relevant, fair, and scientifically credible; 2) whether data collection efforts use the most efficient and cost-effective means as specified; 3) whether standards under the system provide for an opportunity for physicians and other clinicians to review and correct findings; 4) the extent to which measures a) assess health outcomes as specified; b) assess the continuity and coordination of care and care transitions as specified; c)

assess patient experience and patient caregiver and family engagement; d) assess the safety, effectiveness, and timeliness of care; e) assess health disparities as specified; f) address the appropriate use of health care resources and services; g) are designed to be collected as part of health information technologies as specified; h) result in direct or indirect costs to users of such measures; and i) provide utility to both the care of individuals and the management of population health.

The Comptroller General would be required to submit reports to Congress and the Secretary containing a description of the findings and conclusion of the results of each such evaluation.

## **Sec. 205. Collection and Analysis of Quality Measure Data.**

### *Current Law*

No provisions regarding collection and analysis of quality measure data.

Section 3002 of the PHS Act established an HIT Policy Committee to make policy recommendations to the National Coordinator relating to the implementation of a nationwide health information technology infrastructure. The duties of the Committee are specified at section 3002(b)(2)(B).

### *Proposed Law*

This section would amend Part S of Title III of the PHS Act by adding Section 399MM, Collection and Analysis of Quality Measure Data.

This section would require the Secretary to establish a process to collect, and validate, aggregate data on quality measures to facilitate public reporting. This process would be required to: 1) be focused, scientifically sound, and practicable to implement; 2) where practicable, be incorporated into health information technology to allow collection of measures at the point of care; and 3) integrate data from public sources and private sources.

This section would require the Secretary to collect, validate and aggregate data on quality measures from providers receiving funds under this Act. The Secretary would be permitted to award grants or contracts for terms of up to 5 years to eligible entities to collect, validate and aggregate data on quality measures. Eligible entities would be required to: 1) be a public or private entity, or an entity that administers a disease or population registry; 2) provide timely information to providers regarding their performance on quality measures relative to the performance of other providers; 3) make de-identified data on quality measures available to the public in accordance with the process established by the Secretary (and described above); 4) collaborate with the State health information technology entities and exchanges; 5) meet the standards for data aggregators established by the Secretary in this section; and 6) submit to the Secretary an

application containing an assurance that the entity will meet each standard and such other information as the Secretary may require.

This section would require the Secretary to establish standards for data aggregators that would be required to be met by each entity that receives a grant or contract under this subsection, including standards on the protection of privacy and security of patient data.

An appropriation of \$75,000,000 each year from FY2010 to FY2014 would be authorized.

This section would expand the duties of the HIT Policy Committee to include the use of certified electronic health records to collect and report quality measures accepted by the Secretary.

## **Subtitle B- Health Care Quality Improvements**

### **Sec. 211. Health Care Delivery System Research; Quality Improvement Technical Assistance**

#### *Current Law*

Title IX, section 901(a)(1)(G) of the PHS Act, provides AHRQ with broad general authorities in the area of research that develops and presents scientific evidence regarding all aspects of health care, including ways in which patients, consumers, purchasers, and practitioners acquire new information about best practices and health benefits and the determinants and impact of their use of this information.

In addition, section 902(c) provides the Director with the authority to provide financial assistance to assist in meeting the costs of planning and establishing new centers for multidisciplinary health services research, demonstration projects, evaluations, training, and policy analysis.

Title IX, section 934, provides the Agency with broad authority to disseminate results of research, demonstration projects, and evaluations conducted or supported under the title.

Under section 301 of the PHS Act, the Secretary has general authority to conduct and promote the coordination of research, investigations, experiments, demonstrations, and studies related to the causes, diagnosis, treatment, control, and prevention of physical and mental diseases impacting individuals and to award grants for public health purposes.

#### *Proposed Law*

This section would amend the PHS Act by adding section 933, Health Care Quality Improvement Programs, to Part D of Title IX. This section would have the following purposes: 1) enable the Director to identify, develop, evaluate, disseminate, and provide training in innovative methodologies and strategies for quality improvement practices in

the delivery of health care services that represent best practices in health care quality, safety and value; and 2) ensure that the Director is accountable for implementing a model to pursue such research in a collaborative manner with other related Federal agencies.

This section would establish the Patient Safety Research Center in the Agency for Healthcare Research and Quality. The general functions of this Center would include: 1) carrying out its functions using research from a variety of disciplines; 2) conducting or supporting activities identified in the subsection about the Center's purposes, and with respect to best practices for quality improvement practices in the delivery of health care services, and that include changes in processes of care and the redesign of systems used by providers that will reliably result in intended health outcomes, improve patient safety, and reduce medical errors, and facilitate adoption of improved workflow; 3) identifying providers that delivery consistently high-quality, efficient health care services and employ best practices that are adaptable and scalable to diverse health care settings or effective in improving care across diverse settings; 4) assessing research, evidence, and knowledge about what strategies and methodologies are most effective in improving health care delivery; 5) finding ways to translate such information rapidly and effectively; 6) creating strategies for quality improvement through the development of tools, methodologies, and interventions that can successfully reduce variations in the delivery of health care; 7) identifying, measuring and improving organizational, human or other factors that contribute to the success of specific quality improvement strategies; 8) providing for the development of best practices in the delivery of health care services as specified; 9) providing for the funding of the activities of organizations with recognized expertise and excellence in improving the delivery of health care services; and 10) building capacity at the State and community level to lead quality and safety efforts through education, training and mentoring programs.

The Center would be required to support research on health care delivery system improvement and the development of tools to facilitate the adoption of best practices that improve the quality, safety and efficiency of health care delivery services. This could include establishing a Quality Improvement Network Research Program for the purpose of testing, scaling, and disseminating of interventions to improve quality. Recipients of funding would be permitted to include national, State, multi-State, or multi-site quality improvement networks.

The research conducted by the Center would be required to: 1) address specified national priorities; 2) identify areas in which evidence is insufficient to identify strategies and methodologies; 3) address concerns identified by health care institutions and providers and communicated through the Center; 4) reduce preventable morbidity, mortality, and associated costs by building capacity for patient safety research; 5) support the discovery of processes for the reliable, safe, efficient, and responsive delivery of healthcare; 6) be designed to help improve health care quality and is tested in practice-based settings; 7) allow communication of research findings and translate evidence into specified practice recommendations that are adaptable to a variety of settings; 8) expand demonstration projects for improving the quality of children's health care and the use of health information technology; 9) identify and mitigate hazards by analyzing events reported to patient safety reporting systems and organizations and using the results of such analyses

to develop scientific methods of response to such events; 10) include the conduct of systematic reviews of existing practices that improve the quality, safety, and efficiency of health care delivery; and 11) include the examination of how to measure and evaluate the progress of quality and patient safety activities.

This section would require the Director to make the research findings of the Center available to the public through multiple media and appropriate formats. The Secretary would be required to ensure that research findings and results generated by the Center are shared with the Office of the National Coordinator of Health Information Technology, and used as specified. In addition, the Director would be required to identify and regularly update a list of processes or systems on which to focus research and dissemination activities of the Center, taking into account: 1) cost to Federal health programs; 2) consumer assessment of health care experience; 3) provider assessment of such processes or systems and opportunities to minimize distress and injury to the health care workforce; 4) potential impact of such processes or systems on health status and function of patients, including vulnerable populations; 5) specified areas of insufficient evidence; and 6) the evolution of meaningful use of health information technology.

An appropriation of \$20,000,000 each year for fiscal years 2010 through 2014 would be authorized.

Title IX, Part D of the PHS Act, would be amended to add Section 934, Quality Improvement Technical Assistance and Implementation.

This section would require the Director, through the Center, to award: 1) technical assistance grants or contracts to eligible entities to provide technical support to institutions that deliver health care so that such institutions understand, adapt, and implement the models and practices identified in the research conducted by the Center; and 2) implementation grants or contracts to eligible entities to implement the models and practices developed by recipients of the grants described in 1).

To be eligible to receive a technical assistance grant or contract, an entity 1) could be a provider, provider association, professional society, health care worker organization, quality improvement organization, patient safety organization, local quality improvement collaborative, the Joint Commission, academic health center, university physician-based research network, specified primary care extension program, or any other entity identified by the Secretary; and 2) would be required to have demonstrated expertise in providing information and support to health care providers regarding quality improvement. In order to receive a technical assistance grant or contract, an eligible entity would be required to submit an application to the Secretary, at such time in such manner as the Secretary requires, containing a plan for sustainable business model, as specified, and such other information as the Director may require.

To be eligible to receive an implementation grant or contract, an entity: 1) could be a hospital or other provider or consortium of providers; and 2) would be required to have demonstrated expertise in providing information and technical support and assistance to health care providers regarding quality improvement. In order to receive an

implementation grant or contract, an eligible entity would be required to submit an application to the Secretary at such time, in such manner as the Secretary requires, and containing a plan for implementation of a model or practice identified in the research conducted by the Center, as specified, and such other information as the Director may require.

This section would prohibit the Director from awarding a grant or contract to an entity unless the entity agrees that it will make available non-Federal contributions in an amount equal to \$1 for each \$5 of Federal funds provided under the grant or contract. Such non-Federal funds could be provided directly or through donations from public or private entities and may be in cash or in-kind, as specified. This section would also require the Director to evaluate the performance of each entity, which would have to include: 1) the success of such entity in achieving the implementation of the models and practices identified in the research conducted by the Center in section 933; 2) the perception of the health care institutions and providers assisted by such entity; and 3) where practicable, better patient health outcomes and lower cost resulting from the assistance provided by such entity. The decision about whether to renew a grant or contract with such entity would be required to be based on the outcome of this evaluation.

This section also requires entities receiving grants or contracts to coordinate with health information technology regional extension centers and the primary care extension program established under section 399T.

## **Sec. 212. Grants to establish community health teams to support a medical home model**

### *Current Law*

Section 204 of the Tax Relief and Health Care Act of 2006 (PL 109-432) mandated a demonstration in up to 8 States to provide targeted, accessible, continuous and coordinated care to Medicare beneficiaries with chronic or prolonged illnesses requiring regular medical monitoring, advising or treatment. This model is commonly referred to as a medical home. Section 133 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, PL 110-275) allowed the Secretary to expand the demonstration project as appropriate, subject to certain limitations.

### *Proposed Law*

This section would direct the Secretary of Health and Human Services (Secretary) to establish a grant program to establish health teams to provide support to primary care providers and provide capitated payments to primary care providers determined by the Secretary. The section sets forth what the requirements would be for grantees, health teams, and primary care providers, as described below.

An eligible grantee would have to be a State (or designee); submit a specified plan for financial sustainability, as well as a plan for incorporating prevention initiatives, patient education, and care management resources into care delivery; ensure that the health team

that is established includes a multidisciplinary interprofessional team of providers as specified; and submit an application to the Secretary at such time and in such manner as the Secretary may require. Grant recipients would be required to submit to the Secretary as requested a report that describes and evaluates health team activities.

A health team established pursuant to the grant would be required to (1) establish contractual agreements with primary care providers to provide support services; (2) support medical homes as defined in the section; (3) collaborate with specified resources to coordinate specified care for patients; (4) develop plans as specified that integrate preventative services for patients; (5) incorporate providers, patients, caregivers and authorized representatives in program design and oversight; (6) provide support necessary for local primary care providers for specified activities; (7) provide specified 24-hour care management and support during transitions in care settings; (8) serve as a liaison to community prevention and treatment programs; (9) demonstrate a capacity to meet health information technology requirements as specified; and (10) where applicable, report to the Secretary on information quality measures as specified.

Primary care providers who contracted with care teams would be required to provide care plans for patient participants, provide access to participant health records and primary care practices, and meet regularly with the care team to ensure integration of care.

### **Sec. 213. Grants to implement medication management services in treatment of chronic disease**

#### *Current Law*

Nothing in the PHS Act is strictly applicable, although the Secretary could address the issue using general authorities under Title III. Some mechanisms related to medication management (MTM) exist in Medicare Part D and in Medicaid as described below.

The Medicare Modernization Act of 2003 (MMA) under title 42 CFR Part 423, Subpart D, establishes the requirements that Part D Plans must meet with regard to cost control and quality improvement including requirements for MTM Programs (MTMPs). Under section 423.153(d), a Medicare Part D Sponsor must establish a MTMP that (1) is designed to ensure that covered Part D drugs prescribed to targeted beneficiaries are appropriately used to optimize therapeutic outcomes through improved medication use; (2) is designed to reduce the risk of adverse events, including adverse drug interactions, for targeted beneficiaries; (3) is developed in cooperation with licensed and practicing pharmacists and physicians; (4) may be furnished by pharmacists or other qualified providers; (5) may distinguish between services in ambulatory and institutional settings; and (6) describes the resources and time required to implement the program if using outside personnel and establishes the fees for pharmacists or others.

The MMA provided a number of examples of multiple chronic conditions that could be targeted for MTMP, including diabetes, asthma, hypertension, hyperlipidemia, and congestive heart failure. Part D Plans have significant flexibility however, in determining which targeted populations are appropriate for MTM. Plans also have flexibility to

determine other components of their MTMP including method of enrollment, interventions, provider of MTM services, and outcomes.

In response to the MMA's requirement that Part D plans have a MTM program, CMS conducted an investigative study to understand the attributes and features of MTM models currently being used in the public and private sectors. The study, which was completed in July 2008, revealed that it is too soon to tell how the various models contribute to clinical outcomes.

In Medicaid, Section 6081 of the Deficit Reduction Act (DRA) authorizes grant funds to States for Transformation Grants aimed at the adoption of innovative methods to improve effectiveness and efficiency in providing medical assistance under Medicaid. One permissible use of such funds is for implementation of a medication risk management program as part of a drug use review program under section 1927(g) (SSA section 1903(z)).

A medication risk management program is one for targeted beneficiaries that ensures, by means of specified elements, that covered outpatient drugs are appropriately used to optimize therapeutic outcomes through improved medication use and to reduce the risk of adverse events. "Targeted beneficiaries" means Medicaid eligible beneficiaries who are identified as having high prescription drug costs and medical costs, such as individuals with behavioral disorders or multiple chronic diseases who are taking multiple medications.

#### *Proposed Law*

This section would insert a new section 935 into PHS Act Title IX following section 936 [sic.]. The new section would require the Secretary, acting through the Patient Safety Research Center (Center) established in section 933, to commence by May 1, 2010 a program to provide grants to implement medication management (MTM) services as specified. The section sets forth requirements for grantees, MTM services for targeted individuals, defining who is considered a targeted individual, and the Secretary's associated responsibilities, as described below.

To be eligible to receive a grant, entities would have to provide a setting appropriate for MTM services; submit to the Secretary a plan for achieving long term financial sustainability, a plan for meeting specified requirements for MTM services to targeted individuals and, where appropriate a plan for coordinating MTM services through local community health teams as specified; and submit other information if required by the Secretary.

MTM services to targeted individuals provided with the assistance of a grant would have to include, as specified, performing or obtaining assessments of patients' health and functional status; formulating an MTM plan; administering appropriate MTM services; monitoring and evaluating patient response to therapy; performing reviews of medication-related problems initially, quarterly and as needed; documenting the care

delivered and communicating essential aspects to appropriate care providers; providing education and training to enhance the appropriate use of medications; providing information and other specified support to enhance patient adherence to therapy regimes; coordinating and integrating MTM services in broader health care management; and other patient care services as permitted by Federal law.

Targeted individuals would include individuals who take 4 or more prescribed medications; take ‘high risk medications’; have two or more chronic diseases; or have undergone a transition of care or other factors that are likely to create a high risk of medication-related problems.

The Secretary would be required to design and implement MTM services provided under grants in consultation with specified experts, and determine whether it is possible to incorporate improvement concepts in use in other Federal programs that have implemented MTM services. The Secretary would also be required to submit to relevant Congressional committees a report assessing and evaluating specified aspects of the program. The Secretary would be permitted, through the specified quality measure development program, to award grants or contracts for the development of performance measures that assess the use and effectiveness of MTM services.

#### **Sec. 214. Design and Implementation of Regionalized Systems for Emergency Care**

##### *Current Law*

The Trauma Care Systems Planning and Development Act of 1990 (PL 101-590) created Title XII of the PHS Act to improve emergency medical services and trauma care. As amended, Title XII includes a number of grant programs through a grant program available to State Emergency Medical Services (EMS) offices to improve the trauma care component of the State’s EMS plan; a grant program to improve rural EMS care; and discretionary grants for research, evaluation, and demonstration projects for special EMS/trauma initiatives. PL 101-590 also directed the Health Resources and Services Administration (HRSA) to develop a model trauma care systems plan, which was issued in 1992. In 2001, HRSA established the Trauma-EMS Systems Program in accordance with Title XII. This program was last funded in FY2005 at \$3.4 million.

Title XII of the PHS Act has been subsequently amended, most recently by the Trauma Care Systems Planning and Development Act of 2007 (PL 110-23). Among other things, the legislation modified the requirements placed on a State’s plan for emergency medical services, including requirements with respect to the collection and reporting of data on the extent of trauma care provided. The Secretary was also required to update the 1992 model plan for designation of trauma centers and for triage, transfer, and transportation policies. HRSA’s model plan is guidance that may be adopted by States after appropriate consultation and public hearings. Generally, PL 110-23 directs the Secretary not make certain payments authorized by Title XII unless the State has adopted specified standards as included in the model plan.

HRSA helps fund the National EMS Information System (NEMIS), a project to create a national EMS database containing standardized information from State and local EMS agencies across the nation. Since the 1970s, the need for EMS information systems and databases has been well established, and many statewide data systems have been created. However, these EMS systems vary in their ability to collect patient and systems data and allow analysis at a local, State, and national level. The NEMIS project was developed to help States collect more standardized elements and eventually submit the data to a national database. The National Trauma Data Bank (NTDB) is a national registry of trauma incident data submitted by U.S. trauma centers. The NTDB creates and distributes datasets that can be used by researchers. Data are aggregated and used to produce annual reports, hospital benchmark reports, and data quality reports.

### *Proposed Law*

The proposal would amend PHS Act section 1203, which provides grants to States and localities to improve access to and enhance the development of trauma care systems, by modifying the section heading to read “Competitive Grants for Trauma Systems for the Improvement of Trauma Care” and by transferring administration of the program from HRSA to the Assistant Secretary for Preparedness and Response.

The proposal would further amend the PHS Act by adding a new section 1204 authorizing the Secretary, acting through the Assistance Secretary for Preparedness and Response, to award no less than four multiyear contracts or competitive grants for pilot projects to improve regional coordination of emergency services, including acute, prehospital, and trauma care. Entities eligible for funding include individual States, or partnerships of one or more States and one or more local governments. Funding would be awarded to eligible entities that propose a pilot project to design, implement, and evaluate an emergency medical and trauma system that: (1) coordinates with health and emergency care providers throughout the region as specified; (2) includes a mechanism to ensure the patient is taken to the medically appropriate facility in a timely manner; (3) allows for the tracking of prehospital and hospital resources (e.g., inpatient bed and emergency department capacity) and the coordination of such tracking with regional communications and hospital destination decisions; and (4) includes a region-wide data management system that reports data to the NEMIS, the NTDB, and Federal and State databanks and registries, and that contains sufficient information to evaluate key elements of emergency response and care, and relevant health outcomes.

A grant application would have to include an assurance that the proposed system: (1) had been coordinated with the State Office of Emergency Medical Services (or its equivalent); (2) coordinated triage, treatment, and interfacility transport throughout the region; and (3) included a regional medical direction, patient tracking, and resource allocation system supporting emergency care and surge capacity, among other things. Grantees would be required to provide matching funds (in cash or in kind) of at least \$1 for every \$3 of federal funding. Funding priority would be given to entities serving medically underserved areas, as defined in PHS Act section 330. Within 90 days of completing a pilot project, the grantee would be required to submit to the Secretary a

detailed evaluation of the program's characteristics and impact. The Secretary would be required, as appropriate, to disseminate that information to the public and to Congress.

In addition, the proposal would authorize to be appropriated for Title XII Parts A and B trauma care grant programs \$24 million for each of FY2010 through FY2014, and would transfer authority for administering those grants and related authorities to the Assistant Secretary for Preparedness and Response.

Finally, the proposal would amend the PHS Act by adding a new section 498D directing the Secretary to expand and accelerate research on emergency medical care systems and emergency medicine, including pediatric emergency medical care. The Secretary would also be required to support research on the economic impact of coordinated emergency care systems. The proposal would authorize to be appropriated such sums as may be necessary for each of FY2010 through FY2014 to carry out this section.

## **Sec. 215. Trauma Care Centers and Service Availability**

### *Current Law*

Section 1241 of the PHS Act authorizes grants to provide the operating costs of trauma centers that have incurred substantial uncompensated costs providing care in geographic areas with a significant incidence of violence arising from the illicit trafficking of drugs.

In 1976, the American College of Surgeons (ASC) Committee on Trauma developed criteria for categorizing hospitals according to the level of trauma care available. These designations range from Level 1 through Level IV, depending on the clinical capacities, facility resources, and services of the center. States may use these guidelines as a basis for designating or certifying hospitals as trauma centers, with modifications as deemed necessary. In certain States without formal trauma systems, hospitals have voluntarily sought certification from ASC.

### *Proposed Law*

Section 1241 of the PHS Act would be replaced to revise provisions governing grants to trauma centers. The Secretary would be required to establish three programs to award grants to qualified public, nonprofit, Indian Health Service, Indian tribal, and urban Indian trauma centers to (1) assist in defraying substantial uncompensated care costs; (2) to further the core missions of such centers, including addressing costs associated with patient stabilization and transfer, trauma education and outreach, coordination with local and regional trauma systems, and essential personnel and other fixed costs; and (3) to provide emergency relief to ensure availability of trauma services.

A trauma center would not be eligible for such a grant unless it is a participant in a trauma system that substantially complies with the trauma care component of the State plan for the provision of EMS. This requirement would not apply to trauma centers that are located in States with no trauma care system.

The Secretary would award the newly structured substantial uncompensated care grants to qualifying trauma centers that meet one of the criteria in one of the following three categories: The criteria for **Category A** would be (1) at least 50% of the visits in the emergency department in which the trauma center is located were charity or self-pay patients; or (2) at least 70% of the visits in the emergency department were provided to Medicaid, charity, and self pay patients. The criteria for **Category B** would be (1) at least 35% of the visits in the emergency department in which the trauma center is located were charity or self-pay patients; or (2) at least 50% of the visits in the emergency department were provided to Medicaid, charity, and self pay patients. The criteria for **Category C** would be (1) at least 20% of the visits in the emergency department in which the trauma center is located were charity or self-pay patients; or (2) at least 30% of the visits in the emergency department were provided to Medicaid, charity, and self pay patients. Alternatively, the a trauma center may be awarded a substantial uncompensated care grant if it qualifies for funds under a Low Income Pool or Safety Net Pool established under a Medicaid waiver pursuant to section 1115 of the Social Security Act.

Subject to certain requirements, Category A trauma centers would be eligible for grants up to 100% of their uncompensated care costs; Category B trauma centers would be eligible for not more than 75% of their uncompensated care costs; and Category C trauma centers would be eligible for not more than 50% of their uncompensated care costs. With respect to the amount appropriated for substantial uncompensated care grants in a fiscal year, 50% would be available to Category A grantees; 35% would be available to Category B grantees and 15% would be available to Category C grantees.

The term, “uncompensated care costs” would be defined as unreimbursed costs from serving self-pay, charity, or Medicaid patients, without regard to Medicaid disproportionate share hospital (DSH) payments, attributed to emergency and trauma care, including the costs related to subsequent inpatient admissions to the hospital.

