

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

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

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

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

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

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

## TITLE II—ROLE OF PUBLIC PROGRAMS

### Subtitle A—Improved Access to Medicaid

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

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

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

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

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

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

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

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

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

“(k)(1) The medical assistance provided to an individual described in subclause (VIII) of subsection (a)(10)(A)(i) shall consist of benchmark coverage described in section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2). Such medical assistance shall be provided subject to the requirements of section 1937, without regard to whether a State otherwise has elected the option to provide medical assistance through coverage under that section, unless an individual described in subclause (VIII) of subsection (a)(10)(A)(i) is also an individual for whom, under subparagraph (B) of section 1937(a)(2), the State may not require enrollment in benchmark coverage described in subsection (b)(1)

of section 1937