With respect to the new core mission grants, the Secretary would be required to allocate specified percentages of funds allocated for such awards to certain types of trauma centers providing specified services. Specifically, the Secretary would be required to reserve 25% of the allocated amount for core mission awards for Level III and Level IV trauma centers and 25% of the allocated amount for large urban Level I and II trauma centers. To qualify, Level I and II trauma centers would have to (1) have at least 1 graduate medical education fellowship in trauma or trauma related specialties for which demand exceeds supply; and (2) provide either annual uncompensated care costs in excess of \$10 million; or provide at least 20% of emergency department visits to charity, self pay or Medicaid patients, and not be eligible for substantial uncompensated care grants.

The section would establish emergency awards, and would require the Secretary to give funding preference to a trauma center in a geographic area in which the availability of trauma care has significantly decreased or will significantly decrease if the center is forced to close or downgrade services or where the growth in the demand for trauma

services exceeds capacity. The Secretary would also be required to reallocate any emergency funds not obligated due to insufficient or lack of qualified applications to the significant uncompensated care award program. A trauma center would be able to receive emergency grants for three fiscal years unless the Secretary waives the time limit and authorizes an additional year of emergency grants for the center.

The section would amend PHS Act section 1243 to allow the Secretary, in awarding these three grants that would be established by 1241(a), to require a trauma center to maintain access to trauma services at comparable levels to the prior year during the grant program. Moreover, these trauma centers may be required to provide data to a national and centralized registry of trauma centers, in accordance with guidelines developed by the American College of Surgeons (ACS) and other requirements.

PHS Act section 1244 would be amended to do a number of things. It would preclude the Secretary from awarding a grant to a trauma center unless the center submits a grant application that complies with requirements established by the Secretary. It would also limit grants to three years (with a specific exception), and to \$2 million per grant per fiscal year. Except as specified above (centers that receive substantial uncompensated care grants would not be eligible for the reserve funding for core mission grants), receipt of a grant established in this provision would not preclude a trauma center from being eligible for other grants established by section 1241(a), as it would be amended.

Of the total amount appropriated for these grants in a fiscal year, 70% would be used for substantial uncompensated care grants; 20% would be used for core mission grants, and 10% would be used for emergency grants. However, if the amount appropriated for these grants in any year were to be less than \$25 million, all available funding would be used for substantial uncompensated care awards. Grant funds for substantial uncompensated care awards would be distributed as specified.

Section 1245 of the PHS Act would be amended to authorize an appropriation for these grants for an additional \$100 million for FY2009, and such necessary sums authorized for each fiscal year from 2010 to 2015.

Section 1246 of the PHS Act would be amended to include a definition for uncompensated care costs.

A new section 1281 would be added to Title XII of the PHS Act providing for grants to States to promote universal access to trauma care services provided by trauma centers and trauma-related physician specialties. The Secretary would provide funding to States, who would then award grants to eligible entities. Eligible entities would be required to be (1) a public or nonprofit trauma center or consortium that participates in a substantially compliant trauma system (or are located in States with no such trauma care system) that has been verified by the ACS or so designated by an appropriate State or local agency; (2) a safety net public or nonprofit trauma center that meets the requirements of substantial uncompensated care grants; or (3) a hospital in an underserved area (as defined by the State) that seeks to establish new trauma services.

(Note: This requirement is A or B or C, not A and B or C). To receive a State grant, an eligible entity would be required to submit an application as required by the State.

State grants would be awarded for the following activities: (1) to support physician compensation in trauma related physician specialties where shortages exist in the region involved; priority would be given to safety net trauma centers; (2) to provide fiscal stability and cover costs related to having a service available 24 hours a day, seven days a week; priority would be given to safety net trauma centers located in urban, border and rural areas; (3) to reduce overcrowding; (4) to establish new trauma services in underserved areas; (5) to enhance collaboration between trauma centers, other hospitals and EMS personnel; (6) to make capital improvements, including providing helipad and associated safety infrastructure; (7) to enhance trauma surge capacity at specific trauma centers; (8) to expedite receipt of trauma patients transported by ground or air; and/or (9) to enhance interstate trauma center collaboration.

A State would be required to use 40% of the available funding for State grants to safety net trauma centers. A State would not be able to use more than 20% of its funding in a fiscal year for administrative costs. A State would not receive funding unless it agrees that such funds will supplement and not supplant existing State funding for these activities.

If annual appropriations are less than \$10 million in a fiscal year, the Secretary would divide funds evenly among those States that have one or more Category A trauma centers eligible for substantial uncompensated care grants. If annual appropriations are less than \$20 million in a fiscal year, the Secretary would divide funds evenly among those States that have one or more Category A and Category B trauma centers eligible for substantial uncompensated care grants. If annual appropriations are less than \$30 million in a fiscal year, the Secretary would divide funds evenly among those States that have one or more trauma centers eligible for substantial uncompensated care grants. If the appropriated amount were \$30 million or more in a fiscal year, the Secretary would divide such funding evenly among all States. For fiscal years 2010 through 2015, \$100 million would be authorized to be appropriated for State grants.

## **Sec. 216. Reducing and Reporting Hospital Readmissions**

### *Current Law*

No provisions.

### *Proposed Law*

This provision would add a new section 399NN to the PHS Act in order to improve the quality and value of inpatient hospital services to (1) improve the coordination of care; and (2) appropriately reduce inefficiency and waste, such as unnecessary hospital readmissions.

Beginning in 2010, the Secretary would be required to analyze and calculate hospital-specific and national applicable readmissions rates as specified in this provision.

Beginning in 2011, the Secretary would be required to establish procedures to provide for the confidential disclosure to hospitals receiving funds under this Act of information on the hospital-specific and national applicable readmission rates, as specified in this provision.

No later than 2 years after enactment, the Secretary would be required to disclose publicly, in a form and manner determined by the Secretary, this information on applicable readmission rates and other statistical information of hospitals receiving funds under the PHS Act. No later than 180 days after enactment, the Secretary would be required to submit to Congress a report that contains: (A) a summary of the implementation of these procedures; (B) a plan for the public disclosure of this information; and (C) recommendations for such legislation or administrative action as the Secretary would determine appropriate.

The term applicable readmission would mean a readmission: (A) selected by the Secretary; (B) occurring within a time interval (the Secretary would be required to specify a time interval of not less than 7 days and not more than 30 days, between the prior discharge and applicable readmission); and (C) which would be for a condition or procedure selected according to the terms of this provision. The Secretary would be required to determine whether the term applicable readmission would include readmissions to the same hospital as the prior discharge or readmissions to any hospital.

Not later than 6 months after the date of enactment, the Secretary, in consultation with appropriate representatives of CMS and AHRQ, would be required, for each of the conditions or procedures selected, to select readmissions that meet two criteria. First, the readmissions must have been reasonably preventable by the provision of care consistent with evidence-based guidelines during the prior admission or the post discharge follow-up period; and second, they must have been for a condition or procedure related to the care provided during the prior admission or post discharge follow-up period, which includes readmissions for the following: (A) the same condition or procedure as the prior discharge; (B) an infection or other complication of care; (C) a condition or procedure indicative of a failed surgical intervention; and (D) other conditions or procedures as determined by the Secretary.

Not later than 6 months after enactment, the Secretary would be required to select at least 2 conditions or procedures which meet the following requirements: (A) such conditions or procedures would have a high volume; and (B) for the time interval specified by the Secretary (as described above), such conditions or procedures would have a relatively high rate of occurrence of subsequent readmissions (as specified above), as compared to all other conditions or procedures. The Secretary would be required to expand the list of readmission conditions to include at least 8 conditions with the highest volume and highest rate of readmissions.

## **Quality Improvement Program for Hospitals with a High Severity Adjusted Readmission Rate**

Not later than 2 years after the date of enactment, the Secretary would be required to establish a program for eligible hospitals to improve their readmission rates through the use of patient safety organizations. Eligible hospitals would be defined as a hospital which the Secretary would determine (based on the most recent available historical data) has a severity adjusted readmission rate for the selected conditions among the highest 25 percent of all hospitals nationally. The Secretary would be required to utilize appropriate risk adjustment measures to determine eligible hospitals. Eligible hospitals and patient safety organizations working with those hospitals would be required to report to the Secretary on the processes employed by the hospital to improve readmission rates and the impact of such processes on readmission rates.

The Comptroller General of the United States would be required to conduct a study on the impact of section 399NN (which would be comprised of the provisions added by the bill's section 216 that are discussed above) on care furnished to consumers, expenditures under Federal health programs, and the cost and quality of care furnished by hospitals. Not later than January 1, 2013, the Comptroller General would be required to submit to Congress a report on this study together with recommendations for such legislation and administrative action as the Comptroller General would determine appropriate.

### **Sec. 217. Program to Facilitate Shared Decision-Making**

#### *Current Law*

No provisions.

#### *Proposed Law*

The proposal would amend the PHS Act by adding a new section 936 to facilitate shared decision-making between patients and caregivers (or authorized representatives) and their clinicians, by engaging the patient or individual acting on their behalf in clinical decision-making, providing information on trade-offs among treatment options, and incorporating patient preferences and values into the medical plan.

As soon as practicable after enactment of this Act, the Secretary would be required to enter into a renewable 18-month contract with the qualified consensus-based organization created under PHS Act section 399JJ (as added by this Act) to develop and identify standards for patient decision aids for preference sensitive care and to review patient decision aids and develop a certification process for determining whether patient decision aids meet those standards. A patient decision aid is defined as an educational tool to help patients understand and communicate their beliefs and preferences related to their treatment options and to decide which treatment is best for them based on scientific evidence, circumstances, beliefs, and preferences. Preference sensitive care is defined as

medical care for which the clinical evidence does not clearly support one treatment option, such that the appropriate course of treatment depends on the values or preferences of the patient regarding the benefits, harms and scientific evidence for each treatment option.

The Secretary, acting through the AHRQ Director and in coordination with other relevant agencies, would be required to award grants or contracts: (1) to develop, update and produce patient decision aids for preference sensitive care to assist health care providers in educating patients about the relative safety, cost, and effectiveness of different care options; (2) to test such materials to ensure they are balanced and evidence-based; and (3) to educate providers on the use of such materials. Patient decision aids developed under a grant or contract would be required to be designed to engage patients and present up-to-date clinical information that is age-appropriate and can be adapted for patients from a variety of cultural and educational backgrounds, among other requirements. The AHRQ Director would be required to provide for the dissemination of the patient decision aid materials to health providers and to the public, including via the Internet. The Director would also be required to ensure that activities under the section are free from duplication of effort.

The Secretary would be required to award grants for establishing Shared Decision Making Resource Centers to educate providers, develop and disseminate best practices and other information to speed adoption and effective use of patient decisions aids and shared decision-making. The Secretary also would be required to award grants to providers for the development and implementation of shared decision-making techniques, making the awards in accordance with certain specifications. Finally, the Secretary would be required to adopt quality measures for shared decision-making, as specified. Providers receiving a grant would have to report to the Secretary data on those quality measures, and the Secretary would have to provide feedback to those providers. The reports would have to include an assessment of provider and patient satisfaction and experience with shared decision-making, among other items.

The proposal would authorize to be appropriated such sums as may be necessary for FY2010 and each subsequent fiscal year to carry out this section.

## **Sec. 218. Presentation of drug information.**

### *Current Law*

The introduction or delivery for introduction of a misbranded drug into interstate commerce is a prohibited act for which certain penalties may be imposed, according to the Federal Food Drug and Cosmetic Act (FFDCA; 21 USC 352), sections 301(a) and 303. A drug is deemed to be misbranded if it does not meet the requirements of FFDCA section 502. The section lists the items of information that must be listed in a drug's labeling (such as established name, quantity, active and inactive ingredients, adequate directions for use, and adequate warnings). The section also requires that each of these items be included prominently and conspicuously and in such terms as to render it likely

to be read and understood by the ordinary individual under customary conditions of purchase and use. In addition, the section requires that all advertisements and other descriptive printed matter include information in brief summary relating to side effects, contraindications, and effectiveness, as specified in regulation. See also: 21 CFR 201 (Labeling), and 21 CFR 202 (Prescription Drug Advertising).

#### *Proposed Law*

The bill would require the Secretary of Health and Human Services to determine whether the addition to a drug's labeling and print advertising of standardized, quantitative summaries of the benefits and risks of that drug in a tabular or drug facts box format (or any alternative format) would improve health care decision making by clinicians, and patients and consumers.

To reach that determination, the Secretary would act through the Commissioner of Food and Drugs to: review all available scientific evidence regarding the use of standardized, quantitative summaries of the benefits and risks of drugs in a tabular or drug facts box or other format; and to consult with drug manufacturers, clinicians, patients and consumers, experts in health literacy, experts in geriatric and long-term care, and representatives of racial and ethnic minorities. The bill would require that the Secretary submit the determination and the reasoning and analysis underlying it in a report to Congress within one year of enactment.

If the Secretary determined that adding a differently formatted summary of information to a drug's labeling would improve health care decision making, the bill would require the Secretary to promulgate regulations within one year to implement that addition.

The Secretary would be required to ensure that information in the differently formatted summary is objective and up-to-date and is a result of a review process that considers the totality of published and unpublished data. The Secretary also would be required to post the differently formatted summary on the FDA Web site.

#### **Sec. 219. Center for Health Outcomes Research and Evaluation.**

##### *Current Law*

Title IX of the Public Health Service Act established both the Agency for Healthcare Research and Quality (AHRQ) and the National Advisory Council for Healthcare Research and Quality. AHRQ's statutory mission is to enhance the quality, appropriateness, and effectiveness of health services, and access to such services. Its responsibilities include the conduct and support of research, the synthesis and dissemination of scientific evidence, and the advancement of efforts to improve health care quality. Among other topics, AHRQ activities address health disparities research, health care outcome improvement research, public-private partnerships, data collection regarding quality and cost of care, information systems, primary care and access in

underserved areas, health care practice and technology innovation, and patient safety improvement.

In addition, section 902(c) provides the Director with the authority to provide financial assistance to assist in meeting the costs of planning and establishing new centers for multidisciplinary health services research, demonstration projects, evaluations, training, and policy analysis.

### *Proposed Law*

The bill would add a new section to the Public Health Service Act: Sec. 937. Center for Health Outcomes Research and Evaluation. The bill would require the Secretary to establish a Center for Health Outcomes Research and Evaluation (the Center) within AHRQ.

To identify the manner in which diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed clinically, the bill would direct the Center to coordinate, conduct, support, and synthesize research relevant to the comparative health outcomes and effectiveness of the full spectrum of health care treatments, including pharmaceuticals, medical devices, medical and surgical procedures, screening and diagnostics, behavioral health care, and other health interventions. Responsibilities also would cover systematic reviews of clinical research, research that identifies scientific advances in personalized medicines, and research that reduces treatment disparities among populations.

The Center would be required to use a broad range of methodologies; create informational tools that organize, synthesize, and disseminate research findings to providers, patients, and public and private payers; and develop a publicly available resource database that collects and contains high-quality, independent evidence (from government and nongovernment sources) to inform healthcare decision-making. The bill would require the Center to submit to the Secretary and to Congress reports from grantees and contractors. The Center would also be required to encourage the development and use of clinical registries and the development of health outcomes research data networks from electronic health records, post marketing drug and medical device surveillance efforts, and other forms of electronic data.

The bill would require the Center to develop minimum methodological standards to be used when conducting studies of comparative health outcomes and value (and procedures for use of such standards) in order to help ensure accurate and effective comparisons and assessments of treatment options. Such standards would have to be developed within one year of enactment and to be updated at least biennially.

The bill would authorize the Center to secure directly from U.S. departments and agencies any information necessary to enable it to carry out this section. It would direct the heads of those departments and agencies to furnish the information to the Center on an agreed upon schedule.

The bill would direct the Center to use existing published and unpublished information “collected and assessed” by Center staff or under other arrangements; to carry out, or award grants or contracts for, original research and experimentation where existing information is inadequate; to adopt procedures for interested parties to submit information to the Center or the Advisory Counsel; and to comply with existing data privacy standards. The bill would require the Center to be subject to periodic audit by the Comptroller General.

To ensure transparency, the bill would require the Secretary to establish, through AHRQ’s National Advisory Council, an advisory council that includes representatives from the scientific research, patient, provider, and health industry committees. Members shall include the Director and the Chief Medical Officers of the Centers for Medicare and Medicaid Services, and 19 other members representing a broad range of perspectives (epidemiology, health services research, bioethics, communication and decision sciences, health economics, and safe use of medical products) and specified health care communities (e.g., consumers, practicing physicians, nurses, employers, public payers, insurance plans, and clinical researchers). The Secretary or the Secretary’s designee would appoint members to staggered four-year terms and would take into consideration any financial conflicts of interest.

The bill would require actions to ensure transparency, credibility, and access to research conducted, supported, or synthesized under this section. To insulate the research agenda and research conduct from undo political or stakeholder influence, the bill would require that research use scientifically based methods, and take into account scientific advances in personalized medicine and research that reduces treatment disparities (that include ethnic and racial minorities and children). It would require all aspects of the research to be transparent to all stakeholders; public documentation and availability of the research process and methods; and establishment of a process for involved stakeholders to review and comment on the research. The bill would require consultation of representatives of specified groups regarding the priorities, conduct, and dissemination of the research, through transparent mechanisms to be recommended by the Council.

The Center would be required to post on its official Internet site appropriate information from each report (including interim, draft, and final reports, and stakeholder comments) submitted by a grantee or contractor. The bill also would require the Secretary to establish a process for the Center to share with Congress reports and nonproprietary data.

The bill would require the Center to disseminate to health care providers, patients, and other specified groups the findings of the research it supported, conducted, or synthesized. The bill specifies that Center reports and recommendations would not be permitted to be construed as mandates for payment, coverage, or treatment. The bill would require that the Center assist users of health information technology focused on clinical decision support to promote the timely incorporation of research findings into clinical practices; and establish a process to receive feedback about the value of information it disseminates.

The bill would require the Director of AHRQ to submit an annual report, beginning within one year of enactment, to Congress on the activities of the Center and the advisory council and the research conducted. The Secretary would be required to submit a report, not later than December 31, 2011, to Congress on all activities conducted or supported under this section, to include an evaluation of impact, overall costs, and an analysis of the backlog of approved but not funded research proposals. The Secretary's report would also address whether Congress should expand the Center's responsibilities to include studies of the effectiveness of various aspects of the health care delivery system.

## **Sec. 220. Demonstration Program to Integrate Quality Improvement and Patient Safety Training into Clinical Education of Health Professionals**

### *Current Law*

Under section 301 of the PHS Act, the Secretary has general authority to conduct and promote the coordination of research, investigations, experiments, demonstrations, and studies related to the causes, diagnosis, treatment, control, and prevention of physical and mental diseases impacting individuals and to award grants for public health purposes, including for training; to award grants for training of health professionals under Part C of Title VII; and to conduct research and disseminate information regarding health care quality under Title IX; among other things.

### *Proposed Law*

This proposal would allow the Secretary to award grants to eligible entities or consortia under this section to develop and implement academic curricula that integrates quality improvement and patient safety in the clinical education of health professionals.

To be eligible to receive a grant under this provision, an entity or consortium would be required to 1) submit an application according to requirements of the Secretary; 2) be a health professions school; a school of public health; a school of social work; a school of nursing; a school of pharmacy; an institution with a graduate medical education program; or a school of health care administration; 3) collaborate in the development of curricula with an organization that accredits such school or institution; 4) provide for the collection of data regarding the effectiveness of the demonstration project; and 5) provide matching funds in accordance with this section.

A grant could be awarded under this section only if the receiving entity or consortium agrees to make available non-Federal contributions toward the costs of the program in an amount that is not less than \$1 for each \$5 of Federal funds. These non-Federal contributions may be cash or in kind, and may not include amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government.

This proposal would require the Secretary to evaluate the projects funded under this section and publish, make publicly available, and disseminate the results of such evaluations on as wide a basis as is practicable.

Finally, this proposal would require the Secretary to submit, to specified Congressional committees, a report that describes the specific projects supported under this section and contains recommendations for Congress based on the evaluation conducted per the requirements of this section.

## **Sec. 221. Office of Women's Health**

### *Current Law*

Among the Public Health Service (PHS) agencies, offices focused on women's health are established in law in the National Institutes of Health (NIH, in section 486(a) of the PHS Act) and the Substance Abuse and Mental Health Services Administration (SAMHSA, in section 501(f) of the PHS Act), and administratively in the Office of the Secretary (OS), and in the Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA), and Food and Drug Administration (FDA). There is not currently an office for this purpose in the Agency for Healthcare Research and Quality (AHRQ).

### *Proposed Law*

The proposal would establish, under a new PHS Act section 229, an Office of Women's Health (Office) in OS to be headed by a Deputy Assistant Secretary for Women's Health. The Secretary, acting through the Office, would be required to establish goals, establish a Coordinating Committee on Women's Health ("Coordinating Committee") composed of senior-level representatives from each HHS agency and office, and carry out additional activities as specified. The Secretary would be authorized to award grants to carry out this section, and would be required to: (1) conduct evaluations of funded projects, and (2) report to Congress regarding the activities of the office within one year of enactment, and every two years thereafter. The proposal would authorize for the purposes of this subsection the appropriation of such sums as may be necessary for FY2010–FY2014. The office would be required to assume all functions of the Office on Women's Health of the Public Health Service.

The proposal would also establish, under a new PHS Act section 310A, an Office of Women's Health in CDC, whose director would report to the CDC Director regarding CDC activities on women's health conditions (as defined), establish relevant goals and objectives, identify projects on women's health to be carried out by CDC, serve as a member of the Coordinating Committee, and carry out additional activities as specified. The proposal would authorize for the purposes of this subsection the appropriation of such sums as may be necessary for FY2010 through FY2014.

The proposal would amend current authority for offices of women's health in NIH and SAMHSA, to establish that the director of each respective office would report to the senior official of each respective agency.

The proposal would also establish, under a newly designated PHS Act section 927, an Office of Women's Health and Gender-Based Research in AHRQ, whose director shall report to the AHRQ Director regarding AHRQ activities on women's health, establish relevant goals and objectives, identify projects on women's health to be carried out by AHRQ, serve as a member of the Coordinating Committee, and carry out additional activities as specified. The proposal would authorize for the purposes of this subsection the appropriation of such sums as may be necessary for FY2010 through FY2014.

The proposal would also establish, under a new PHS Act section 713, an Office of Women's Health in HRSA, whose director would report to the HRSA Administrator regarding HRSA activities on women's health, establish relevant goals and objectives, identify projects on women's health to be carried out by HRSA, serve as a member of the Coordinating Committee, and carry out additional activities as specified. The director of the office would be required to continue implementation of existing women's health activities at HRSA. The proposal would authorize for the purposes of this subsection the appropriation of such sums as may be necessary for FY2010 through FY2014.

The proposal would also establish, under a new section 911 of the Federal Food, Drug, and Cosmetic Act, an Office of Women's Health in FDA, whose director would report to the FDA Commissioner regarding FDA activities on women's health (including with respect to clinical trials), establish relevant goals and objectives, identify projects on women's health to be carried out by FDA, serve as a member of the Coordinating Committee, and carry out additional activities as specified. The proposal would authorize for the purposes of this subsection the appropriation of such sums as may be necessary for FY2010 through FY2014.

This section and amendments made by it would not alter existing regulatory authority, terminate (without the approval of Congress) authority away from women's health offices in existence as of the date of enactment, or change existing administrative activities at HHS regarding women's health.

## **Sec. 222. Administrative Simplification**

### *Current Law*

The Health Insurance Portability and Accountability Act of 1996 (HIPAA; P.L. 104-191) included a set of provisions, subtitled Administrative Simplification, requiring the HHS Secretary to develop standards to support the growth of electronic record keeping and claims processing in the health care system. The standards apply to health care providers (who transmit any health information in electronic form in connection with a HIPAA-specified transaction), health plans, and health care clearinghouses. HIPAA instructed the Secretary to issue electronic format and data standards for nine routine administrative and

financial transactions between health care providers and health plan/payers. Those transactions include claims and encounter information, payment and remittance advice, and claims status inquiry and response. The Secretary was to rely on the recommendations of the National Committee on Vital and Health Statistics (NCVHS), consult with appropriate Federal and State agencies and private organizations, and publish in the Federal Register any NCVHS recommendation regarding the adoption of a standard. HIPAA also instructed the Secretary to review and, not more frequently than once a year, modify the Administrative Simplification standards. Again, the Secretary was to rely on the recommendations of the NCVHS and publish in the Federal Register any NCVHS recommendation regarding the modification of a standard. Any such modification has to be completed in a manner that minimizes disruption and the cost of compliance.

HIPAA does not mandate that providers submit transactions electronically, though health plans/payers increasingly require it. However, if a health care provider chooses to submit one or more of the HIPAA-specified transactions electronically, then he or she must comply with the standard for that transaction. In 2001, Congress enacted the Administrative Simplification Compliance (P.L. 107-105), which, among other things, requires Medicare providers to submit claims electronically.

HIPAA further required the Secretary to issue national identification numbers for health care providers, health plans, employers, and individuals (i.e., patients) for use in standard transactions. Unique identifiers for providers and employers have been adopted, while the health plan identifier is still under review.

### *Proposed Law*

The proposal would require the Secretary, within two years of enactment of this Act and building on existing standards and related requirements, to adopt and regularly update a set of standards, implementation specifications, and operating rules for electronic financial and administrative transactions. The standards, implementation specifications, and operating rules would be required to: (1) be unique with no conflicting or redundant standards; (2) be authoritative, requiring no additional standards; (3) be comprehensive and robust, requiring minimal augmentation by paper transactions; (4) enable real-time determination of a patient's financial responsibility at the point of service; (5) provide for timely acknowledgment; and (6) require that all data elements within a standard, specification, or criteria be described in unambiguous terms with no optional fields permitted. Further, the initial set of standards, implementation specifications, and operating rules must include requirements to clarify, refine, and expand the HIPAA Administrative Simplification standards. In addition, they must include requirements for acknowledgments (such as those for receipt of a claim) and to permit electronic funds transfers, as well as requirements for timely and transparent claim and denial management processes and other functions relating to administrative simplification as identified by the Secretary. Within two years of enactment of this Act, the Secretary would be required to submit to Congress a five-year implementation and enforcement plan for the new standards, implementation specifications, and operating rules.

Within one year of enactment of this Act, the Secretary would be required to promulgate a final rule to establish a National Health Plan Identifier system.

## **Title III – Improving the Health of the American People**

### **Subtitle A – Modernizing Disease Prevention of Public Health Systems**

#### **Sec. 301. National Prevention, Health Promotion and Public Health Council**

*Current Law*

Nothing strictly applicable.

*Proposed Law*

This proposal would require the President to establish a National Prevention, Health Promotion and Public Health Council (“Council”), composed of secretaries, chairmen, and directors of Federal departments, boards and agencies (as specified), and appoint a chairperson. The Council would be required to provide Federal coordination and leadership with respect to prevention, wellness, and health promotion practices; develop, within one year of enactment, a national prevention, health promotion, public health, and integrative health care strategy; and other activities as specified. The Council would meet at the call of the chairperson. The Council would be required, not later than July 1, 2010, and annually thereafter through January 1, 2015, to report to the President and Congress on activities under the strategy, and progress toward identified goals. The chairperson would be required to annually request an opportunity to testify before Congress regarding activities under the strategy, the amount and source of applicable Federal funds, and the results of program evaluations.

#### **Sec. 302. Prevention and Public Health Investment Fund**

*Current Law*

Nothing strictly applicable.

*Proposed Law*

The stated purpose of this section is to establish a Prevention and Public Health Investment Fund (“Fund”) to provide for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs. The Fund would be established in the U.S. Treasury, with amounts appropriated or credited to it to remain available until expended. The proposal would appropriate to the Fund \$10 billion for each of fiscal years 2010 through 2019; and for FY2020 and each fiscal year thereafter, an amount that is not

less than the amount appropriated for FY2019. Amounts in the Fund would be permitted to be appropriated to increase funding, over the FY2008 level, for programs authorized by the Public Health Service Act (PHS Act) for prevention, wellness, and public health activities, including prevention research and health screenings. Amounts so appropriated, and outlays flowing from such appropriations, would not be taken into account for purposes of any budget enforcement procedures. The Subcommittees on Labor, Health and Human Services, Education, and Related Agencies of the Committees on Appropriations of the House of Representatives and the Senate would be able to provide for the transfer of funds appropriated from the Fund among eligible activities authorized by the PHS Act for prevention, wellness, and public health activities, including prevention research and health screenings.

### **Sec. 303. Clinical and Community Preventive Services**

#### *Current Law*

The U.S. Preventive Services Task Force (USPSTF) is established in Section 915(a) of the PHS Act. Current authority requires the USPSTF to “review the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of clinical preventive services for the purpose of developing recommendations for the health care community, and updating previous clinical preventive recommendations.” The section also requires AHRQ to provide administrative, research, and technical support to the USPSTF, and exempts the USPSTF from requirements of the Federal Advisory Committee Act (FACA).

The Task Force on Community Preventive Services (TFCPS) is a non-governmental panel of public health and prevention experts whose members are appointed by the CDC Director. It conducts systematic reviews of evidence, similar to the process carried out by the USPSTF, but applied to population-based, rather than clinical, interventions. Its recommendations are published in the Guide to Community Preventive Services. The TFCPS is not explicitly authorized; rather, it is conducted under general authorities of the Secretary in Title III of the PHS Act.

#### *Proposed Law*

The first subsection of this proposal would strike and replace the existing authority for the USPSTF with language requiring the AHRQ Director to convene an independent Preventive Services Task Force (“Clinical Task Force”), composed of individuals with appropriate expertise. The Clinical Task Force would be required to review the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of clinical preventive services for the purpose of developing recommendations for the health care community, and updating previous clinical preventive recommendations, to be published in the Guide to Clinical Preventive Services, for individuals and organizations delivering clinical services, including primary care professionals, health care systems, professional societies, employers, community organizations, non-profit organizations, Congress and

other policy-makers, governmental public health agencies, health care quality organizations, and organizations developing national health objectives.

Duties of the Clinical Task Force would include: (1) development of additional topic areas for review, including interventions for specific populations and age groups; (2) review and revision of existing recommendations at least once every five years; (3) improved integration with Federal government health objectives and related target setting for health improvement; (4) the enhanced dissemination of recommendations; (5) the provision of technical assistance to health care professionals, agencies and organizations that request help in implementing the recommendations; and (6) the submission of yearly reports to Congress and related agencies identifying gaps in research and recommending priority areas that deserve further examination, including areas related to populations and age groups not adequately addressed by current recommendations.

AHRQ would be required to provide administrative, research, and technical support for Clinical Task Force operations, including support for the dissemination of recommendations, and assistance to organizations in their implementation.

The Clinical Task Force would be required to coordinate its work with the Community Preventive Services Task Force (authorized in the next subsection) and the Advisory Committee on Immunization Practices, including the examination of how each task force's recommendations interact at the nexus of clinic and community. The proposal would appear to exempt the Clinical Task Force from FACA requirements. There would be authorized to be appropriated such sums as may be necessary for each fiscal year to carry out the activities of the Clinical Task Force.

The next subsection of this proposal would create a new Section 399S of the PHS Act, that requires the CDC Director to establish a Community Preventive Services Task Force ("Community Task Force") composed of individuals with appropriate expertise, to review the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of community preventive interventions for the purpose of developing recommendations, to be published in the Guide to Community Preventive Services, for individuals and organizations delivering population-based services. These would include primary care professionals, health care systems, professional societies, employers, community organizations, non-profit organizations, schools, governmental public health agencies, medical groups, Congress, and other policy-makers. Community preventive services include any policies, programs, processes, or activities designed to affect or otherwise affecting health at the population level.

Duties of the Community Task Force would include: (1) development of additional topic areas for review, including interventions for specific populations and age groups, and other specified topics; (2) review and revision of existing recommendations at least once every five years; (3) improved integration with Federal government health objectives and related target setting for health improvement; (4) the enhanced dissemination of recommendations; (5) the provision of technical assistance to health care professionals, agencies and organizations that request help in implementing the recommendations; and

(6) the submission of yearly reports to Congress and related agencies identifying gaps in research and recommending priority areas that deserve further examination, including areas related to populations and age groups not adequately addressed by current recommendations.

The CDC Director would be required to provide administrative, research, and technical support for Clinical Task Force operations, including support for the dissemination of recommendations, and assistance to organizations in their implementation.

The Community Task Force would be required to coordinate its work with the Clinical Task Force (authorized in the prior subsection) and the Advisory Committee on Immunization Practices, including the examination of how each task force's recommendations interact at the nexus of clinic and community. The Community Task Force would appear to be exempt from FACA requirements. There would be authorized to be appropriated such sums as may be necessary for each fiscal year to carry out the activities of the Community Task Force.

### **Sec. 304. Education and Outreach Campaign Regarding Preventive Benefits**

#### *Current Law*

Nothing strictly applicable. The Secretary has general authority to conduct public health education campaigns under Titles II and III of the PHS Act, among other authorities.

#### *Proposed Law*

This proposal would require the Secretary, in consultation with the Institute of Medicine, to plan and implement a national public-private partnership for a prevention and health promotion outreach and education campaign. The purpose of the campaign would be to raise public awareness of health improvement across the life span, to include the dissemination of information that, among other things, describes the benefits of preventive services and healthy lifestyles, and describes the preventive services covered under health plans offered through a Gateway. There would be authorized to be appropriated such sums as may be necessary to carry out this section.

## **Subtitle B – Increasing Access to Clinical Preventive Services**

### **Sec. 311. Right Choices Program**

#### *Current Law*

Several Federal programs that are authorized in current law pay for certain screening or preventive services for low-income individuals who are not eligible for Medicaid, CHIP, or other Federal health care financing programs. Some examples include: (1) The CDC National Breast and Cervical Cancer Early Detection Program (Title XV of the PHS Act),

funded through annual discretionary appropriations. (2) The Vaccines for Children (VFC) program (Section 1928 of the SSA), funded through the Medicaid appropriation. VFC provides recommended pediatric vaccines to certain uninsured and underinsured children. VFC is operated by CDC. Medicaid-eligible children are also eligible for VFC-funded vaccines; (3) Community Health Centers (Section 330 of the PHS Act), which provide a number of specified primary care and preventive health services to medically underserved populations.

Medicare and Medicaid each cover health assessments for certain beneficiaries. Medicare Part B covers a one-time initial preventive physical examination (IPPE) to identify diseases and risk factors, and to provide education, counseling, and referral for covered screening and other preventive services. (Sections 1833, 1861, and 1862 of the SSA) States are required, under Medicaid, to cover a package of “well-child” and preventive service benefits for most eligible children under the age of 21, called Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. (Section 1905 of the SSA)

The “Gateways” referred to in the proposal are not currently authorized.

### *Proposed Law*

Beginning upon enactment, the Secretary would be required to provide annual grants to each State to establish a “Right Choices” program, which the State could administer through its Medicaid program or a comparable program. Under this program, States would be required to conduct outreach to the uninsured, and provide a “Right Choices” card to eligible individuals. Eligible individuals would be citizens and legal immigrants without private insurance coverage for the six months prior to the date of determination of eligibility; who have a family income at or below 350% of the Federal poverty level; and who are not eligible for Medicare, Medicaid, CHIP, armed services, or veterans health benefits.

An eligible individual would receive a one-time health risk appraisal and a risk-stratified care plan from a primary care physician participating in Medicare or Medicaid, or with a State or Federal safety net provider (such as a community care team, community health center, rural clinic, mobile clinic, or others, as identified by the State). The care plan would include recommendations for lifestyle changes and referrals to community-based resources. Care plans would also include referrals for age- and gender-appropriate immunizations and screenings as identified by the Secretary, in consultation with CDC, AHRQ, HRSA, SAMHSA, and other appropriate sources. To the extent feasible, care plans would also include referrals to Federal and State programs for which they may be eligible. A program participant diagnosed with a chronic illness would be referred for treatment to existing State or Federal safety net providers/facilities, as appropriate (such as public hospitals, community health centers, and rural clinics).

Program providers would be paid by the States, with reimbursement based upon Medicaid rates, and not to exceed Medicare rates. States would have to require

individuals with family incomes above 200% of the Federal poverty level to contribute a portion of the cost of their care, on a sliding scale determined by the Secretary.

Grants would be distributed to States in amounts according to the percentage of uninsured adults and children, and the prevalence of the most common costly chronic diseases (in each case as compared to all States), as determined by the Secretary. The Secretary would be required to determine what amount of the grant could be used for State administration of the program. The Secretary would be allowed to set aside not more than 20% of the funds appropriated to the program to allocate to other programs that would fund the treatment of participating individuals. The Secretary would be required to determine how payments would be made to States on a prospective basis, to enable them to provide program participants with access to items and services until Federal or State Gateways were available. The Secretary would be prohibited from obligating more than \$5 billion per fiscal year to the program.

For the purposes of this section, a “State” would be defined as each of the several States; the District of Columbia; each of the U.S. territories; and Indian tribes and tribal organizations (as such terms are defined in Sections 4(b) and 4(c) of the Indian Self-Determination and Education Assistance Act). The Secretary would be required to conduct an annual evaluation of the effectiveness of the pilot program under this section. The program would sunset on the date on which Federal or State Gateways were available, or on a date determined by the Secretary.

### **Sec. 312. School-Based Health Clinics**

#### *Current Law*

School-based health clinics (SBHCs) are not explicitly authorized, but have been established pursuant to the general authority to establish community health centers, under Section 330 of the PHS Act. Explicit authorities for school-based health services are limited to authorities in the PHS Act for certain dentistry and mental health/substance abuse services.

#### *Proposed Law*

This proposal would add a new Section 399Z-1 to the PHS Act, which would define “comprehensive primary health services,” “medically underserved children and adolescents,” “school-based health clinic,” and other terms. The new section would also require the Secretary to prescribe criteria for determining the specific shortages of personal health services for medically underserved children and adolescents, considering input from State and local officials, and taking into account specified matters regarding access to health care services in the area.

The Secretary would be required to award grants for the operation of SBHCs. An eligible SBHC would be one that submitted a timely application to the Secretary with information regarding (1) evidence of need; (2) evidence that the criteria developed above are met; (3)

assurances regarding compliance with Federal, State and local laws regarding parental or guardian consent, and regarding privacy of patient and student records; collaboration with neighboring providers; availability of services; and responsibility for facility administration; and (4) other information required by the Secretary. The Secretary would be authorized to give preference to applicants who demonstrate ability to serve communities with specified barriers to access.

The Secretary would be authorized to waive certain requirements of an SBHC for up to two years; and to waive the requirement that the SBHC provide all required comprehensive primary health services for a designated period of time, as determined by the Secretary.

An SBHC would be authorized to use grant funds provided under this section for (1) acquiring and leasing equipment; (2) certain training; (3) management and operation of center programs; and (4) salaries for physicians, nurses, and other SBHC personnel. The Secretary would be authorized to award grants which could be used to pay construction costs associated with expanding and modernizing existing buildings for use as an SBHC, including purchase of trailers or manufactured buildings to install on the school property. The Secretary would be authorized to determine the amount of an award to an SBHC based on financial need; State, local, or other funding provided to the SBHC; and other factors as determined appropriate by the Secretary. Entities that receive a grant under this section would be required to match 20% of the grant amount from non-Federal sources. The Secretary would be allowed to waive all or part of the matching requirement for any fiscal year if he/she determines that applying the matching requirement would result in serious hardship or an inability to carry out the purposes of this section. Grantees would have to use funds provided to supplement, not supplant, other Federal or State funds.

The Secretary would be required to establish programs to: provide specified technical assistances to grantees; and evaluate SBHCs and monitor grantee quality performance. There would be authorized to be appropriated such sums as may be necessary to carry out this section for FY2010 through FY2014.

### **Sec. 313. Oral Healthcare Prevention Activities**

#### *Current Law*

Nothing strictly applicable. The PHS Act currently authorizes certain activities focused specifically on oral health, including community water fluoridation activities, and a school-based dental sealant program in underserved areas (both in Section 317M); a program to improve oral health among children under six years of age who are eligible for services under a Federal health care program (Section 320A); programs to bolster the dental health workforce (Sections 340F, 340G, and 768); and the National Institute of Dental Research at NIH (Section 453).

#### *Proposed Law*

This proposal would establish a new Part S in the PHS Act, titled “Oral Healthcare Prevention Activities.” It would include a new Section 399GG in the PHS Act, requiring the Secretary, acting through the CDC Director, to establish a five-year national, public education campaign focused on oral health care prevention and education, including prevention of oral disease such as early childhood and other caries, periodontal disease, and oral cancer. In establishing the program, the Secretary is to ensure that activities targeted toward specific populations are provided in a culturally and linguistically appropriate manner; and that science-based strategies are used to convey messages including, but not limited to, community water fluoridation and dental sealants. The Secretary would be required to begin implementation within two years of enactment, and to begin planning activities upon enactment.

This proposal would also establish a new Section 399GG-1 in the PHS Act, requiring the Secretary, acting through the CDC Director, to award grants to eligible entities to demonstrate the effectiveness of research-based dental caries disease management activities. Eligible entities would be community-based providers of dental services (as defined by the Secretary), including Federally-qualified Health Centers, clinics of a State-owned hospital; State or local departments of health; private providers of dental services; medical, dental, public health, nursing, or nutrition educational institutions; or national organizations involved in improving children’s oral health. Entities would have to apply to the Secretary, providing such information in such manner as the Secretary prescribes. Grantees would be required to use amounts received under a grant under this section to demonstrate the effectiveness of research-based dental caries disease management activities. The Secretary would be required to utilize information generated from grantees under this section in planning and implementing the public education campaign under Section 399GG, as established in this Act.

There would be authorized to be appropriated such sums as may be necessary to carry out this Part.

### **Sec. 314. Oral Health Improvement**

#### *Current Law*

The PHS Act currently authorizes a school-based dental sealant program for underserved areas, under which the Secretary may award grants to States and Indian tribes to develop programs to improve children’s access to sealants. (Section 317M(c)) The program’s authorization of appropriations expired at the end of FY2005.

The proposal for CDC cooperative agreements with States to establish oral health programs is not explicitly authorized, but could be carried out under broad authorities of the Secretary in Title III of the PHS Act.

Four national surveys or surveillance systems referenced in the proposal are authorized in broad authorities in the PHS Act. They are (1) the Pregnancy Risk Assessment Monitoring System (PRAMS), administered by CDC (general authorities in Title III,

among others); (2) the National Health and Nutrition Examination Survey (NHANES), administered by CDC (Section 306, among others); (3) the Medical Expenditures Panel Survey (MEPS), administered by AHRQ (Title IX); and (4) the National Oral Health Surveillance System (NOHSS), administered by CDC (general authorities in Title III, among others).

### *Proposed Law*

This proposal would make the school-based dental sealant program mandatory, amending PHS Act Section 317M(c) to require the Secretary to award grants for the dental sealant program to each of the 50 States and territories and to Indians, Indian tribes, tribal organizations and urban Indian organizations (as such terms are defined in Section 4 of the Indian Health Care Improvement Act).

This proposal would also reorder and add a new subsection (d) to PHS Act Section 317M, requiring the Secretary, acting through the CDC Director, to enter into cooperative agreements with State, territorial, and tribal units of government to establish oral health leadership programs, including data collection and interpretation, (to include determinants of poor oral health among vulnerable populations), a multi-dimensional delivery system for oral health, and implementation of science-based programs (including dental sealants and community water fluoridation) to improve oral health. There would be authorized to be appropriated such sums as may be necessary to carry out this subsection for fiscal years 2010 through 2014.

This proposal would also require the Secretary to implement oral health components in four national health surveys and surveillance systems. (1) For PRAMS, State grantees would be required, within five years of enactment, and every five years thereafter, to report to the Secretary regarding oral health care measurement. There would authorized to be appropriated to carry out this paragraph such [sums] as may be necessary. (2) For NHANES, the Secretary would be required to develop oral health care survey components, to include tooth-level surveillance. Such components would have to be updated at least every six years. (3) For MEPS, the Secretary would be required to include the verification of dental utilization, expenditure, and coverage findings through conduct of a look-back analysis. (4) For NOHSS, there would be authorized to be appropriated such sums as may be necessary for each of fiscal years 2010 through 2014 to increase participation from 16 States to all 50 States, territories, and District of Columbia. The Secretary would be required to ensure that the NOHSS system includes the measurement of early childhood caries.

## **Subtitle C – Creating Healthier Communities**

### **Sec. 321. Community Transformation Grants**

#### *Current Law*

Nothing strictly comparable. Several sections in Title III of the PHS Act provide broad authority that could be used to support grants for community preventive health activities. Title XVII requires the Secretary to establish goals, support research, provide technical and other assistance, and use other authorities as applicable to support disease prevention and health promotion purposes.

*Proposed Law*

The Secretary, acting through the CDC Director, would be required to award competitive grants to State and local governmental agencies and community-based organizations for the implementation, evaluation, and dissemination of proven evidence-based community preventive health activities in order to reduce chronic disease rates, address health disparities, and develop a stronger evidence base of effective prevention programming.

**Sec. 322. Healthy Aging, Living Well**

*Current Law*

Nothing strictly applicable. There is at least one example of an explicitly authorized Federal program that pays for screening services for low-income individuals who are not eligible for Medicaid, CHIP, or other Federal health care financing programs, and then provides a mechanism to finance treatment services for those individuals whose screenings indicate the need for it. The National Breast and Cervical Cancer Early Detection Program (Title XV of the PHS Act) is administered by CDC and funded through annual discretionary appropriations. Women who are found to have breast or cervical cancer through the program then become eligible for coverage under Medicaid for the duration of their treatment. (Section 1902 of the SSA)

Community Health Centers (Section 330 of the PHS Act) provide a number of specified primary care and preventive health services to medically underserved populations.

*Proposed Law*

This section would require the Secretary, acting through the CDC Director, to award grants to State and local health departments for five-year pilot programs to provide public health community interventions, screenings, and, where necessary, clinical referrals, for individuals who are between 55 and 64 years of age. Grant applicants would be required to submit such information and in such a manner as required by the Secretary, including demonstration of the capacity, if funded, to develop relationships with health agencies, providers, and insurers, as needed, and identification of a community-based clinical partner such as a community health center or rural health clinic.

Grantees would be required to collaborate with CDC, the Administration on Aging, and relevant local agencies and organizations and use the funds awarded to deliver interventions to the target population to, among other things, improve nutrition, increase physical activity, reduce tobacco use and substance abuse, improve mental health, and

promote healthy lifestyles. Grantees would also be required to conduct ongoing health screenings to identify risk factors for cardiovascular disease, stroke, and diabetes. Such screening activities could include: mental health/behavioral health; physical activity, smoking, and nutrition; and any other measures deemed appropriate by the Secretary. Grantees would be required to maintain records of screening results to establish baseline data for monitoring the target population. Grantees would further be required to use funds to assure that individuals found to have chronic disease risk factors received clinical referral/treatment for follow-up services to reduce such risk.

For individuals found to have risk factors for chronic disease under this program, grantees would be required to determine whether such individuals have a source of health insurance coverage. Covered individuals would be referred to providers participating in their plans. For uninsured individuals, the grantee's community-based clinical partner would be required to assist the individual in determining eligibility for available public coverage options and identify other appropriate community health care resources and assistance programs. A grantee would be required to use amounts received under this program to assist in the referral of at-risk patients for clinical follow-up, and to help determine eligibility for other public programs.

Grantees would be required to use funds provided under this program to measure changes in the prevalence of chronic disease risk factors among participants. The Secretary would be required to conduct an annual evaluation of the effectiveness of this program, by examining changes in the prevalence of uncontrolled chronic disease risk factors among new Medicare enrollees (or individuals nearing enrollment, including those who are 63 and 64 years of age) who reside in States or localities receiving grants under this section as compared with national and historical data for those States and localities for the same population. There would be authorized to be appropriated such sums as may be necessary for FY2010 through FY2014 to carry out this section.

### **Sec. 323. Wellness for Individuals with Disabilities**

#### *Current Law*

Section 502 of the Rehabilitation Act established the Architectural and Transportation Barriers Compliance Board to develop design standards for, and to assure compliance by, facilities designed, built, altered, or leased with Federal funds, in order to improve access for people with disabilities.

#### *Proposed Law*

This proposal would amend Title V of the Rehabilitation Act by adding a new Section 510, requiring the Architectural and Transportation Barriers Compliance Board to issue standards for minimal technical criteria for medical diagnostic equipment (as defined) used in medical settings. The standards must ensure that individuals with disabilities can use, enter, and exit such equipment independently, to the maximum extent possible. The

Board would be required periodically to review the standards and amend them as necessary.

### **Sec. 324. Immunizations**

#### *Current Law*

Section 317 of the PHS Act authorizes the Secretary to make grants to States for prevention programs, including immunization programs. A portion of awarded funds may be used by States to purchase vaccines.

#### *Proposed Law*

This provision would amend Section 317 of the PHS Act to provide explicit authority to the Secretary to negotiate and enter into contracts with manufacturers for the purchase of vaccines for adults, and for States to purchase such vaccines at the prices negotiated by the Secretary.

This provision would also add a new subsection 317(m), which would require the Secretary, acting through the CDC Director, to conduct a demonstration program of grants to States to improve immunization coverage of children, adolescents, and adults, using evidence-based, population-based interventions for high-risk populations. To be eligible, States would have to submit an appropriate plan to the Secretary. States would be required to use funds provided to implement recommendations of the Task Force on Community Preventive Services (administered by CDC), or other evidence-based interventions, regarding the use of recalls and reminders; patient and provider education and outreach approaches; ways to decrease out-of-pocket costs; use of home visits; and other approaches as specified, alone or in combination. In awarding grants under this subsection, the Secretary would be required to consider any reviews or recommendations of the Task Force on Community Preventive Services.

Within three years of receiving a grant, a State would be required to report to the Secretary regarding an evaluation of progress in improving immunization rates in high-risk populations. Within five years of enactment, the Secretary would be required to report to Congress regarding the effectiveness of the demonstration program, and recommendations regarding whether it should be extended or expanded. There would be authorized to be appropriated such sums as may be necessary for FY2010 through FY2014 to carry out this subsection.

This section would also reauthorize the program of immunization grants to States by striking the dates in current law in PHS Act Section 317(j), in effect making the authorization of appropriations for the program permanent.

### **Sec. 325. Nutrition Labeling of Standard Menu Items at Chain Restaurants and of Articles of Food Sold at Vending Machines**

### *Current Law*

Section 301(a) of the Federal Food, Drug and Cosmetic Act (FFDCA) prohibits the introduction or delivery for introduction into interstate commerce of any food that is misbranded. FFDCA Section 403 list the circumstances that would cause a food to be deemed misbranded, including failure to adhere to the Act's nutrition labeling requirements. Certain food is exempt from those requirements, including: (i) food that is served in restaurants or other establishments in which food is served for immediate human consumption or which is sold for sale or use in such establishments; and (ii) food which is processed and prepared primarily in a retail establishment, which is ready for human consumption, which is of the type described in subclause (i), and which is offered for sale to consumers but not for immediate human consumption in such establishment and which is not offered for sale outside such establishment.

FFDCA Section 403A prohibits States and localities from requiring their own nutrition labeling that is not identical to the FFDCA's labeling requirements. This prohibition does not apply to food that is exempt from FFDCA's labeling requirements, discussed in the paragraph above.

### *Proposed Law*

This proposal would modify the nutrition labeling exemption for food served in certain restaurants and similar retail food establishments. Failure to comply with the new requirements would deem a food misbranded under FFDCA Section 403. For such food, the proposal would require labeling of standard menu items offered for sale in a restaurant or similar retail food establishment that is part of a chain with 20 or more locations doing business under the same name (regardless of the type of ownership of the locations) and offering for sale substantially the same menu items. Such establishments would be required, for standard menu items, to disclose, in a clear and conspicuous manner on the menu, and on a menu board (as defined, including a drive-through menu board), in addition to other information required: (1) the number of calories contained in the item, as it is usually prepared and offered for sale; and (2) a succinct statement concerning suggested daily caloric intake, as specified by the Secretary by regulation and posted prominently on the menu, according to additional specifications. Such establishments would also be required to make the above information, in written form, available at the premises upon request. Existing law regarding insignificant amounts of nutrients would apply.

Except where inapplicable as described below, a restaurant or similar retail food establishment offering food for sale at a salad bar, buffet line, cafeteria line, or similar self-service facility, and for self-service beverages or food that is on display and that is visible to customers, would be required to place adjacent to each food offered a sign that lists calories per displayed food item or per serving.

An establishment would be required to have a reasonable basis for its nutrient content disclosures, including use of nutrient databases, cookbooks, laboratory analyses, and

other reasonable means, as described in 21 CFR 101.10 (or any successor regulation), or in a related FDA guidance.

The Secretary would be required to establish by regulation standards for determining and disclosing the nutrient content for standard menu items that come in different flavors, varieties, or combinations, but which are listed as a single menu item, such as soft drinks, ice cream, pizza, doughnuts, or children's combination meals, through means determined by the Secretary, including ranges, averages, or other methods.

If the Secretary determines that a nutrient (other than a nutrient whose disclosure is already required) should be disclosed for the purpose of providing information to assist consumers in maintaining healthy dietary practices, the Secretary would be permitted to require, by regulation, disclosure of such nutrient in written form. For such regulations, existing law regarding insignificant amounts of nutrients would apply. (FFDCA Section 403(q)(5)(C)).

The requirements above would not apply to items that are not listed on a menu or menu board (such as condiments and other items placed on the table or counter for general use); daily specials, temporary menu items appearing on the menu for less than 60 days per calendar year, or custom orders; or such other food that is part of a customary market test appearing on the menu for less than 90 days, under terms and conditions established by the Secretary.

In the case of an article of food sold from a vending machine that (a) does not permit a prospective purchaser to examine the Nutrition Facts Panel before purchasing the article or does not otherwise provide visible nutrition information at the point of purchase; and (b) is operated by a person who is engaged in the business of owning or operating 20 or more vending machines, the vending machine operator would be required to provide a sign in close proximity to each article of food or the selection button that includes a clear and conspicuous statement disclosing the number of calories contained in the article.

An authorized official of any restaurant or similar retail food establishment or vending machine operator not subject to the requirements of this provision would be permitted to elect to be subject to such requirements by voluntarily registering, biannually, the name and address of such restaurant or similar retail food establishment or vending machine operator with the Secretary, as specified by the Secretary by regulation. Within 120 days of enactment, the Secretary would be required to publish a notice in the Federal Register specifying the terms and conditions for implementation of such voluntary election, pending promulgation of regulations. Nothing in this provision would authorize the Secretary to require, in order to voluntarily register, an application, review, or licensing process.

Not later than 1 year after the date of enactment, the Secretary would be required to promulgate proposed regulations to carry out this proposal. In promulgating regulations, the Secretary would be required to (a) consider standardization of recipes and methods of preparation, reasonable variation in serving size and formulation of menu items, space on

menus and menu boards, inadvertent human error, training of food service workers, variations in ingredients, and other factors, as the Secretary determines; and (b) specify the format and manner of the nutrient disclosure requirements. The Secretary would be required to provide quarterly reports to Congress that describe the Secretary's progress toward promulgating final regulations.

This proposal would also amend FFDC 403A, narrowing the scope of what states and their political subdivisions could regulate regarding foods served in restaurants, retail food establishments, and vending machines. The new parameters would prohibit such state regulation except for food that is offered for sale in a restaurant or similar retail food establishment that is not part of a chain with 20 or more locations doing business under the same name (regardless of the type of ownership of the locations) and offering for sale substantially the same menu items.

Nothing in the amendments made by this proposal would: (1) preempt any provision of state or local law except regarding nutrient content disclosures of the type required under provisions in this bill and expressly preempted under them; (2) apply to any state or local requirement about safety warnings on food labels; or (3) (except as provided regarding the voluntary provision of nutrition information) apply to any restaurant or similar retail food establishment other than those described in this proposal, regarding general requirements for restaurants and similar retail food establishments.

## **Subtitle D - Support for Prevention and Public Health Information**

### **Sec. 331. Research on Optimizing the Delivery of Public Health Services**

#### *Current Law*

Nothing strictly applicable. The Secretary has general authority to conduct public health research under several sections in Title III of the PHS Act.

#### *Proposed Law*

This proposal would require the Secretary, acting through the CDC Director, to provide funding for research on the following: (1) examining evidence-based practices relating to prevention, focused on high-priority areas as identified by the Secretary in the National Prevention Strategy or Healthy People 2020, including comparing community-based public health interventions in terms of their effectiveness and cost; (2) analyzing the translation of interventions from academic to real-world settings; (3) identifying effective strategies for organizing, financing, or delivering public health services in community settings, including comparing State and local health department structures and systems in terms of their effectiveness and cost; and (4) collecting and disseminating specified information about the public health workforce.

The Secretary would be required to coordinate research efforts with the Community Preventive Services Task Force, and make use of existing partnerships and initiatives within the Federal government, with State and local governments, and with the private sector. The Secretary would be required, annually, to report to Congress concerning the activities and findings of research supported under this section.

### **Sec. 332. Understanding Health Disparities: Data Collection and Analysis**

#### *Current Law*

While federal data collection efforts assemble a broad range of data for measuring disparities in the quality of and access to health care, there are no statutory requirements to ensure that a sample size is large enough to generate reliable, statistically significant estimates for various racial and ethnic groups.

Since 1999 HHS has required, as a matter of policy, that all HHS-funded and sponsored data collection systems require the inclusion of information on race and ethnicity, according to OMB standards. OMB Directive 15, “Standards for the Classification of Federal Data on Race and Ethnicity,” outlines standards for the collection of race and ethnicity data in federally-sponsored surveys, forms, and other records (e.g., school applications or mortgage lending applications). The directive does not mandate collection of such data. However, it requires: (1) when race data are collected, that a minimum of five racial categories (White, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander) be used; and (2) when ethnicity data are collected, that a dichotomous question “Hispanic or Latino” or “not Hispanic or Latino” be used. (Data collection instruments may include additional ethnicity categories, under specified conditions). When individuals are asked to self-identify (OMB’s preferred method), the directive also requires that they be given the opportunity to report multiple races in response to a single question. Including “multiracial” is not a permitted option. Requirements to use OMB Directive 15 may be waived if an organization can demonstrate that it is unreasonable to use the categories in a particular situation, or if it can be shown that race and ethnicity data are not critical to the administration of the program seeking this information.

OMB standards do not apply to state and local public health departments or to Medicaid. While the standards do apply to the CHIP program, they are not binding on states that opt to use CHIP funding to finance a Medicaid expansion, or that use a hybrid approach.

OMB standards do not address data on primary or preferred language. However, CMS requires that this information be reported for Medicaid beneficiaries. CMS does not require the collection of primary language data for CHIP enrollees and their parents.

The recently enacted Health Information Technology for Economic and Clinical Health (HITECH) Act (P.L. 111-5) instructed the new HIT Policy Committee to recommend standards to ensure that HIT systems collect patient demographic data, including, at a minimum, race, ethnicity, primary language, and gender.

There is no current law that requires the Secretary to share health disparities measures, data, and analyses with other HHS agencies. Section 903 of the PHS Act requires the Director of AHRQ to conduct and support research on health disparities, and to produce and publish an annual report on the matter, to describe prevailing disparities in health care delivery as it relates to racial and socioeconomic factors in priority populations.

The health information privacy rule, promulgated under the 1996 Health Insurance Portability and Accountability Act (HIPAA), places certain restrictions on the use and disclosure of individually identifiable health information that is created and maintained by health plans, health care providers, and their business associates.

### *Proposed Law*

This proposal would establish a new Title XXXIII in the PHS Act, regarding “Data Collection, Analysis, and Quality.” Section 3301 would require the Secretary, within one year of enactment, to assure that any ongoing or federally conducted or supported health care or public health program, activity or survey meets certain standards regarding the collection and reporting of data. All such activities would be required to collect and report the following data for applicants, recipients or beneficiaries: (A) race and ethnicity; (B) gender, geographic location, socioeconomic status (including education, employment or income), primary language, and disability status; (C) the smallest geographic level if such data can be aggregated; and (D) if practicable, racial and ethnic subgroups, using statistical oversamples if needed.

The Secretary (or designee) would be required to develop data standards for the above requirements. In so doing, the Secretary would be required to: (A) use OMB standards, at a minimum, for race and ethnicity measures; (B) develop standards for measures of gender, geographic location, socioeconomic status, primary language, and disability; and (C) develop standards [regarding data that are] self-reported by the applicant, recipient, or beneficiary; [and/or] from a parent or legal guardian if such person is a minor or legally incapacitated. The Secretary would also be required, acting through the National Coordinator for Health Information Technology, to develop national standards for the management of data collected, and interoperability and security systems for data management.

The Secretary would be required to: analyze the data collected as above to detect and monitor trends in health disparities (as defined in section 485E of the PHS Act) at the Federal and State levels; make such analyses available to specified agencies in HHS and other agencies and entities as the Secretary determines; report such data and analyses through public Internet sites and other appropriate mechanisms; and make such data available for additional research, analysis, and dissemination to other Federal agencies, non-governmental entities, and the public.

The proposal states that nothing in the new Section 3301 should be construed to permit the use of information collected under this new section in a manner that would adversely

affect any individual. The Secretary would be required to ensure, through regulation or otherwise, that all data collected as above would be: (1) covered by privacy safeguards that are at least as protective as the HIPAA privacy rule; and (2) protected from all inappropriate internal use by any entity that collects, stores, or receives the data, including use of such data in determinations of eligibility (or continued eligibility) in health plans, and from other inappropriate uses, as defined by the Secretary.

There would be authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2010 through 2014.

### **Sec. 333. Health Impact Assessments**

#### *Current Law*

Nothing strictly applicable. The proposed activity would be authorized under general authorities of the Secretary in Title III of the PHS Act.

#### *Proposed Law*

The purpose of this provision is to facilitate the use of health impact assessments as a means to assess the effect of the built environment on health outcomes. Built environment is defined as “an environment consisting of building, spaces, and products that are created or modified by individuals and entities, including homes, schools, workplaces, greenways, business areas, transportation systems, and parks and recreation areas, electrical transmission lines, waste disposal sites, and land-use planning and policies that impact urban, rural and suburban communities.” Health impact assessment is defined as “a combination of procedures, methods, and tools by which a regulation, program, or other project is assessed as to its potential effects on the health of a population, and the distribution of those effects within the population.”

The proposal would require the Secretary, in coordination with the Administrator of the Environmental Protection Agency, to establish a program at the National Center for Environmental Health at CDC to foster advances and provide technical support in the field of health impact assessment. The Secretary would be required to collect and disseminate evidence-based practices; to provide grants for technical assistance and training; and to provide guidance for implementation and program evaluation. There would be authorized to be appropriated sums as may be necessary for each of fiscal years 2010 through 2014 to carry out this section.

### **Sec. 334. CDC and Employer-based Wellness Programs**

#### *Current Law*

Nothing strictly applicable. Workplace wellness programs are increasingly common. Under HIPAA non-discrimination requirements in Section 702 of the Employee Retirement Income Security Act (ERISA), employers are permitted to reward

participation in such programs, subject to certain conditions. Final regulations are at 29 CFR 2590.702.

### *Proposed Law*

This provision would amend the PHS Act, adding several new sections. A new PHS Act Section 399HH would require the CDC Director, in consultation with others, to conduct targeted educational campaigns to: (1) make employers, employer groups, and other interested parties aware of the benefits of employer-based wellness programs; (2) establish a culture of health by emphasizing health promotion and disease prevention; (3) emphasize an integrated and coordinated approach to workplace wellness; and (4) ensure informed decisions through high quality information to organizational leaders.

A new PHS Act Section 399HH-1 would require the CDC Director to provide employers with technical assistance and other resources to evaluate workplace wellness programs, including measuring employee participation; developing standardized measures of factors that have a positive effect on health behaviors, outcomes, and expenditures; and evaluating the effect of programs on health outcomes, absenteeism, productivity, workplace injury rates, and medical costs. The Director would also be required to build evaluation capacity among workplace staff by providing resources, technical assistance, and consultation through Web portals, call centers, or other means.

A new PHS Act Section 399HH-2 would require the CDC Director, within two years of enactment and at regular intervals thereafter (as determined by the Director), to conduct a national survey to assess employer-based health policies and programs, and to report to Congress on survey findings and recommendations for the implementation of effective employer-based health policies and programs.

A new PHS Act Section 399HH-3 would require the CDC Director, in collaboration with academic institutions and employers, to institute workplace demonstration projects across small, medium, and large employers. Projects should be designed to determine best practices for achieving effective and sustainable workplace wellness interventions. The Director would be required to report to Congress on findings of the demonstrations, including recommendations of the Director for the implementation of effective employer-based health policies and programs.

## **Title IV – Health Care Workforce**

### **Subtitle A – Purpose and Definitions**

#### **Sec. 401. Purpose**

##### *Current Law*

No provision.

### *Proposed Law*

The purpose of Title IV of the bill is to improve access to and the delivery of health care services for all individuals, particularly low-income, underserved, uninsured, minority, health disparity, and rural populations. It would do so by: (1) gathering and assessing comprehensive data in order for the health care workforce to meet the health care needs of individuals, including research on the supply, demand, distribution, diversity, and skill needs of the health care workforce; (2) increasing the supply of a qualified health care workforce; (3) enhancing health care workforce education and training; and (4) providing support to the existing health care workforce.

### **Sec. 402. Definitions.**

#### *Current Law*

Under current law “institution of higher education,” “low income individual,” “State workforce investment board,” “local workforce investment board,” “registered apprenticeship program,” “clinical social worker,” “federally qualified health center,” “health disparity population,” “one-stop delivery system,” “racial and ethnic minority group,” and “rural health clinic” are defined.

#### *Proposed Law*

The bill would define the following terms in Title IV of the bill:

(1) “health care career pathway” to mean a rigorous, engaging, and high quality set of courses and services that (A) includes an articulated sequence of academic and career courses, including 21<sup>st</sup> century skills; (B) is aligned with the needs of healthcare industries in a region or State; (C) prepares students for entry into the full range of postsecondary education options, including registered apprenticeships, and careers; (D) provides academic and career counseling in student-to-counselor ratios that allow students to make informed decisions about academic and career options; (E) meets State academic standards, State requirements for secondary school graduation and is aligned with requirements for entry into postsecondary education, and applicable industry standards; and (F) leads to 2 or more credentials, including (i) a secondary school diploma; and (ii) a postsecondary degree, an apprenticeship or other occupational certification, a certificate, or a license;

(2) “institution of higher education” to have the same meaning as sections 101 and 102 of the Higher Education Act of 1965 (20 U.S.C. 1001 and 1002);

(3) “low-income individual,” “State workforce investment board,” and “local workforce investment board” to have the same meanings as section 101 of the Workforce Investment Act of 1998 (29 U.S.C. 2801);

(4) “postsecondary education” to mean (A) a 4-year program of instruction, or not less than a 1-year program of instruction that is acceptable for credit toward a baccalaureate degree, offered by an institution of higher education; or (B) a certificate or registered apprenticeship program at the postsecondary level offered by an institution of higher education or a non-profit educational institution;

(5) “registered apprenticeship program” to mean an industry skills training program at the postsecondary level that combines technical and theoretical training through structured on the job learning with related instruction (in a classroom or through distance learning) while an individual is employed, working under the direction of qualified personnel or a mentor, and earning incremental wage increases aligned to enhance job proficiency, resulting in the acquisition of a nationally recognized and portable certificate, under a plan approved by the Office of Apprenticeship or a State agency recognized by the Department of Labor.

The bill would amend Title VII of the Public Health Service Act (PHSA) by deleting language defining “program for training of physician assistants” and inserting new language defining the following:

(3) “physician assistant education program” to mean an educational program in a public or private institution in a State that (A) has as its objective the education of individuals who, upon completion of their studies in the program, are qualified to provide primary care medical services with the supervision of a physician; and (B) is accredited by the Accreditation Review Commission on Education for the Physician Assistant.

The bill also would amend Title VII of the PHSA to include the following definitions:

(12) “area health education center” to mean a public or non-profit private organization that has a cooperative agreement or contract in effect with an entity that has received an award under subsection (b) or (c) of section 751, satisfies the requirements in section 751(d)(1), and has as one of its principal functions the operation of an area health education center. Appropriate organizations may include hospitals, health organizations with accredited primary care training programs, accredited physician assistant educational programs associated with a college or university, and universities or colleges not operating a school of medicine or osteopathic medicine;

(13) “area health education center program” to mean a cooperative program consisting of an entity that has received an award under subsection (b) or (c) of section 751 for the purpose of planning, developing, operating, and evaluating an area health education center program and one or more area health education centers, which carries out the required activities described in subsection (b)(4) or (c)(4) of section 751, satisfies the program requirements in such section, and has as one of its principal functions identifying and implementing strategies and activities that address health care workforce needs in its service area, in coordination with the local workforce investment boards;

(14) “clinical social worker” to have the same meaning as stated in section 1861(hh)(1) of the Social Security Act (42 U.S.C.1395x(hh)(1));

(15) “cultural competency” to mean (A) with respect to health-related services, the ability to provide healthcare tailored to meet the social, cultural, and linguistic needs of patients from diverse backgrounds; and (B) when used to describe education or training, means education or training designed to prepare those receiving the education or training to provide health-related services tailored to meet the social, cultural, and linguistic needs of patients from diverse backgrounds;

(16) “federally qualified health center” to have the same meaning as stated in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa));

(17) “graduate psychology” to mean a master’s or doctoral degree program in psychology;

(18) “health disparity population” to have the same meaning as stated in section 903(d)(1) of the PHSA;

(19) “health literacy” to mean the degree to which an individual has the capacity to obtain, communicate, process, and understand health information and services in order to make appropriate health decisions;

(20) “mental health service professional” to mean an individual with a graduate or postgraduate degree from an accredited institution of higher education in psychiatry, psychology, school psychology, behavioral pediatrics, psychiatric nursing, social work, school social work, marriage and family counseling, school counseling, or professional counseling;

(21) “one-stop delivery system” to mean a one-stop delivery system described in section 134(c) of the Workforce Investment Act of 1998 (29 U.S.C.2864(c));

(22) “paraprofessional child and adolescent mental health worker” to mean an individual who is not a mental or behavioral health service professional, but who works at the first stage of contact with children and families who are seeking mental or behavioral health services;

(23) “racial and ethnic minority group” and “racial and ethnic minority population” to have the same meaning as defined in section 1707 of the PHSA; and

(24) “rural health clinic” to have the meaning given that term in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa)).

The bill would amend Title VIII of the PHSA by inserting new language to amend the definition of the following:

(2) “school of nursing” to mean an accredited (as defined in paragraph 6) collegiate, associate degree, or diploma school of nursing in a State where graduates are (A) authorized to sit for the National Council Licensure EXamination-Registered Nurse (NCLEX-RN); or (B) licensed registered nurses who will receive a graduate or equivalent degree or training to become an advanced education nurse as defined by section 811(j).

It would also define the following terms:

(16) “accelerated nursing degree program” to mean a program of education in professional nursing offered by an accredited school of nursing in which an individual holding a bachelors degree in another discipline receives a BSN or MSN degree in an accelerated time frame as determined by the accredited school of nursing; and

(17) “bridge or degree completion program” to mean a program of education in professional nursing offered by an accredited school of nursing, as defined in section 801(2), that leads to a baccalaureate degree in nursing. Such programs may include Registered Nurse (RN) to Bachelor’s of Science of Nursing (BSN) programs, RN to MSN (Master of Science of Nursing) programs, or BSN to Doctoral programs.

## **Subtitle B – Innovations in the Health Care Workforce**

### **Sec. 411. National health care workforce commission.**

#### *Current Law*

No provision.

#### *Proposed Law*

This section would establish a National Health Care Workforce Commission (“Commission”). The Commission would serve as a national resource, communicate and coordinate with specified departments, and engage in other specified activities focused on evaluating and meeting the need for health care workers.

The Comptroller General would appoint the Commission’s 15 members to serve staggered three-year terms. Members, who would be nationally recognized experts in health care labor markets and other specified areas, would represent a range of professional and geographic perspectives and a range of specified stakeholders. A majority of the Commission would be comprised of members not directly involved in health professions education or practice. Members would be compensated for their time and expenses as specified, and other Commission personnel would be treated as if they were Senate employees. The Chairman and Vice-Chairman would be elected by the Commission. The Commission would meet quarterly or more often if called by the Chairman.

Employees of the Federal government would be permitted to be detailed to the Commission without reimbursement, and without interruption or loss of Federal service status. The Commission, subject to such review as the Comptroller General deems necessary, could employ and fix the compensation of an executive director and other staff. It could also seek assistance and support from appropriate Federal agencies; enter into contracts (without regard to 41 U.S.C. 5); make advance, progress, and other payments; provide transportation and subsistence for persons serving without compensation; and publish internal rules and regulations.

The Commission, in consultation with relevant Federal, State, and local agencies, would review specified health care workforce supply and distribution information, and make two annual reports with recommendations to Congress. The first, due by April 1 of each year starting in 2011, would focus on one or more high priority areas: integrated health care workforce planning; analysis of specified aspects of health care work in the enhanced information technology and management workplace; Medicare and Medicaid graduate medical education policies; workforce capacity in nursing, oral health, mental and behavioral health, and/or allied health and public health; geographic distribution of health care providers; and other topics determined by the Commission. The second report, due by October 1 of each year starting in 2011, would focus on specified topics, including health care workforce education and training capacity, health care workforce implications of new and existing Federal policies, and health care workforce needs of special populations.

The Commission would also oversee the State health care workforce development grants program (established under section 412 of the bill), study effective mechanisms for financing education and training for careers in health care; make recommendations to Congress and specified Federal agencies about improving health care workers' safety, health and worker protections; and receive and assess reports from the National Center for Healthcare Workforce Analysis (which would be established by section 413 of the bill). The Commission would consult with specified Federal agencies, and to the extent practicable, with State and local agencies, and other specified organizations.

The Commission would be permitted, consistent with established privacy rules, to securely and directly obtain data from any U.S. department or agency. In order to carry out its functions, the Commission would be required to utilize existing information; carry out or support original research; consult with Federal agencies; and enable interested parties to submit information for reports and recommendations.

The Comptroller General would have unrestricted access to all of the Commissions' deliberations, records, and non-proprietary data. The Commission would be subject to periodic audits by a third party appointed by the Secretary.

The Commission would be required to submit appropriations requests in the same manner as those for the Comptroller General. These requests would be separate from those appropriated for the Comptroller General. Such amounts as necessary would be authorized to be appropriated. The Commission may also accept gifts.

The section would define the terms “health care workforce” and “health professionals.”

**Sec. 412. State health care workforce development grants.**

*Current Law*

No provision.

*Proposed Law*

A competitive health care workforce development grant program (“program”) would be established for the purpose of enabling State partnerships to complete comprehensive planning and to carry out activities leading to coherent and comprehensive health care workforce development strategies at the State and local levels. HRSA would be responsible for administering the program and providing technical assistance to grantees, under the direction of the Commission (established in section 411 of the bill).

The bill would authorize two types of grants: planning grants and implementation grants. Planning grants of not more than \$150,000 (with a 15% match requirement) would fund specified statewide health care workforce assessment and policy-related activities for one year or less. Grants would be awarded to eligible State partnerships that met specified eligibility requirements. The Governor of a recipient State would be authorized to appoint a fiscal and administrative agency for the partnership. Appropriations of \$8 million for FY2010 and such sums as may be necessary for each subsequent fiscal year would be authorized to award planning grants.

Implementation grants of up to two years (with a possible 1 year extension), with a 25% match requirement, would be awarded to State partnerships that had received and completed planning grants or completed satisfactory applications as specified. The Commission would make recommendations to the fiscal and administrative agent for implementation grants. The State partnership receiving such a grant would appoint a fiscal and administrative agency for the administration of the grant. Recipients would use at least 50% of grant funds to make seed grants to regional partnerships to address health care workforce development needs, and to promote innovative career pathway activities. Recipients would also take specified steps to develop and implement a statewide health care workforce strategy, and conduct other specified activities. Appropriations of \$150 million for FY2010 and such sums as may be necessary for each subsequent fiscal year would be authorized to award implementation grants.

For both planning and implementation grants, HRSA would establish the timing and application requirements in accordance with certain specifications, and would work jointly with partnerships to determine performance benchmarks for the grants. Recipients of both types of grants would report to HSRA on specified performance elements of the grant. HSRA would submit to the Commission a report for each type of grant, analyzing

the specified aspects of the grantees implementation of the grants and identifying promising practices.

### **Sec. 413. Health care workforce program assessment.**

#### *Current Law*

Section 761 of the PHSА provides for the development of information describing the health professions workforce and the analysis of workforce related issues, and necessary information for decision-making regarding future directions in health professions and nursing programs in response to societal and professional needs. The Secretary is authorized to make specified grants or contracts to State or local governments, health professions schools, schools of nursing, academic health centers, community-based health facilities, and other appropriate public or private nonprofit entities to provide for: (1) targeted information collection and analysis activities; (2) research on high priority workforce questions; (3) the development of a non-Federal analytic and research infrastructure; and (4) the conduct of program evaluation and assessment.

Appropriations for this program were authorized through FY2002. While current authorization has expired, these programs continued to receive Federal funding through FY2005. The Secretary is also required to reserve no less than \$600,000 of the amounts appropriated for conducting health professions research and for carrying out data collection and analysis in accordance with section 792 of the PHSА (with respect to Health Professions Data). Specifically, section 792(a) of the PHSА requires the Secretary to establish a program to collect, compile, and analyze data on health professions personnel.

#### *Proposed Law*

Section 761 of the PHSА would be amended, deleting language about the purposes for which grants or contracts could be provided. As described below, new language would require the Secretary to create a National Center for Health Care Workforce Analysis (National Center) and State and Regional Centers for Health Workforce Analysis (State and Regional Centers), and to increase grants for longitudinal evaluations.

The National Center would provide for the development of information describing the health care workforce and the analysis of health care workforce related issues; carry out activities under PHSА section 792(a); and collect, analyze, and report data related to programs under PHSА title IV in coordination with the State and Regional Centers and with the state agency responsible for statewide employment statistics.

In coordination with the Commission (established by section 411 of the bill), the National Center would annually evaluate the effectiveness of programs under title VII of the PHSА (Health Professions Education), develop and publish performance benchmarks for such programs, establish and maintain a publicly available health workforce database; and establish and maintain a registry of each grant awarded under title VII.

The National Center would be required to collaborate with Federal agencies and other specified entities to link data regarding grants awarded under title VII of the PHSA with data maintained by specified Federal agencies and other organizations, and with other data sets determined by the Secretary.

The National Center would be permitted to contract with specified types of organizations or societies to carry out its activities.

The National Center could award grants or contracts to State Centers to collect, analyze, and report to the National Center data regarding programs under title VII of the PHSA; conduct and disseminate research on health workforce issues; evaluate the effectiveness of programs under title VII; and provide specified technical assistance to local and regional entities. Entities eligible for a grant or contract would be State centers that meet specified requirements. These requirements include: (1) being a State, a State workforce investment board, a public health or health professions school, an academic health center, or an appropriate public or private nonprofit entity or partnership of such entities; and (2) having submitted an application to the Secretary in such time, in such manner, and containing such information as the Secretary may require.

The Secretary would be required to increase the amount of a grant or contract awarded to an eligible entity for the establishment and maintenance of longitudinal evaluation of specified individuals who received education, training, or financial assistance from programs under title VII of the PHSA. Such evaluations would be required to be capable of (1) studying participation in the National Health Service Corps, practice in federally qualified professional shortage areas and medically underserved areas, and practice in primary care; and (2) collecting and reporting data on performance measures developed under sections 749(d)(3), 757(d)(3), and 762(a)(3) of the PHSA. Studies would also be required to follow specified guidelines, and grantees would have to meet specified eligibility criteria.

Longitudinal studies would be added to the list of those to be given priority by the secretary under section 701(a)(1) of the PHSA. In addition, the following duties related to the longitudinal studies would be given to the Advisory Committee on Training in Primary Care Medicine and Dentistry, the Advisory Committee on Interdisciplinary, Community-Based Linkages, and the Advisory Council on Graduate Medical Education: (1) developing, publishing and implementing performance measures as specified; (2) developing and publishing guidelines for longitudinal evaluations; and (3) recommending appropriation levels for specified programs.

For the National Centers, appropriations of \$5 million per year would be authorized for FY2010 and FY2011, and \$10 million per year for FY2012 through FY2014, and such sums as may be necessary for subsequent fiscal years. For State Centers, \$4.5 million per year would be authorized for FY2010 through FY2014, and such sums as may be necessary for subsequent fiscal years. For grants for longitudinal evaluations, such sums

as may be necessary would be authorized for FY2010 through FY2014. Grantees could carry over grant funds from one fiscal year to the next for a maximum of three years.

Not later than 180 days after enactment, all functions, authorities, and resources of HRSA's National Center for Workforce Analysis would be transferred to the newly established National Center.

## **Subtitle C – Increasing the Supply of the Health Care Workforce**

### **Sec. 421. Federally supported student loan funds.**

#### *Current Law*

Title VII, Part A, Subpart II of the PHSA establishes “Federally-Supported Student Loan Funds.” Under Section 721, the Secretary is authorized to enter into agreements with schools to administer a program of student loans for full-time students pursuing a degree of doctor of medicine, doctor of dentistry, doctor of osteopathy, doctor of podiatric medicine, doctor of optometry, or doctor of veterinary medicine; or bachelor of science, or doctor of pharmacy. Section 722 establishes a loan repayment interest rate of 5% per year. Section 723 requires loan recipients at schools of medicine and osteopathic medicine to practice in primary care for the duration of the repayment period, and establishes an 18% annual interest rate on the loan balance for recipients who are not compliant. Section 723 also requires that schools participating in the primary care loan program meet certain requirements regarding the proportion of their graduates who train and practice in primary care, and that schools failing to meet these requirements pay a specific portion of their income from the loan program back to the Secretary. Sections 723 and 735(e) require the Secretary to use all returned funds for a Federal capital contributions fund, to be used to make loans available under Section 721. Current law does not require that the Secretary take into account parental financial information when determining a student's financial need.

#### *Proposed Law*

The bill would amend Section 722 of the PHSA by setting the loan repayment interest rate at 2% less than the interest rate described in Section 427 of the Higher Education Act of 1965.

It would also amend section 723(a) by deleting certain requirements for medical students under the health professions student loan program and inserting new language that would require medical students receiving loan funds to practice in primary care for either 10 years (including residency training time) or until the loan is repaid in full, whichever period occurs first.

The bill would delete language regarding noncompliance by medical students receiving loan funds and insert new language regarding noncompliance. Specifically, it would

require that each agreement entered into with a medical student under the loan program provide that, if the student fails to comply with the agreement, the loan involved will accrue interest at a rate of 2% per year greater than the rate if compliant in such year.

It would further amend Section 723 to add new language stating that it is the sense of Congress that funds repaid under the loan program would not be transferred to the Treasury or used for any other purpose except for providing funds for loan program. The bill would also amend Section 723 regarding student loan guidelines. Specifically, the Secretary would be prohibited from requiring parental financial information when determining financial need for the loan program. Rather, the determination of need would be made by the applicable school loan officer. The Secretary would be required to amend student loan guidelines issued by HRSA regarding parental financial information.

### **Sec. 422. Nursing student loan program.**

#### *Current Law*

Title VIII, Part E of the PHSA establishes nursing loan programs. These programs provide long-term, low-interest rate loans to financially needy students pursuing studies leading to a diploma, associate, baccalaureate or graduate degree in nursing. Participating schools select loan recipients and determine the amount of loan assistance.

Under Section 836, a nursing student may receive loan funds in amounts not to exceed \$2,500 per academic year, or \$4,000 per year in the final two years of a program; and not to exceed \$13,000 for all years of nursing school. Current law does not provide for adjustment of these amounts.

Current law provides that for loans made after 1986, financial need is a required eligibility criterion for the recipient. Additionally, current law provides for partial loan cancellation for recipients who received loans before enactment of the Nurse Training Amendments of 1979, and who work as full-time nurses in public or non-profit settings.

#### *Proposed Law*

The bill would amend Section 836(a) to increase the maximum amount of loan funds a recipient can receive per year during fiscal years 2010 and 2011 from \$2,500 to \$3,300; increase the final two-year amounts from \$4,000 to \$5,200 per year; and increase the total loan amount from \$13,000 to \$17,000. The bill would provide, for loans made after FY2011, for a cost of living increase for the yearly and aggregate amounts.

The bill would amend applicable dates in Section 836(b). Specifically, it would require that financial need be a criterion for receiving a loan after 2000. Additionally, it would provide for partial loan cancellation for loan recipients working as full-time nurses in public or non-profit settings who received loan funds before 1995.

### **Sec. 423. Health care workforce loan repayment programs.**

### *Current Law*

Current law does not explicitly authorize a loan repayment program for clinical practice in pediatrics. Section 487F of the PHSA Act establishes a loan repayment program, through NIH, for health professionals conducting pediatric research. Several loan repayment programs for health professionals authorized elsewhere in the Act—such as for Public Health Service officers, the National Health Service Corps (NHSC), and for certain faculty in health professions schools—may be available to professionals in pediatrics who otherwise qualify, but support of practice in pediatrics is not the focus of these programs.

### *Proposed Law*

Part E of Title VII of the PHSA would be amended by adding the following new Section 775 under a new Subpart 3 – Recruitment and Retention Programs:

#### **Subpart 3 – Recruitment and Retention Programs**

##### ***Sec. 775. Investment in Tomorrow’s Pediatric Health Care Workforce.***

The provision would require the Secretary to establish and implement a pediatric specialty loan repayment program. Under the program, the Secretary would enter into contracts to provide loan repayment to health professionals who agree to work full-time for not less than two years in pediatric medicine or surgery, or in child and adolescent mental and behavioral health care. Through this program the Secretary would be required to enter into contracts with qualified health professionals who agree to provide pediatric care in their pediatric subspecialty in an area where there is a shortage of the specified pediatric subspecialty that has a sufficient pediatric population to support such as subspecialty, as determined by the Secretary.

The Secretary would agree to make payments on the principal and interest of the undergraduate or graduate medical education loans to these subspecialty health care professionals. Payments would not be more than \$35,000 per year for each year of service, for up to three years. Service could be through participation in an accredited pediatric medical specialty, pediatric surgical specialty, or child and adolescent mental health subspecialty residency or fellowship; or employment in the same fields serving an area or a population with a shortage of the specified pediatric subspecialty.

For purposes of contracts with pediatric medical or surgical specialists, the bill would define “qualified health professional” to mean a licensed physician who: (1) is entering or receiving training in an accredited pediatric medical subspecialty or pediatric surgical specialty residency or fellowship or who has completed an accredited residency or fellowship; and (2) is licensed to practice in one of these fields within the calendar year prior to enactment.

For the purposes of contracts with child and adolescent mental and behavioral health professionals, the bill would define “qualified health professional” to mean a health care professional who: (1) has completed specialized training or clinical experience in child and adolescent mental health in psychiatry, psychology, school psychology, behavioral pediatrics, psychiatric nursing, social work, school social work, marriage and family therapy, school counseling, or professional counseling; and (2) has a State license or certification to practice allopathic medicine, osteopathic medicine, psychology, school psychology, psychiatric nursing, social work, school social work, marriage and family therapy, school counseling, or professional counseling; or (3) is a mental health service professional who completed (but not before the end of the calendar year of enactment) specialized training or clinical experience in child and adolescent mental health.

The Secretary would be prohibited from entering into contracts with individuals unless they are citizens or legal residents of the United States and, for students enrolled in a graduate program, have an acceptable level of academic standing as determined by the Secretary. When entering into contracts the Secretary would be required to give priority to individuals who: (1) work with high-priority populations in a Health Professional Shortage Area, a Medically Underserved Area, or with a Medically Underserved Population; (2) have familiarity with evidence-based methods and culturally and linguistically competent health care services; and (3) demonstrate financial need.

The bill would authorize to be appropriated \$30 million for each of FY2010 through FY2014.

#### **Sec. 424. Public health workforce recruitment and retention programs.**

##### *Current Law*

Current law does not explicitly authorize a loan repayment program for public health practice. The Pandemic and All-Hazards Preparedness Act (P.L. 109-417) amended Section 338L of the PHSA to require the Secretary, depending upon an appropriation, to establish a demonstration project for individuals who are eligible for the NHSC loan repayment program described in PHS Act Section 338B et seq. and who agree to serve in a state health department that serves a significant number of health professional shortage areas or areas at risk of a public health emergency, as determined by the Secretary, or in a local health department that serves a health professional shortage area or an area at risk of a public health emergency.

##### *Proposed Law*

The provision would amend Part E of Title VII of the PHSA, as amended by section 423 of the bill, to include the following new section 776 under the new Subpart 3 – Recruitment and Retention Programs.

#### ***Sec. 776. Public Health Workforce Loan Repayment Program.***

The provision would require the Secretary to establish the Public Health Workforce Loan Repayment Program to assure an adequate supply of public health professionals needed to eliminate critical public health workforce shortages in Federal, State, local, and tribal public health agencies. To be eligible, individuals must be accepted for enrollment or be presently enrolled in an accredited academic education institution in a State or territory in the final year of a course of study or program leading to a public health or health professions degree or certificate, and have accepted employment with a Federal, State, local and tribal public health agency after graduation. Individuals who have graduated during the past 10 years from an accredited educational institution in a State or territory and received a public health or health professions degree or certificate and who are either employed by or have accepted employment with a Federal, State, local and tribal public health agency, or a related training fellowship recognized by the Secretary, are also eligible. In addition, an eligible individual must be a U.S. citizen, submit an application to the Secretary, and execute a written contract as required.

The proposal would require the written contract between the Secretary and the individual to contain an agreement that the Secretary will repay, on behalf of the individual, the loans that the individual incurred while earning a degree in public health or other health professions. In return, the individual would be required to agree to serve as a full-time employee of a Federal, State, local, or tribal public health agency or in a related fellowship program in a position related to the individual's academic field. The individual must be employed or in a fellowship for a period of time of either three years or as long as determined appropriate by the Secretary and the individual, whichever time period is longer. The individual must agree, as appropriate, to relocate to a priority service area determined by the Secretary for an additional loan repayment incentive amount determined by the Secretary. The written contract would also contain agreements that any financial obligation of the U.S. arising out of a contract entered into, and any obligation of the individual that is conditioned thereon, is contingent on funds being appropriated for loan repayments. In addition, the written contract would contain agreements to include a statement of the damages to which the U.S. is entitled for breach of contract and such other statements of the rights and liabilities of the Secretary and the individual.

A loan repayment provided for an individual under a written contract under the program would be required to consist of payment of principal and interest on behalf of the individual and related expenses on government and commercial loans received by the individual for tuition and other reasonable expenses related to undergraduate or graduate education. For each year of obligated service that the individual contracts to serve the Secretary would be authorized to pay up to \$35,000 on behalf of the individual for loans. With respect to participants under the program whose total eligible loans are less than \$105,000, the Secretary would be required to pay an amount that does not exceed one-third of the eligible loan balance for each year of the individual's obligated service. The Secretary would be required to make additional payments in an amount not to exceed 39% of the total amount of loan repayments to reimburse the individual for any tax liability resulting from the loan repayments for the taxable year involved. Individuals

could postpone obligated service with approval by the Secretary. Individuals who failed to comply with the terms of the contract would be subject to the same financial penalties as laid out in subsection 338E of the PHSA.

The bill would authorize to be appropriated \$195 million for fiscal year 2010 and such sums as may be necessary for each of fiscal years 2011 through 2015.

#### **Sec. 425. Allied health workforce recruitment and retention programs.**

##### *Current Law*

Section 428K of the Higher Education Act of 1965 authorizes a program of loan forgiveness for service in areas of national need, administered by the Secretary of Education (in this paragraph, “the Secretary”). Such areas are 17 listed items, which include a type of work and, for some items, also a type of setting (e.g., nurses working full time in a clinical setting or a school of nursing). Listed workers qualify for loan forgiveness under specified conditions. Health workers among those listed (in each case, under specified circumstances) include: nurses (as above); speech-language pathologists and audiologists; public health workers; nutrition professionals; medical specialists; mental health professionals; dentists; physical therapists; and occupational therapists. In general, for eligible individuals, the Secretary may forgive up to \$2,000 per year of full-time service. The Secretary is prohibited from forgiving more than \$10,000 of the loan obligation of any one borrower, and no borrower shall receive forgiveness under this program for more than five years of continuous service. The Secretary shall grant forgiveness under this program on a first-come, first-served basis, subject to available appropriations.

PHSA Section 340F authorizes a program of grants to states for dental workforce development, which allows states to use funds for loan forgiveness, among other authorized uses. There are no other federal loan forgiveness programs explicitly authorized for health professionals. There are, however, other health workforce assistance programs authorized in PHSA Title VII (such as scholarships and loan repayment) for which allied health professionals may be eligible, if they meet applicable criteria. Section 755 of the PHSA provides broad authority for the Secretary of HHS to make grants or contracts to assist eligible entities in administering programs to bolster the allied health workforce.

##### *Proposed Law*

The bill would amend section 428K of the Higher Education Act of 1965 to include, among those eligible for a loan forgiveness program, an individual who is employed full-time as an allied health professional in a Federal, State, local and tribal public health agency, or in a setting where patients might require health care services, including acute

care and ambulatory care facilities, personal residences, and other settings, as recognized by the Secretary of HHS.

The proposal would define the term “allied health professional” as an individual, as defined in section 799B(5) of the PHSA, who has graduated and received an allied health professions degree or certificate from an institution of higher education; and is employed with a Federal, State, local or tribal public health agency, or in a setting where patients might require health care services, including acute care and ambulatory care facilities, personal residences and other settings, as recognized by the Secretary of HHS.

#### **Sec. 426. Grants for State and local programs.**

##### *Current Law*

Section 765 of the PHSA authorizes grants to be awarded to eligible entities to increase the number of individuals in the public health workforce, to enhance the quality of such workforce, and to enhance their ability to meet national, State, and local health care needs. Preference for such grants is given to entities serving individuals from disadvantaged backgrounds and those entities that graduate large proportions of individuals that serve in underserved communities. Amounts provided under a grant or contract awarded may be used for the following activities: (1) the costs of planning, developing, or operating demonstration training programs; (2) faculty development; (3) trainee support; (4) technical assistance; (5) to meet the costs of projects — (A) to plan and develop new residency training programs and to maintain or improve existing residency training programs in preventive medicine and dental public health, that have available full-time faculty members with training and experience in the fields of preventive medicine and dental public health; and (B) to provide financial assistance to residency trainees enrolled in such programs; (6) the retraining of existing public health workers as well as for increasing the supply of new practitioners to address priority public health, preventive medicine, public health dentistry, and health administration needs; (7) preparing public health professionals for employment at the State and community levels; or (8) other activities that may produce outcomes that are consistent with the purposes of this section.

##### *Proposed Law*

The bill would amend Section 765(d) of the PHSA regarding authorized Public Health Workforce grant activities by redesignating paragraphs and inserting new language that would authorize public health workforce loan repayment programs among the activities funded under public health workforce grants.

The bill would also amend Part E of Title VII of the PHSA, as amended by section 424 of the bill, to include the following new Section 777:

#### ***Sec. 777. Training for Mid-Career Public Health Professionals.***

The Secretary would be authorized to make grants or enter into contracts with eligible entities to award scholarships to eligible individuals who enroll in degree or professional training programs for the purpose of enabling certain mid-career professionals to receive additional training in public health and allied health.

Eligible entities would include accredited educational institutions that offer a course of study, a certificate program or professional training program in public health or a related discipline, as determined by the Secretary. Eligible individuals include those individuals employed in public health positions at the Federal, State, tribal or local level who are interested in retaining or upgrading their education.

The bill would authorize to be appropriated \$60,000,000 for FY2010, and such sums as may be necessary for each of FY2011 through FY2015. It would require 50% of appropriated funds to be allotted for mid-career public health professionals and 50% for mid-career allied health professionals.

#### **Sec. 427. Funding for National Health Service Corps.**

##### *Current Law*

Sections 331, 338A, 338B, and 338I of the PHS Act authorize the National Health Service Corps (NHSC), administered by HRSA. The NHSC provides scholarship and loan repayment programs for medical school students, nurse practitioners, nurse midwives, physician assistants, dental school students, and allied health professionals who enter primary care in health professional shortage areas (HPSAs). NHSC clinicians may fulfill their service commitments in health centers, rural health clinics, public or nonprofit medical facilities, federal or state correctional facilities, or within other community-based systems of care. The PHS Act authorizes the following amounts for the NHSC scholarship and loan repayment programs: \$131,500,000 for FY2008; \$143,335,000 for FY2009; \$156,235,150 for FY2010, \$170,296,310 for FY2011, and \$185,622,980 for FY2012.

##### *Proposed Law*

The bill would amend Section 338H of the PHS Act to authorize the following amounts for the NHSC program: \$320,461,632 for FY2010; \$414,095,394 for FY2011; \$535,087,442 for FY2012; \$691,431,432 for FY2013; \$893,456,433 for FY2014; and \$1,154,510,336 for FY2015. For FY2016 and subsequent years, the amount authorized to appropriate for that year would be based on the amount authorized to appropriate for the preceding fiscal year adjusted by the product of (1) one plus the average percentage increase in the costs of health professions education during the prior fiscal year, and (2) one plus the average percent change in the number of individuals residing in HPSAs during the prior fiscal year relative to the number of individuals residing in HPSAs during the previous fiscal year.

#### **Sec. 428. Nurse-managed health clinics.**

*Current Law*

No provision.

*Proposed Law*

The provision would amend the PHSA to establish a grant program to fund the development and operation of nurse-managed health clinics that provide comprehensive primary health care and wellness services to vulnerable populations living in medically underserved communities, and to reduce the level of health disparities experienced by vulnerable populations. Specifically, the bill would amend Subpart 1 of Part D of Title III of the PHSA by inserting a new Section 330A-1 to include the following:

***Sec. 330A-1. Grants to Nurse-Managed Health Clinics.***

The bill would define “comprehensive primary health care services” to mean the primary health care services defined in PHSA Section 330(b)(1). It would also define the term “nurse-managed health clinic” to mean a nurse-practice arrangement, managed by advanced practice nurses, that provides primary care or wellness services to underserved or vulnerable populations and that is associated with a school, college, university or department of nursing, a federally qualified health center, or independent nonprofit health or social services agency.

The Secretary would award grants for the cost of operations of nurse-managed health clinics that meet certain requirements. The grant amount for any fiscal year would be determined by the Secretary taking into account the financial need of the nurse-managed health clinic and other factors that the Secretary deems appropriate. The bill would authorize to be appropriated \$50,000,000 for FY2010 and sums as may be necessary for each of the FY2011 through FY2014.

**Sec. 429. Elimination of cap on commissioned corp.**

*Current Law*

Section 202 of P.L. 102-394, the Departments of Labor, Health and Human Services, Education, and Related Agencies Appropriations Act of 1993, which provided funds for the U.S. Public Health Service Commissioned Corps, capped the number of commissioned officers in the Regular Corps (vs. the Reserve Corps) at 2,800, prohibiting the use of appropriations from that Act, or any subsequent appropriations act, to fund additional positions. The ceiling was raised to 4,000 in Section 222 of P.L. 111-8, the Omnibus Appropriations Act, 2009.

*Proposed Law*

The bill would amend Section 202 of P.L. 102-394 by eliminating the cap on the number of commissioned officers in the Regular Corps.

## **Sec. 430. Establishing a Ready Reserve Corps.**

### *Current Law*

Section 203 of the PHSA establishes the Commissioned Corps of the U.S. Public Health Service, composed of a Regular Corps and Reserve Corps. It requires commissioned officers of the Reserve Corps to be appointed by the President, and commissioned officers of the Regular Corps to be appointed by the President with the advice and consent of the Senate. Commissioned officers of the Reserve Corps are required to be, at all times, subject to call to active duty by the U.S. Surgeon General, including call to active duty for the purpose of training.

### *Proposed Law*

The bill would amend Section 203 of the PHSA to establish a Ready Reserve Corps within the U.S. Public Health Service Commissioned Corps, for times of national emergency, in addition to the existing Regular Corps. The bill would replace all mentions of the existing Reserve Corps with “Ready Reserve Corps.” Effective upon enactment, all members of the existing Reserve Corps serving on active duty would be deemed to be members of the Regular Corps.

The purpose of the Ready Reserve Corps would be to fulfill the need for additional Commissioned Corps personnel who can be available on short notice to assist the Regular Corps to meet both routine public health and emergency response missions. The Ready Reserve Corps would be required to: participate in routine training to meet the needs of the Commissioned Corps; be available and ready for involuntary calls to active duty during national emergencies and public health crises; be available to backfill critical positions vacated during the deployment of active duty Commissioned Corp personnel; be available for deployment in responding to public health emergencies, foreign and domestic; and be available for service assignment in isolated, hardship, and medically underserved communities to improve access to health services.

The bill would authorize to be appropriated such sums as may be necessary to the Office of the Surgeon General for each of FY2010 through FY2014. Funds appropriated would be used to recruit and train the Commissioned Corps Officers.

## **Subtitle D – Enhancing Health Care Workforce Education and Training**

*Current Law* (with respect to Sections 431, 432, and 433 of bill)

Title VII, Part C of the PHSA establishes “Training in Family Medicine, General Internal Medicine, General Pediatrics, Physician Assistants, General Dentistry, and Pediatric Dentistry.” Section 747 authorizes funding to hospitals, schools, and other nonprofit entities for health professions training programs in family medicine, general internal medicine, or general pediatrics, and comparable programs in dentistry. Authority for appropriations under Section 747 expired at the end of FY2002.

*Proposed Law*

### **Sec. 431. Training in family medicine, general internal medicine, and general pediatrics, and physician assistantship.**

The bill would delete Section 747 of the PHSA and insert new language. This provision would provide grants for the support of primary care training programs and capacity building in primary care.

Specifically, the provision would authorize the Secretary to award grants or enter into contracts with an accredited public or nonprofit hospital, school of medicine or osteopathic medicine, academically affiliated physician assistant training program, or a public or private nonprofit entity, determined capable of carrying out such grant by the Secretary, to engage in a variety of specified activities for the support and development of primary care training programs. These activities include: (1) to plan, develop, operate, or participate in an accredited professional training program in the field of family medicine, general internal medicine, or general pediatrics for medical students, interns, residents, or practicing physicians as defined by the Secretary; (2) to provide need-based financial assistance in the form of traineeships and fellowships to those specified medical personnel who are program participants and plan to specialize or work in the above fields; (3) to plan, develop, and operate physician training programs for those who plan to teach in the above fields; (4) to plan, develop, and operate physician assistant education programs, and for the training of individuals who will teach in training programs; (5) to plan, develop, and operate a demonstration program that provides training in new competencies; and (6) to plan, develop, and operate joint degree programs to provide interdisciplinary and interprofessional graduate training in public health and other health professions. Grants or contracts would be awarded for 5 years.

The Secretary would also be authorized to award grants or enter into contracts for capacity building in primary care with accredited schools of medicine or osteopathic medicine to establish, maintain, and improve academic units or programs that improve clinical teaching and research in the above fields or programs that integrate these entities in order to enhance interdisciplinary recruitment, training, and faculty development. In making awards, the Secretary would be required to give preferences to qualified

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applicants who agree to expend the award for the purposes of establishing academic units or programs in these fields or substantially expanding such units or programs. The Secretary would further be required to give priority to qualified applicants for grants or contracts for capacity building in primary care, based on several specified criteria with respect to their proposals, and/or their history in providing training. These criteria include: specified approaches to primary care and disease management, including models such as the patient centered medical home; a successful record of training providers who are from underrepresented or disadvantaged groups, and/or enter practice in primary care; a successful record of providing training in the care of vulnerable populations; and other criteria. Grants or contracts would be awarded for 5 years.

The bill would authorize the appropriation of \$125 million for each of fiscal years 2010 through 2014. It would require 15% of the amount appropriated in each fiscal year to be allocated to the physician assistant training programs that prepare students for practice in primary care. For purposes of carrying out programs that integrate academic administrative units and programs, the provision would authorize the appropriation of \$750,000, out of the total amount authorized, for each of fiscal years 2010 through 2014.

**Sec. 432. Training opportunities for direct care workers.**

The bill would amend section 747 to add a new Section 747A that would provide training opportunities for direct care workers in long-term care settings as follows:

***Sec. 747A. Training Opportunities for Direct Care Workers.***

The provision would require the Secretary to award grants to eligible entities to provide new training opportunities for direct care workers employed in long-term care settings, such as nursing homes, assisted living facilities, home care settings, and other settings the Secretary determines appropriate. In order to receive a grant, entities would be required to be an institution of higher education that is accredited by a nationally recognized accrediting agency or association listed under section 101(c) of the Higher Education Act of 1965 and have established a public-private educational partnership with a nursing home, home health agency, or other long-term care provider. In addition, an entity must submit an application to the Secretary containing required information.

An eligible entity would be required to use grant awards to provide assistance to eligible individuals to offset the cost of tuition and required fees for enrollment in academic programs. To be eligible for assistance, an individual must be enrolled in courses provided by a grantee under this subsection and maintain satisfactory academic progress in such courses. As a condition of receiving assistance, an individual, after completion of the assistance period, must agree to work in the field of geriatrics, long-term care, or chronic care management for a minimum of 2 years under guidelines set by the Secretary.

The provision would authorize to be appropriated \$10 million for fiscal years 2011 through 2013.

### **Sec. 433. Training in general, pediatric, and public health dentistry.**

The bill would amend Part C of Title VII of the PHSA by redesignating section 748, as amended by section 413 of the bill, as section 749; and inserting new language after section 747A, as added by section 432 of the bill, as follows:

#### ***Sec. 748. Training in General, Pediatric, and Public Health Dentistry.***

The provision would authorize the Secretary to make grants or enter into contracts with a school of dentistry, public or nonprofit private hospital, or public or private nonprofit entity deemed appropriate by the Secretary to conduct the following activities: (1) to plan, develop, and operate, or participate in, an approved professional training program in the field of general dentistry, pediatric dentistry, or public health dentistry for dental students, residents, practicing dentists, or dental hygienists or other approved primary care dental trainees that emphasizes training for the above fields; (2) to provide needed financial assistance to the above dental students and professionals who participate in the program and continue to work in these areas of dental practice; (3) to plan, develop, and operate a program for the training of oral health care providers who plan to teach in the above fields; (4) to provide financial assistance in the form of traineeships and fellowships to dentists who plan to teach or are teaching in the above fields; (5) to fund projects to establish, maintain, or improve dental faculty development programs in primary care; (6) to fund projects to establish, maintain, or improve predoctoral and postdoctoral training in primary care programs; (7) to create a loan repayment program for faculty in dental programs; and (8) to provide technical assistance to pediatric training programs in developing and implementing instruction regarding the oral health status, dental care needs, and risk-based clinical disease management of all pediatric populations with an emphasis on underserved children.

The provision would also establish a faculty loan repayment program in dentistry. A grant or contract could be awarded to general, pediatric, or public health dentistry programs to plan, develop, and operate a loan repayment program under which individuals agree to serve full-time as faculty members, and the program agrees to pay the principal and interest on the outstanding student loans. Payments would be made to the individual upon completion of each of the first, second, third, fourth, and fifth years of service in an amount equal to 10, 15, 20, 25, and 30 percent, respectively, of the individual's student loan balance as calculated based on principal and interest owed at the initiation of the agreement.

Eligible entities for grants and contracts in general, pediatric, or public health dentistry, would include entities that have programs in dental or dental hygiene schools, or approved residency or advanced education programs in the practice of general, pediatric, or public health dentistry. Eligible entities may partner with schools of public health to permit the education of these practices for a master's in public health.

With respect to training provided, the Secretary would be required to give priority in awarding grants or contracts to qualified applicants based on several specified criteria

with respect to their proposals, and/or their history in providing training. These criteria include: specified approaches to primary care; a successful record of training providers who are from underrepresented or disadvantaged groups, and/or enter practice in primary care; a successful record of providing training in the care of vulnerable populations; and other criteria.

The Secretary shall give preferences in making awards of grants or contracts to qualified applicants that have a high rate for placing graduates in practice settings that focus on underserved areas or health disparity populations, or have achieved a significant increase in the placement rate of graduates or graduating practitioners who serve health disparity populations during the 2-year period before the fiscal year of the award.

Eligible entities would be required to submit an application containing such information as required by the Secretary. Grants or contracts would be awarded for 5 years. The provision of payments would be subject to annual approval by the Secretary and subject to the availability of appropriations for the fiscal year involved.

This provision would authorize to be appropriated \$30 million for fiscal years 2010, and such sums as may be necessary for fiscal years 2011 through 2015. An entity that receives an award may carry over funds from one fiscal year to another without obtaining approval. Funds may not be carried over for more than 3 years.

#### **Sec. 434. Alternative dental health care providers demonstration project.**

##### *Current Law*

No provision.

##### *Proposed Law*

The bill would amend Subpart X of Part D of Title II of the PHSA to add section 340H, which would authorize the Secretary to award grants to 15 eligible entities for the establishment of demonstration programs. The demonstration programs would establish programs to train or employ alternative dental health care providers in order to increase access to dental health care services in rural and other underserved communities. Alternative dental health care providers would include community dental health coordinators, advance practice dental hygienists, independent dental hygienists, supervised dental hygienists, primary care physicians, and dental therapists. The demonstration projects funded by these grants would begin within 2 years and conclude within 7 years of enactment.

An eligible entity for these grants would be defined as: an institution of higher education; a public-private partnership; a federally qualified health center; an Indian Health Service facility; a State or county public health clinic; or a public hospital or health system. The eligible entity would be within a program accredited by the Commission on Dental

Accreditation or within a dental education program in an accredited institution and submit an application to the Secretary as required.

Grant awards would be at least \$4 million over a 5-year period, with the first disbursement of no more than 20% of the total funding awarded beginning 1 year after enactment. In the subsequent years of the grant, at least 15% of the remaining funds will be disbursed. All grant recipients under this section would certify their compliance with applicable State licensing requirements.

The bill would authorize the Director of the Institute of Medicine to conduct a study of the demonstration programs. It would require the Director to gather baseline data and comparison data from each demonstration project for the study.

**Sec. 435. Geriatric education and training; career awards; comprehensive geriatric education.**

*Current Law*

Section 753 of the PHSA requires the Secretary to make grants or enter into contracts with schools that train a broad slate of health professionals (including physician assistants and allied health professionals), as defined. Grants or contracts are for the establishment of Geriatric Education Centers (GECs) to develop and provide programs of training in geriatrics, including faculty training, curriculum development, and the establishment of residencies and fellowships. The section also authorizes programs for geriatrics training of physicians, dentists, and mental health professionals; and a program of faculty fellowships in geriatrics. Authority for appropriations for this part of the PHSA expired at the end of FY2002. Geriatrics training authorities in Title VII of the PHSA do not explicitly address intensive training or family caregiving.

Title III, Part E, establishes the “National Family Caregiver Support Program” (NFCSP) under the Older Americans Act (OAA). The NFCSP provides funding under a formula grant program to states for a variety of activities to support family caregivers primarily caring for the elderly, including training for family caregivers. Additional support to family caregivers is authorized under Title XXIX, the Lifespan Respite Care, which provides respite care to informal caregivers caring for individuals of all ages. Under Section 2902 eligible State agencies awarded a grant or cooperative agreement may use funds for training and education for new caregivers.

*Proposed Law*

Section 753 of the PHSA would be amended by adding the following new language:

The bill would require the Secretary to award grants or contracts to entities that operate a GEC for the purposes of geriatric workforce development. Eligible entities would be required to submit an application containing such information as required by the Secretary. Amounts awarded under a grant or contract would be used to carry out the

fellowship program and carry out 1 of the 2 additional required activities. A GEC that receives an award would be required to use such funds to offer short-term intensive courses (fellowships) that focus on geriatrics, chronic care management, and long-term care that provide supplemental training for faculty member in medical schools and other health professions schools with programs in psychology, pharmacy, nursing, social work, dentistry, public health, and allied health or other health disciplines, as approved by the Secretary.

A fellowship would be offered either at the GEC sponsoring the course or at medical schools, specified health professions schools, and other health professions schools approved by the Secretary affiliated with the GECs. Participation in a fellowship would comply with continuing medical education requirements. As a condition of acceptance, the recipient would agree to provide a minimum of 18 hours of voluntary instructional support through a GEC that is providing clinical training to students or trainees in long-term care settings.

A GEC that receives an award would be required to use funds to carry out 1 of the following 2 activities: (1) practical training to family caregivers designed to provide support for frail elders and individuals with disabilities; and (2) incorporation of best practices in order to develop material on depression and other mental disorders common among adults, medication safety issues for older adults, and aspects of dementia and techniques for communicating with individuals who have dementia.

A geriatric education center that receives an award would be required to meet targets approved by the Secretary for providing geriatric training to faculty or practitioners, as well as other parameters established by the Secretary. The bill would require each award to be \$150,000 with no more than 24 GECs authorized to receive an award.

A GEC that receives an award would be required to provide assurances to the Secretary that these funds will be used to supplement and not supplant the amount of Federal, State, and local funds otherwise expended. The bill would authorize \$10,800,000 to be appropriated to carry out the geriatric workforce development grant program for the period of FY 2011 through FY2014.

The Secretary also would be authorized to award career incentive grants or contracts to eligible individuals to foster greater interest among a variety of health professionals in entering the field of geriatrics, long-term care, and chronic care management. As a condition of receiving an award an individual must agree to teach or practice in the field of geriatrics, long-term care, or chronic care management for a minimum of 5 years under certain guidelines. The bill would authorize \$10,000,000 to be appropriated for geriatric career incentive awards for the period of FY2011 through FY2013.

Section 753(c) of the PHSA would be amended by redesignating paragraphs and deleting paragraphs concerning individuals eligible for geriatric academic career awards (GACA), and replacing them with new language as follows:

To be eligible to receive a GACA award an individual would be required to be board certified or eligible in internal medicine, family practice, or psychiatry, or have completed any required training in a discipline and employed in an accredited health professions school approved by the Secretary; have completed an approved fellowship program in geriatrics; and have a junior faculty appointment at certain specified accredited medical, health professions schools, or other health professions schools approved by the Secretary. An eligible individual could not receive an award unless they submit an application to the Secretary as required and provide for specified assurances. An individual that receives an award would be required to provide assurances to the Secretary that funds would be used to supplement and not supplant the amount of Federal, State, and local funds otherwise expended.

The bill would amend the requirements for eligible individuals receiving GACA awards to specify that individuals who are board certified or board eligible in internal medicine, family practice, or psychiatry would be physicians. It would also require the Secretary to determine the amount of an award under the section for individuals who are not physicians.

The Secretary would be required to transfer funds awarded to an individual to the institution where they will carry out the award in order to facilitate financial management of the award as pursuant to HRSA guidelines.

Section 855 of the PHSA would be amended to include new language establishing traineeships for individuals who are preparing for advanced education nursing degrees in geriatric nursing or other nursing areas that specialize in the care of the elderly population. It would delete the expired authorization, and authorize to be appropriated such sums as may be necessary for each of FY2010 through FY2014.

### **Sec. 436. Mental and behavioral health education and training grants.**

#### *Current Law*

Section 757 of the PHSA provides the authorization for appropriations for all programs under Part D of Title VII, namely the Area Health Education Centers programs, and the geriatric education and training programs that would be reauthorized under the prior section 435 of this bill.

Schools and training programs in social work are generally not eligible for funding under Title VII of the PHSA, with the exception of training programs in health administration under Section 769. In contrast, most graduate programs in mental and behavioral health are generally eligible for broad health professions training grants under Title VII.

*Proposed Law*

The bill would amend Part D of Title VII of the PHSA to delete section 757. It would redesignate section 756 (as amended by section 413) as section 757, and insert a new section 756, as follows:

***Section 756. Mental and Behavioral Health Education and Training Grants.***

The bill would authorize the Secretary to award grants to eligible institutions of higher education to support: the recruitment, education, and clinical experience of students in social work programs; the development and implementation of interdisciplinary training of students in psychology for providing mental health services; institutions of higher education or professional training programs for internships or field placement programs in child and adolescent mental health in specified fields; and State licensed mental health organizations for training of paraprofessional child and adolescent mental health workers.

To be eligible for these grants, institutions would demonstrate: (1) program participation in certain diversity groups; (2) knowledge and understanding of those diversity groups; (3) prioritization of cultural and linguistic competency; (4) provide data, assurances, and information to the Secretary as required; and (5) pay liquidated damages for any violation of the agreement between the Secretary and the institution.

The bill would require at least 4 of the grant recipients to be historically black colleges or institutions or other minority-serving institutions. For grants for education and training in social work, priority would be given to applicants that are accredited by the Council on Social Work Education, have a graduation rate of at least 80% for social work students, are able to recruit from and place social workers into areas with a high need and high demand population. For grants in graduate psychology, priority would be given to institutions that focus on the needs of specified vulnerable groups.

For grants to training programs in child and adolescent mental health, priority would be given to applicants that have shown they are able to collect data on their students who are trained in child and adolescent mental health and the populations served by those students after graduation, are familiar with evidence-based methods, have programs designed to increase the number of professional serving and coming from high-priority populations and who plan to serve in Health Professional Shortage Areas, Medically Underserved Areas, or Medically Underserved Populations, and offer a curriculum taught collaboratively with the family experience or family-professional partnership.

For grants for pre-service or in-service training of paraprofessional child and adolescent mental health workers, priority would be given to applicants that have demonstrated the ability to collect data on the number of child and adolescent mental health workers trained and the populations they serve upon completion of the training, are familiar with evidence-based methods, have programs designed to increase the number of child and adolescent mental health workers serving high-priority populations, and provide services

through a community mental health program described in section 1913(b)(1) of the PHSA.

For FY2010 through FY2013, there would be authorized to be appropriated \$8 million for social work training; \$10 million for graduate psychology training; \$10 million for professional training in child and adolescent mental health; and \$5 million for paraprofessional training in child and adolescent work.

Section 757(b)(2) of the PHSA, as redesignated by subsection (a), is amended by striking sections 751(a)(1)(A), 751(a)(1)(B), 753(b), 754(3)(A), and 755(b) and inserting sections 751(b), 753(b) and 755(b).

**Sec. 437. Cultural competency, prevention and public health and individuals with disabilities training.**

*Current Law*

Section 741 of the PHSA authorizes funding to public and nonprofit entities for research and demonstration projects for the training of health professionals for the reduction of disparities in health care outcomes and the provision of culturally competent health care. Appropriations authority expired at the end of FY2004.

*Proposed Law*

This bill would amend Part B of Title VII of the PHSA to add the following:

***Section 742. Cultural Competency, Prevention and Public Health and Individuals with Disabilities Training.***

This bill would require the Secretary to support the development, evaluation, and dissemination of model curricula for cultural competency, prevention, and public health proficiency and aptitude for working with individuals with disabilities, for the purposes of training in health professional and continuing education programs, and for other purposes.

In developing these model curricula, the Secretary would collaborate with health professional societies, licensing and accreditation entities, health professions schools, experts in minority health and cultural competency, prevention and public health and disability groups, community-based organizations, and other organizations as determined appropriate. These model curricula would focus on cultural competency measures, prevention and public health competency measures, and working with individuals with disabilities competency measures. It would also include self-assessment methodology for health providers, systems, and institutions on cultural competency, prevention, and public health proficiency, and working with individuals with disabilities aptitude.

These model curricula would be disseminated through the Internet Clearinghouse under section 270 and other means as deemed appropriate. The Secretary would evaluate the adoption and implementation of cultural competency, prevention, public health, and working with individuals with disabilities training curricula, and the inclusion of these measures in quality measurement systems as appropriate.

#### **Sec. 438. Advanced nursing education grants.**

##### *Current Law*

Section 811 of the PHSA establishes Advanced Education Nurse Grants to fund projects that support the enhancement of advanced nursing education and practice and traineeships for individuals in advanced nursing education programs. Eligible entities include authorized nurse practitioners and nurse midwives programs, authorized nurse anesthetists programs, and others as specified.

Eligible nurse practitioner and nurse midwifery programs are those for registered nurses that: meet guidelines prescribed by the Secretary; and have as their objective the education of nurses who will, upon the program's completion, be qualified to effectively provide primary health care, including primary health care in homes and in ambulatory care facilities, long-term care facilities, acute care, and other health care settings.

##### *Proposed Law*

The bill would amend Section 811 of the PHSA to establish separate authorizations for the support of Nurse Practitioner programs and Nurse Midwifery programs, by redesignating subsections, and inserting new material as follows:

Midwifery programs would be eligible for funding under Section 811 if (1) their objective is the education of midwives who would, upon program completion, become qualified to provide primary health care services to women at health care locations including acute care facilities, ambulatory care facilities, birth centers, personal residences, and other settings as authorized by State or Federal law; and (2) they are accredited by the American College of Nurse-Midwives Accreditation Commission of Midwifery Education.

#### **Sec. 439. Nurse education, practice, and retention grants.**

##### *Current Law*

Section 831 of the PHSA establishes a Nurse Education, Practice, and Retention Grants program. Under this program, the Secretary would be authorized to award grants or enter into contracts with a school of nursing, health care facility, or a partnership of the two, to respond to the nursing shortage and increase the number of registered nurses in specific priority areas, as described. Appropriations authority expired at the end of FY2007.

### *Proposed Law*

The bill would amend Section 831 of the PHSA. Specifically, it would amend the title of the grant program to be “Nurse Education, Practice, and Quality Grants.” It would delete the provisions for providing support for developing and implementing internship and residency programs to encourage mentoring and the development of specialties within nursing. The bill would restate grant priority activities from “managed care and quality improvement” to “coordinated care,” and would require that nursing schools be defined to have the same meaning as the term in Section 801(2) of the PHSA, a health care facility, or a partnership of such a school and facility. The bill would authorize to be appropriated such sums as may be necessary for each of fiscal years 2010 through 2014, for activities under this section.

The bill would amend Title VIII of the PHSA to create a new Section 831A, as follows:

#### ***Sec. 831A. Nurse Retention Grants.***

The bill would establish a Nurse Retention Grant program, authorizing the Secretary to provide funding to eligible entities for nurse retention and promotion (“career ladder”) programs. The Secretary would be authorized to award grants or contracts for developing and implementing internship and residency programs, in collaboration with an accredited school of nursing (as defined by section 801 of the PHSA) to encourage mentoring and the development of specialties. The bill would also authorize the Secretary to award grants or contracts to create programs to assist individuals in obtaining education and training required to enter into or advance within the nursing profession.

The Secretary would be authorized to award grants to eligible entities to improve the retention of nurses and enhance patient care that is directly related to nursing activities by enhancing collaboration and communication between nurses and other health care professionals, and by promoting nurse involvement in facilities’ organizational and clinical decision-making processes. When making grant awards, the Secretary would be required to give preference to applicants that have not previously received a grant award; and to make the continuation of an award beyond the second year contingent on demonstrated improvement in nursing retention or patient care. The Secretary would be authorized to award grants or enter into contracts with eligible entities that address other areas that are of high priority to nurse retention, as determined by the Secretary. The Secretary would be required to report to Congress before the end of each fiscal year on the grants or contracts awarded.

The bill would define the term “eligible entity” as an accredited school of nursing, a health care facility, or a partnership of the two. The bill would authorize such sums as may be necessary to be appropriated to carry out grant programs in this section for each of fiscal years 2010 through 2012.

## **Sec. 440. Loan repayment and scholarship program.**

### *Current Law*

Title VIII, Part E, of PHSA, (“Student Loans”) includes the following sections: Section 840, Administrative Provisions; Section 842, Procedures for the Appeal of Terminations; Section 846, the Loan Repayment and Scholarship Programs; Section 846A, the Nurse Faculty Loan Program; and Section 810, Provisions Regarding Prohibition Against Discrimination by Schools on the Basis of Sex.

Section 846(a)(3) provides that a nurse who serves for a specified period of time in a health care facility with a critical shortage of nurses would be eligible for the scholarship and loan repayment program established under this section.

### *Proposed Law*

The bill would make technical amendments to Title VIII of the PHSA to redesignate Sections 842 (relating to appeals), 846 (relating to loan repayment and scholarship programs), 846A (relating to the nurse faculty loan program), and 810 (relating to discrimination) as sections 840A, 840B, 840C, and 840E, respectively.

The proposal would also amend Section 840B(a)(3) [846(a)(3) in current law] to add a nurse who serves at an accredited school of nursing, as defined by Section 801(2), as eligible for the scholarship and loan repayment program established under this section.

## **Sec. 441. Nurse faculty loan program.**

### *Current Law*

Section 846A of the PHSA directs the Secretary, acting through the HRSA Administrator, to enter into an agreement with any school of nursing for the establishment and operation of a student loan fund to increase the number of qualified nursing faculty. Total loans for any academic year made by schools of nursing from loan funds may not exceed \$30,000, plus any amount determined by the Secretary on an annual basis to reflect inflation. Authority for appropriations under this section expired at the end of fiscal year 2007.

### *Proposed Law*

The bill would amend Section 840C of the PHSA (as redesignated from the former Section 846A by section 440 of the bill), to specify the name of the loan fund as the School of Nursing Student Loan Fund. Additionally, it would specify that agreements may be entered into with any accredited school of nursing (instead of any school of nursing) for the establishment and operation of the loan fund. The loan limit would be increased from \$30,000 to \$35,500 during fiscal years 2010 and 2011. Thereafter, such amounts would be adjusted to provide for a cost-of-living increase for the yearly loan rate

and the aggregate loan. The bill would authorize to be appropriated such sums as may be necessary for each of FY2010 through FY2014.

The bill would create a new Section 840D in the PHSA, as follows:

***Section 840D. Eligible Individual Student Loan Repayment.***

The bill would authorize the Secretary, acting through the HRSA Administrator, to enter into an agreement with eligible individuals for the repayment of education loans so as to increase the number of qualified nursing faculty. It would require each eligible individual to serve as a full-time member of the faculty of an accredited school of nursing for a total of at least 4 years during a 6-year period beginning either when the degree is conferred, or when the individual enters into an agreement under this section. The bill would specify provisions for agreements and breach of agreements, and would stipulate that any funds returned pursuant to a breach would remain available to the Secretary until expended, to make loans under this section. It would define “eligible individual” as an individual who: is a U.S. citizen, national, or lawful permanent resident; holds an unencumbered license as a registered nurse; and has either already completed a master’s or doctorate nursing program at an accredited school of nursing or is currently enrolled on a full-time or part-time basis in such program. Funding priority would be awarded to School of Nursing Student Loans or Individual Student Loan Repayments that support doctoral students. The bill would authorize to be appropriated such sums as may be necessary for each of fiscal years 2010 through 2014.

**Sec. 442. Authorization of appropriations for parts B through D of title VIII.**

*Current Law*

Part F of Title VIII of the PHSA (which consists solely of Section 841) authorizes funds to be appropriated for Part B, “Nurse Practitioners, Nurse Midwives, Nurse Anesthetists, and Other Advanced Education Nurses”; Part C, “Increasing Nursing Workforce Diversity”; and Part D, “Strengthening Capacity For Basic Nurse Education and Practice”. Section 841(a) in Part F authorizes the appropriation of \$65 million in total for activities under the three parts for FY1998, and such sums as may be necessary for fiscal years 1999 through 2002. Subsequent subsections of Section 841 specify the allocation of funds among the parts.

*Proposed Law*

The bill would strike language in current Section 841 of the PHSA and replace it as follows:

***Sec. 841 Authorization of Appropriations.***

For the purposes of carrying out Parts B, C, and D (subject to section 845(g) of the PHSA regarding the National Advisory Council on Nurse Education and Practice), the bill

would authorize to be appropriated \$338 million for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2016. The proposal would not retain the allocation language in current law.

**Sec. 443. Grants to promote the community health workforce.**

*Current Law*

Training of community health workers is among the activities required of Health Education Training Centers funded under PHSA Section 752. There is no specific program for community health worker training or development in current law.

Section 134(c) of the Workforce Investment Act of 1998 (P.L. 105-20) requires States (as a condition of grant funds) to implement one-stop delivery systems for their training, education, and employment programs.

*Proposed Law*

The bill would amend Part P of Title III of the PHSA by adding a new Section 399S, as follows:

***Sec. 399S. Grants to Promote Positive Health Behaviors and Outcomes.***

The Secretary would be required to award grants to eligible entities to promote positive health behaviors for populations in medically underserved communities through the use of community health workers. Grants would have to be used to support community health workers who would provide education, guidance, and outreach to communities regarding: health problems that are prevalent in the medically underserved; effective strategies to promote positive health behaviors within the family; enrollment in available health insurance programs, including CHIP and Medicaid; referral to appropriate healthcare agencies and community-based programs and organizations; and to educate, guide, and provide home visitation services to promote maternal health and prenatal care.

Eligible entities would be required to submit applications as outlined by the Secretary. In awarding grants, the Secretary would be required to prioritize applicants that propose to target geographic areas with: a high percentage of residents who are eligible for health insurance but are uninsured or underinsured; a high percentage of residents who suffer from chronic diseases; and a high infant mortality rate. The Secretary would also be required to prioritize applicants that have experience in providing health and health-related social services to individuals who are underserved and who have documented community activity and experience with community health workers.

The Secretary would be required to encourage community health worker programs in this program to collaborate with academic institutions and one-stop delivery systems established under section 134(c) of the Workforce Investment Act of 1998. The bill would not mandate such collaboration.

The Secretary would be required to encourage community health worker programs receiving funding through the grant program to implement an outcome-based payment system that rewards community health workers for connecting underserved populations with the most appropriate and timely services. The bill would not mandate such a payment system.

The Secretary would be required to establish guidelines for assuring the quality of training and supervision of community health workers and the cost-effectiveness of the programs funded by the grants. The Secretary would be required to monitor community health worker programs that receive grants and determine whether such programs are following established guidelines for training and supervision. The bill would authorize the Secretary to provide technical assistance to these grant programs.

The bill would authorize to be appropriated such sums as may be necessary to provide grants to promote positive health behaviors for each of fiscal years 2010 through 2014.

The bill would define the terms *community health worker*, *community setting*, and *medically underserved community*.

#### **Sec. 444. Youth public health program.**

##### *Current Law*

Section 751 of the PHSA authorizes the Area Health Education Centers program to, among other things, promote recruitment into the health professions of minority individuals or individuals from disadvantaged backgrounds. It would be rewritten pursuant to Section 453 of the bill, but would retain the same general purpose. The new Section 751 would require the Secretary to make infrastructure development awards, for grantees to develop a number of specified recruitment approaches.

##### *Proposed Law*

This bill would amend section 751(b)(4)(A) of the PHSA, as amended by section 453 of the bill, with respect to infrastructure development awards for Area Health Education Centers. It would add, to the list of eligible activities, programs to expose and recruit high school students into health careers, with a focus on careers in public health.

#### **Sec. 445. Fellowship training in public health.**

##### *Current Law*

No provision.

### *Proposed Law*

The bill would amend Title VII, Part E of the PHSA, as amended by section 426 of the bill, to include:

#### ***Section 778. Fellowship Training in Applied Public Health Epidemiology, Public Health Laboratory Science, Public Health Informatics, and Expansion of the Epidemic Intelligence Service.***

The bill would authorize the Secretary to address workforce shortages in State and local health departments in the critical areas of applied public health epidemiology, public health laboratory science and informatics through certain activities and authorize the Secretary to expand the Epidemic Intelligence Service. This would be carried out through the expansion of existing fellowship programs at the Centers for Disease Control and Prevention. The bill would also authorize the expansion of other applied epidemiology training programs that meet similar objectives to the existing fellowship programs. Participants in the fellowship training programs would need to satisfy work obligations stipulated in contracts under section 338I(j) of the PHSA. This funding would also be authorized to be used for expansion of the Public Health Informatics Fellowship Program to better support all systems of government.

## **Subtitle E – Supporting the Existing Health Care Workforce**

### **Sec. 451. Centers of excellence.**

#### *Current Law*

Section 736 of the PHSA created a Centers for Excellence (COE) program. The Secretary is required to award grants and enter into contracts with designated health professions schools and other public and nonprofit health or educational entities to support programs of excellence in health professions education for underrepresented minority individuals. Section 736(h) authorizes funds for COE grants to health professions school that are: Historically Black Colleges and University (HBCU) with accredited allied health programs; health professions schools that are designated Hispanic Centers of Excellence or Native American Centers of Excellence; and health professions schools that are Other Centers of Excellence, which are schools that have an above average enrollment of underrepresented minorities.

Funds for COE grants are allocated according to the following methodology. If the amount appropriated in a fiscal year is \$24 million or less, the Secretary must make available \$12 million for grants to HBCUs. Of the amount remaining, the Secretary must make available 60% to Hispanic or Native American COEs, and 40% to Other COEs.

If the amount appropriated in a fiscal year is more than \$24 million, but less than \$30 million, then 80% of the amount in excess of \$24 million must be allocated for grants to

Hispanic or Native American COEs, and the remaining 20% of the amount in excess of \$24 million must be allocated to Other COEs.

If the amount appropriated in a fiscal year exceeds \$30 million, then not less than \$12 million must be allocated to HBCUs, not less than \$12 million to Hispanic or Native American COEs, and not less than \$6 million to Other COEs. After all grants are made with the allocated funds, remaining funds can be distributed to any of the four types of COEs.

The Secretary cannot award grant funds to a COE unless the center agrees to maintain non-Federal expenditures at the center at same levels as prior to receiving the Federal grant. The center must first expend funds from other Federal sources prior to spending grant funds. Current law does not specify conditions for how funds should be allocated should the appropriation exceed \$30 million in a fiscal year.

#### *Proposed Law*

The provision would modify the allocation formula for COE funding for appropriations that exceed \$30 million as follows. If the amount appropriated in a given fiscal year were more than \$30 million, but less than \$40 million, the Secretary would have to make no less than \$12 million available to HBCUs, no less than \$12 million to Hispanic or Native American COEs, and no less than \$6 million for grants to Other COEs. After the grants were made, any remaining excess amount would be made available for grants to all categories of COEs.

If the amount appropriated in a given fiscal year were more than \$40 million, the Secretary would have to make no less than \$16 million available to HBCUs, no less than \$16 million to Hispanic or Native American COEs, and no less than \$8 million to Other COEs. After the grants were made as specified above, any remaining excess amount would be made available for grants to all categories of COEs.

There would be authorized to be appropriated \$50 million for each of FY2010 through FY2015, and such sums as may be necessary for each subsequent fiscal year.

#### **Sec. 452. Health care professionals training for diversity.**

##### *Current Law*

Section 738(a)(1) of the PHSA authorizes loan repayments and fellowships to individuals from disadvantaged backgrounds who have a degree in medicine, osteopathic medicine, dentistry, nursing, or another health profession, or who are enrolled in, or in the final year of study at, an accredited program leading to one of these degrees, and who agree to serve as a faculty member in an eligible health professions school. Eligible individuals may receive \$20,000 of educational loan repayment for each year they serve as a faculty member.

Section 740 of the PHSA authorizes appropriations for: (1) Section 737 scholarships to disadvantaged students; (2) Section 738 loan repayments and fellowships to individuals in faculty positions at specified health professions schools; and (3) Section 739 educational assistance in health professions regarding individuals from a disadvantaged background. While current authorization for these activities have expired, Congress continues to appropriate funding.

#### *Proposed Law*

The bill would amend Section 738(a)(1) by increasing from \$20,000 to \$30,000 the annual loan repayment amount. It would further amend Section 740 by authorizing the following appropriations: (1) for Section 737 scholarships to disadvantaged students, \$51 million for FY2010 and such sums as may be necessary for each of FY2011 through FY2014; (2) for Section 738 loan repayments and fellowships regarding faculty positions, \$5 million for each of FY2010 through FY2014; and (3) for Section 739 educational assistance in health professions for individuals from disadvantaged backgrounds, \$60 million for FY2010, and such sums as may be necessary for each of FY2011 through FY2014.

#### **Sec. 453. Interdisciplinary, community-based linkages.**

#### *Current Law*

The Area Health Education Center (AHEC) program is authorized in Section 751 of the PHSA. Generally, the AHEC program provides cooperative agreements to accredited medical and nursing to encourage the establishment and maintenance of community-based training programs in off-campus rural and underserved areas. The AHEC grants are for the planning, development and operation of programs that (1) improve the recruitment, distribution, supply, quality, and efficiency of personnel providing health services in underserved rural and urban areas; (2) increase the number of primary care providers in underserved areas; (3) recruit individuals from underserved areas and underrepresented population, including minority and other elementary or secondary students, into the health professions; (4) prepare individuals to more effectively provide health services in underserved areas or to underrepresented populations; (5) conduct health professions education and training activities for students of health professions schools and medical residents; (6) conduct at least 10% of required clinical education at remote sites; and (7) disseminate information to reduce professional isolation, increase retention, enhance the practice environment, and improve health care.

Section 752 of the PHSA authorizes funds for health education and training centers. To receive funding, an entity must be otherwise eligible for a Section 751 (AHEC) grant and must (1) address unmet health care needs along the border between the United States and Mexico, in Florida, and in other urban and rural areas with serious unmet health care needs; (2) establish an advisory board; (3) conduct training in health education services; (4) conduct training in health education services; and (5) support health professionals (including nursing).

*Proposed Law*

The provision would replace the existing PHSA Sections 751 and 752 with the following two new sections.

***Sec. 751. Area Health Education Centers.***

The provision would authorize the Secretary to award infrastructure development grants to medical and nursing schools to plan, develop, and operate AHEC programs. Funding must be used to (1) develop and implement strategies to recruit and support individuals from underrepresented minority populations or from disadvantaged or rural backgrounds into health professions; (2) develop and implement strategies to and provide community-based training and education to individuals seeking health careers within underserved areas or for health disparity population, in collaboration with other health care workforce development programs; (3) prepare individuals to more effectively provide health services in underserved areas and health disparity populations through field placements or preceptorships in conjunction with community-based organizations, accredited primary care residency training programs, federally qualified health centers, rural health clinics, or other appropriate facilities; (4) conduct and participate in interdisciplinary training with other health professionals; and (5) deliver or facilitate continuing education or information dissemination programs for health professionals, with an emphasis on those providing care in underserved areas or for health disparities populations.

Funds may also be used to (1) develop and implement innovative curricula to increase the number of primary care providers in underserved areas and for health disparities populations; (2) coordinate community-based participatory research with academic health centers and facilitate the rapid dissemination of evidence-based health care information; and (3) develop and implement other strategies to address identified workforce needs and enhance the health workforce.

The Secretary also would be authorized to award point of service maintenance and enhancement grants to maintain and improve the effectiveness of existing AHEC programs. Eligible entities would be those who had received AHEC funds prior to enactment of this Act, are operating an AHEC program, and have at least one center that is no longer eligible for such funding. Funds must be used to (1) develop and implement strategies in coordination with the applicable one-stop delivery system established under the Workforce Investment Act of 1998 to recruit and support individuals from underrepresented minority populations, underserved areas, or with disadvantaged or rural backgrounds into health professions; (2) develop and implement strategies to foster and provide community-based training and education to individuals seeking health careers within underserved areas or for health disparities population, in collaboration with other workforce development programs; (3) prepare individuals to more effectively provide health services in underserved areas and health disparities populations through field placements or preceptorships in conjunction with community-based organizations, accredited primary care residency training programs, federally qualified health centers,

rural health clinics, mental health facilities, public health departments, or other appropriate facilities; (4) conduct and participate in interdisciplinary training; (5) deliver or facilitate continuing education or information dissemination programs for health professionals; and (6) propose and implement effective program and outcome measurement and evaluation strategies. In addition, funds must be used to carry out at least one of the following activities: (1) develop innovative curricula to increase the number of primary care providers in underserved areas and for health disparities populations; (2) coordinate community-based participatory research with academic health centers and facilitate the rapid dissemination of evidence-based health care information; and (3) develop and implement other strategies to address identified workforce needs and enhance the health workforce.

An entity receiving funds under this section would have to conduct at least 10% of clinical education required for medical students in community settings that are removed from the primary teaching facility of the contracting institution. Entities receiving maintenance and enhancement grants would not be able to distribute funds to a center that is eligible for the AHEC infrastructure development grants.

The Secretary would have to ensure that each AHEC program included at least one area health education center which: (1) is a public or private organization that has independent structure, governance and operations; (2) is not a school of medicine or osteopathic medicine, or a parent institution, branch campus or consortium of the such entities; (3) designates an underserved area or remote service population that is not duplicated by other AHEC centers; (4) fosters networking and collaboration between relevant entities; (5) serves communities with a demonstrated need for health professionals in partnership with academic medical centers; (6) addresses communities' health care workforce needs in coordination with the public workforce investment system; and (7) has a community-based governing or advisory board.

For an entity to be eligible to receive an AHEC grant under this section, the entity would have available recurring non-Federal contributions that are equal to not less than 50% of its operating costs. At least 25% of these required contributions would be in cash. An entity receiving infrastructure grants may apply for a waiver of not more than 75% of the matching fund amount for the first three years of the grant period. Not less than 75% of the total amount of AHEC funding for infrastructure development or maintenance grants would be allocated to centers participating in the program. The Secretary would be able to waive this requirement for the first two years for a new AHEC center receiving an infrastructure grant. Grants under this section would not be less than \$250,000. If appropriations are not sufficient to meet that requirement, the Secretary would reduce the per center grant amount as necessary, provided the distribution established in subsection (k)(2) is maintained.

Infrastructure grants would be awarded for a period of up to 12 years for AHEC programs and up to 6 years for AHEC centers within programs. These time limits would not apply to programs receiving maintenance grants. The provisions included in Section

791(a) of the PHSa (which establishes certain funding preferences) would not apply to AHEC funding established by this section.

There would be \$125 million authorized to be appropriated in each of FY2010 through FY2014 of which not more than 35% would go to infrastructure grants, not less than 60% would go to maintenance grants, not more than 1% would be used for outcomes evaluation, and not more than 4% would be used for technical assistance grants. Any entity receiving an AHEC grant would be able to carry over funds from one fiscal year to the next without obtaining approval from the Secretary. In no case, however, would funds be able to be carried over for more than 3 years. It would be a sense of Congress that every State have an AHEC center program.

***Sec. 752 Continuing Educational Support for Health Professionals Serving in Underserved Communities.***

The provision would authorize grants and contracts with eligible entities to improve health care, increase retention, increase representation of minority faculty members, enhance the practice environment and provide education support to reduce professional isolation through the timely dissemination of research findings. Eligible entities would be health professions schools, academic health centers, State or local governments, or other appropriate public or private entities. The Secretary would have the discretion to accept applications from appropriate for-profit private entities. To receive grants, entities would have to submit applications containing required information. The grants would be used to fund innovative supportive activities to enhance education through distance learning, continuing educational activities, collaborative conferences, and electronic and telelearning activities, with a priority for primary care. An amount of \$5 million for each of FY2010 through FY2014 would be authorized to be appropriated.

**Sec. 454. Workforce diversity grants.**

*Current Law*

Section 821 of the PHSa authorizes the Secretary to award grants to increase nursing education opportunities for individuals from disadvantaged backgrounds by providing student scholarships or stipends, pre-entry preparation, and retention activities. In awarding these grants, the Secretary is required to take into account the recommendations of the First (1992), Second (1993) and Third (1997) Invitational Congress for Minority Nurse Leaders, as well as consult with various specified nursing associations.

*Proposed Law*

The provision would modify Section 821 by expanding the allowable uses of diversity grants to include stipends for diploma or associated degree nurses to enter a bridge or degree completion program, student scholarships or stipends for accelerated nursing degree programs, pre-entry preparation, advanced education preparation, and retention activities. The consultation requirements also would be modified. The Secretary would be

required to take into account the recommendations of the National Advisory Council on Nurse Education and Practice and consult with nursing associations including the National Coalition of Ethnic Minority Nurse Associations and other appropriate organizations.

#### **Sec. 455. Primary care extension program.**

##### *Current Law*

Section 399 of the PHSA established the funding authority for various projects to improve maternal, infant, and child health.

##### *Proposed Law*

This provision would add a new Section 399T to the PHSA requiring the Secretary to establish a Primary Care Extension Program to educate and provide support to primary care providers about evidence-based therapies, preventive medicine, health promotion, chronic disease management, and mental health. Primary care providers would work with community-based health connectors, referred to as “Health Extension Agents.” These agents would be any local, community-based health worker who provides assistance by implementing quality improvement or system redesign that incorporates the principles of the patient-centered medical home, provides guidance to patients in culturally and linguistically appropriate ways, and links practices to diverse health system resources.

The Secretary would be required to award competitive grants to States to establish State-multistate-level Primary Care Extension Program State Hubs (referred to as hubs). A hub would consist of the State health department, the entity that administers the State Medicaid program (if other than the health department), the state entity administering the Medicare program, and the departments of one or more primary care health professions schools in the State. A hub also may include entities such as hospital associations, primary care practice-based research networks, health professional societies, State primary care associations, State licensing boards, consumer groups and other. Hubs would be required to: (1) submit a plan to coordinate functions with quality improvement organizations and area health education centers (if such entities are included as part of the hub); (2) contract with and provide grant funds to county or local entities to serve as Primary Care Extension Agencies; and (3) organize statewide or multistate networks of such agencies to share information.

Primary Care Extension Agencies would be required to (1) assist primary care providers to implement a patient-centered medical home; (2) develop and support primary care learning communities; (3) participate in a national network of hubs and proposed how best practices can be shared; and (4) develop a plan for financial sustainability after the initial 6-year period of funding under this section is completed. They might also (1) provide technical assistance, training and organizational support for community health teams established under Section 212 of this bill; (2) collect data and provide feedback to improve quality; (3) collaborate with local health departments, community health centers

and other community agencies to identify priorities and workforce needs; and (4) develop performance measures for the Primary Care Extension Program.

The provision would authorize both 6-year program grants for entities that submit a fully developed hub plan, and 2-year planning grants for entities to develop such a plan. A State receiving a program grant would be evaluated at the end of the grant period. After the 6<sup>th</sup> year of a grant, a State may receive additional support if its program receives a satisfactory evaluation. The provision would authorize to be appropriated \$120 million for each of FY2010 and FY2011, and such sums as may be necessary for FY2013 and FY2014.

## **Subtitle F – General Provisions**

### **Sec. 461. Reports.**

#### *Current Law*

No provision.

#### *Proposed Law*

The bill would require the Secretary to submit an annual report to the appropriate congressional committees. The report would include the activities carried out under the amendments made by Title IV of the bill, and their effectiveness. The Secretary would be authorized to require entities receiving awards to submit reports on activities carried out under the amendments and the effectiveness of those activities as a condition of receiving awards.

## **Title V – Preventing Fraud and Abuse**

### **Subtitle A- Establishment of New Health and Human Services and Department of Justice Health Care Fraud Positions**

#### **Sec. 501. Health and Human Services Senior Advisor**

#### *Current Law*

There are multiple federal and state agencies that share responsibility for preventing health care fraud, waste, and abuse. These include the Department of Health and Human Services (HHS) Office of the Inspector General (OIG), the Department of Justice (DOJ), the Federal Bureau of Investigations (FBI), and state and local law enforcement agencies. The OIG is an independent unit within HHS that has the primary responsibility for detecting health care fraud and abuse in all federal health care programs. Most of its work, however, relates to the Medicare and Medicaid programs. The FBI is the lead

investigative agency in the fight against health care fraud. Unlike the OIG, which has the authority to investigate fraud impacting federal health care programs only, the FBI has jurisdiction over federal and private sector insurance programs. The FBI does not have the authority to impose sanctions. The OIG, FBI, and state and local law enforcement agencies all refer potential health care fraud cases to the DOJ for prosecution.

#### *Proposed Law*

This provision would require the Secretary to appoint a Senior Advisor for Health Care Fraud within the Office of the Deputy Secretary in Health and Human Services. The Senior Advisor would serve as the principal advisor on policy, program development, and oversight with respect to the detection and prevention of fraud involving public and private health insurance coverage as well as the coordination of anti-fraud efforts within HHS, the DOJ, state and local law enforcement agencies, and private health insurance plans. The Senior Advisor would be required to be a Schedule C appointee and would not be subject to confirmation by the Senate or any House or Senate committee or subcommittee. The Senior Advisor would also not be a current career or career-conditional Federal executive branch employee as defined in regulations.

### **Sec. 502. Department of Justice Position**

#### *Current Law*

There are multiple federal and state agencies that share responsibility for preventing health care fraud, waste, and abuse. These include the Department of Health and Human Services (HHS) Office of the Inspector General (OIG), the Department of Justice (DOJ), the Federal Bureau of Investigations (FBI), and state and local law enforcement agencies. The OIG is an independent unit within HHS that has the primary responsibility for detecting health care fraud and abuse in all federal health care programs. Most of its work, however, relates to the Medicare and Medicaid programs. The FBI is the lead investigative agency in the fight against health care fraud. Unlike the OIG, which has the authority to investigate fraud impacting federal health care programs only, the FBI has jurisdiction over federal and private sector insurance programs. The FBI does not have the authority to impose sanctions. The OIG, FBI, and state and local law enforcement agencies all refer potential health care fraud cases to the DOJ for prosecution.

#### *Proposed Law*

This provision would require the Attorney General to appoint a Senior Counsel for Health Care Fraud Enforcement within the Office of the Deputy Attorney General. The Senior Advisor would serve as the principal advisor to the Attorney General on policy, program development, and oversight with respect to the investigation and prosecution of health care fraud involving public and private health insurance coverage as well as the coordination of anti-fraud efforts within HHS, the DOJ, state and local law enforcement agencies, and private health insurance plans.

## **Subtitle B – Health Care Program Integrity Coordinating Council**

### **Sec. 511. Establishment**

#### *Current Law*

None

#### *Proposed Law*

The provision establishes a new section in Part C of title XXVII of the Public Health Service Act.

#### ***Sec. 2797. Health Care Program Integrity Coordinating Council.***

This provision would require the establishment of a Health Care Program Integrity Coordinating Council to be composed of the Secretary of Health and Human Services, the Attorney General, the Inspector General for Health and Human Services, the Secretary of Labor, the Secretary of Defense, the Director of the Office of Personnel Management, the Under Secretary of Health for the Veterans Health Administration, the Commissioner of the Social Security Administration, the President of the National Association of Insurance Commissioners, and the President of the National Association of Medicaid Fraud Control Units. The Council would also have the authority to appoint other members, provided a majority of the Council determines that it's necessary, and provided that the individual does not represent a regulated entity under this Act.

The duties of the Council would be the following: 1) No later than 6 months after the enactment date of this legislation, develop a strategic plan for improving the coordination and information sharing among Federal and State agencies and private health insurance coverage with respect to the prevention, detection, and control of fraud, waste, and abuse, including fraud and abuse related to consumers and private health insurance issuers; 2) submit an annual report to Congress on any actions taken to implement the plan; 3) while recognizing that private health care coverage may be responsible for fraud, waste, and abuse, evaluate ways to ensure that private health insurance coverage, with adequate protections in place for sensitive data extracted from law enforcement agencies, is included in investigative and data sharing programs; 4) no later than one year after this legislation is enacted, develop and issue guidelines for executing the strategic plan, recognizing that health care fraud can impact both public and private sector health insurance coverage and that the prevention, detection, investigation, and prosecution of fraud against private health insurance coverage is integral to fraud control efforts; 5) update the strategic plan and guidelines for implementation at least once every five years; 6) develop recommendations, in consultation with the Office of Management and Budget (OMB), for measures to estimate the amount of fraud, waste, and abuse impacting public and private health insurance coverage, and the annual savings resulting from program integrity initiatives; 7) identify improvements needed for the purposes of information sharing systems and activities used in implementing the strategic plan; and 8) establish a

consultative panel composed of representatives of the private sector health insurance industry and consult with this panel when formulating the Council's recommendations. The Council would be required to allow for reasonable public participation in all matters before the Council provided that such participation would not compromise the Council's or any other Federal or State agencies fraud control efforts.

This provision would exempt the Council from administrative requirements related to the rulemaking process and the procedures for conducting hearings, as well as the Federal Advisory Committee Act to protect against the release of information which might undermine Federal, State and local fraud control activities.

## **Subtitle C – False Statements and Representations**

### **Sec. 521 Prohibition on False Statements and Representations**

#### *Current Law*

The Employment Retirement Income Security Act of 1974 (ERISA) protects the interests of participants and beneficiaries in private sector employee benefit plans. Governmental plans and church plans generally are not subject to the law. ERISA generally supersedes state laws relating to employee benefit plans except for matters related to state insurance, banking and securities laws, and divorce property settlement order by state courts. An employee benefit plan may be either a pension plan (which provides retirement benefits) or a welfare benefit plan (which provides other kinds of employee benefits such as health and disability).

A Multiple Employer Welfare Arrangement (MEWA) is an employee welfare benefit plan established and maintained to provide specified benefits, including health insurance coverage, to the employees of two or more employers. MEWAs may not include plans covering collective bargaining agreements, rural electric cooperative and rural telephone cooperative associations.

#### *Proposed Law*

This provision would prohibit individuals from making false statements in connection with the marketing or sale of a plan sponsored by a MEWA. False statements could not be made to employees, members of employee organizations, beneficiaries, employers, employer organizations, the Secretary, or the State concerning the following items: 1) the financial condition of the plan; 2) the benefits provided by the plan; 3) the regulatory status of the plan governing collective bargaining, labor management relations, or internal union affairs, or the regulatory status of the plan regarding exemption from state regulatory authority under ERISA. Any representative of a MEWA who willfully violates the reporting, disclosure and other related provisions of ERISA may be fined up to \$100,000, imprisoned up to 10 years, or both.

## **Subtitle D – Federal Health Care Offense**

### **Sec. 531 Clarifying Definition**

#### *Current Law*

Title 18 of the U.S. Code provides for the definition of Federal health care offenses.

#### *Proposed Law*

This provision includes clarifying definitions for amending the definition of Federal health care offenses in the U.S. Code by including sections 411, 518 and 511 of ERISA in the definitions.

## **Subtitle E – Uniformity in Fraud and Abuse Reporting**

### **Sec. 541 Development of Model Uniform Report Form**

#### *Current Law*

None

#### *Proposed Law*

The Secretary would be required to request that the National Association of Insurance Commissioners (NAIC) develop a model uniform report form for private health insurance issuers seeking to refer suspected cases of fraud and abuse to State insurance departments or other State agencies for investigation. The Secretary is required to request that the NAIC develop uniform reporting standards for such referrals.

## **Subtitle F – Applicability of State Law to Combat Fraud and Abuse**

### **Sec. 551 Applicability of State Law to Combat Fraud and Abuse**

#### *Current Law*

The Employment Retirement Income Security Act of 1974 (ERISA) protects the interests of participants and beneficiaries in private sector employee benefit plans. Governmental plans and church plans generally are not subject to the law. ERISA generally supersedes state laws relating to employee benefit plans except for matters related to state insurance, banking and securities laws, and divorce property settlement order by state courts. An

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employee benefit plan may be either a pension plan (which provides retirement benefits) or a welfare benefit plan (which provides other kinds of employee benefits such as health and disability).

A Multiple Employer Welfare Arrangement (MEWA) is an employee welfare benefit plan established and maintained to provide specified benefits, including health insurance coverage, to the employees of two or more employers. MEWAs may not include plans covering collective bargaining agreements, rural electric cooperative and rural telephone cooperative associations.

*Proposed Law*

This provision would authorize the Secretary to promulgate regulations mandating that any person engaged in the business of selling insurance through a MEWA would be subject to state insurance laws, regardless of whether or not the law is preempted under other such provisions. The provision would only apply to MEWAs.

**Subtitle G – Enabling the Department of Labor to Issue Administrative Summary Cease and Desist and Summary Seizure Orders Against Plans that are in Financially Hazardous Condition**

**Sec. 561 Enabling the Department of Labor to Issue Administrative Summary Cease and Desist and Summary Seizure Orders Against Plans that are in Financially Hazardous Condition**

*Current Law*

A cease and desist order is an order issued by a court or agency prohibiting the recipient from continuing a particular course of conduct. Summary seizure orders can authorize a government official to immediately take possession of the subject of the order. Currently ERISA provides no authority for the Secretary of Labor to issue cease and desist orders or summary seizure orders regarding the conduct or assets of a multiple employer welfare arrangement (MEWA).

*Proposed Law*

This legislation would authorize the Secretary of Labor to issue cease and desist orders against a MEWA prohibiting alleged fraudulent conduct, or any conduct that creates an immediate danger to the public safety or welfare, or is causing or can be reasonably expected to cause significant, imminent, and irreparable public injury. These orders would be issued ex parte, but may be reviewed in a hearing before the Secretary upon request by any adversely affected party. Such hearings may be confidential if the

Secretary requires, and the party requesting the hearing bears the burden of demonstrating why a cease and desist order should be modified or set aside. This legislation would also authorize the Secretary to issue a summary seizure order if it appears that a MEWA is in a financially hazardous condition. The Secretary would also be authorized to promulgate regulations or other guidance necessary to carry out cease and desist orders or summary seizure orders.

## **Subtitle H – Requiring Multiple Employer Welfare Arrangement (MEWA) Plans to File a Registration Form with the Department of Labor Prior to Enrolling Anyone in the Plan**

### **Sec. 571 MEWA Plan Registration with Department of Labor**

#### *Current Law*

The Secretary is authorized to require MEWA's, which are not group health plans, to report at least annually on their compliance with requirements related to portability, access, and renewability, among other requirements.

#### *Proposed Law*

This provision would require the Secretary to promulgate regulations mandating that MEWA's, which are not group health plans, to register with the Secretary prior to operating in a State and report at least annually on their compliance with requirements related to portability, access, and renewability, among others.

## **Subtitle I – Permitting Evidentiary Privilege and Confidential Communications**

### **Sec. 581 Permitting Evidentiary Privilege and Confidential Communications**

#### *Current Law*

Evidentiary privileges protect information covered by the privilege from disclosure during the course of a judicial or administrative proceeding. Some privileged information may also be protected from disclosure under the Freedom of Information Act.

#### *Proposed Law*

This provision would authorize the Secretary of Labor to create, through regulation, an evidentiary privilege that would protect communications related to an investigation, audit, examination, or inquiry conducted or coordinated by: state insurance departments and attorneys general; the National Association of Insurance Commissioners; the United States Departments of Labor, Treasury, Justice, and Health and Human Services; or any other federal or state regulatory authority that the Secretary determines is appropriate. The privilege also covers communications made by these entities or their agents, consultants, or employees.

## **Title VI – Improving Access to Innovative Medical Therapies**

### **Subtitle A—Biologics Price Competition and Innovation**

[POLICY UNDER DISCUSSION]

### **Subtitle B—More Affordable Medicines for Children and Underserved Communities**

#### **Sec. 611. Expanded Participation in 340B Program**

##### *Current Law*

Section 340B of the Public Health Service Act (PHSA), established under Section 602 of the Veterans Health Care Act of 1992 (P.L. 102-585), requires pharmaceutical drug manufacturers that participate in the Medicaid drug rebate program, to enter into a pharmaceutical pricing agreement (PPA). Under PPAs manufacturers agree to provide discounts on covered outpatient drugs purchased by specified government public health facilities, called covered entities. The Health Resources and Services Administration (HRSA) is the federal agency that administers the 340B program. HRSA lists approximately 13,000 covered entity sites in a program participation database. According to HRSA, there are also 800 pharmaceutical manufacturers that participate in the 340B program. Covered entities include hospitals owned or operated by state or local government and serve a higher percentage of Medicaid beneficiaries. Other 340B covered entities are federal grantees such as federally qualified community health centers (FQHCs), FQHC look-alikes, family planning clinics, AIDS drug assistance programs, and a number of other public health organizations identified in the PHSA.

Participating covered entities receive discounts on all covered outpatient drugs. The 340B discount is the average manufacturer price (AMP) reduced by a minimum rebate percentage of 15.1 percent for brand name prescription drugs and 11 percent for generic and over-the-counter drugs.

Summary based on BAI09A84.xml

### *Proposed Law*

This provision would expand the covered entities that could qualify to receive discounted prices under the 340B Program. The new entities would include (1) children's hospitals excluded from the Medicare prospective payment system but who would otherwise meet existing 340B hospital requirements, (2) critical access hospitals, and (3) rural referral centers or sole community hospitals (these entities must have a disproportionate share adjustment (DSH) percentage of at least 8%). The provision would also expand discounts available to participating hospitals to inpatient drugs. Further, the hospitals that participate in the 340B program would be permitted to participate in group purchasing arrangements for inpatient drugs. However, the prohibition on hospitals also participating in outpatient drug group purchasing agreements would remain. The Secretary would be authorized to create exceptions to the group purchasing participation for a hospital's purchasing of outpatient drugs. These exceptions would include (1) outpatient drugs unavailable due to supply shortages, (2) outpatient drugs when generic drugs are available at lower prices, (3) exceptions that help reduce the administrative burdens of managing 340B drug inventories and uncovered products (as long as duplicate discounts occur or a drug diversion problem results). As determined by the Secretary, hospitals would be required within 90 days after filing their Medicare cost reports to issue a credit to the state Medicaid program for inpatient drugs provided to Medicaid beneficiaries. These changes would take effect on January 1, 2010 and apply to drugs purchased on or after that date.

The calculation of 340B prescription drug discounts would be unchanged, except in the case when a covered drug is not distributed to the retail pharmacy class of trade. In this situation, the average manufacturer price would be defined as the average price paid to the manufacturer for the drug by US wholesalers for distribution to the acute care class of trade, after deducting for prompt pay discounts. The Secretary would establish a mechanism for collecting information from manufacturers on prices paid by the acute care class of trade to wholesalers.

### **Sec. 612. Improvements to 340B Program Integrity**

#### *Current Law*

There are a number of provisions in Section 340B to ensure compliance with statutory and program rules. Under Section 340B covered entities are prohibited from reselling or transferring drugs to other organizations or patients of programs other than the covered entity. HRSA has published regulations defining a 340B patient, but not yet issued a final rule. In addition, covered entities are prohibited from receiving multiple discounts for the same product, such as a Medicaid rebate and a 340B discount. Manufacturers are permitted to audit the records of covered entities if they suspect product diversion is taking place and there are criminal penalties for intentional drug diversion.

#### *Proposed Law*

The Secretary would develop systems to improve program integrity activities for manufacturers and covered entities, as well as administrative procedures to resolve disputes.

**Prescription Drug Manufacturers.** The Secretary would be responsible for developing a system to verify the accuracy of manufacturers' ceiling prices. The system would include the following features (1) the development of appropriate standards and methodology to calculate ceiling prices, (2) a regular comparison of ceiling prices with quarterly pricing data submitted by manufacturers, (3) spot checking sales transactions to covered entities, (4) investigating pricing discrepancies by manufacturers and requiring manufacturers to take appropriate action. In addition, the system would have a number of other features. It would establish procedures for manufacturers to follow in issuing refunds to covered entities for overcharges. It would allow Internet access of the Health and Human Services website to the applicable ceiling price information in a secure way (i.e., through the use of mechanisms like password protection) to assure the protection of privileged pricing data. The system would include a mechanism so that the Secretary is aware of rebates and other manufacturer discounts provided to other than 340B purchasers. If such discounts or rebates have the effect of lowering the applicable ceiling price an appropriate credit would be issued for 340B purchasers. The system would establish procedures for selective auditing of manufacturers and wholesalers; and the imposition of civil money penalties on manufacturers and wholesalers when pricing violations are discovered.

**Covered Entities.** The Secretary also would develop procedures and systems to help ensure covered entities compliance with program rules in order to prevent the diversion and violation of duplicate discount provisions and other requirements. The following features would be included in the program integrity program. The improvements would (a) enable covered entities to update their program participation information over the internet, (b) provide for detailed guidance so that covered entities can better avoid duplicate discounts when billing covered drugs to state Medicaid agencies, (c) establish a single standardized identification system so that covered entity sites can be identified by manufacturers, distributors, covered entities, and the Secretary for purposes of facilitating the ordering, purchasing, and delivery of covered drugs, including the chargeback processing for such drugs, (d) imposing sanctions on a covered entity for program violations.

**Dispute Resolution.** The Secretary also would be responsible for developing an administrative dispute resolution process. This process would address covered entity overpayment claims as well as manufacturer claims of drug diversion or claims against covered entities for obtaining double discounts. The dispute resolution process shall identify a decision making body or individual, as well as administrative requirements, such as: time frames, deadlines, and documentation required to support claims. The administrative resolution of claims shall be a final agency decision and shall be binding on the parties, unless invalidated by an appropriate court.

There is an authorization for appropriation of such as sums may be necessary to carry out these program integrity activities beginning in fiscal year 2010 and for succeeding years.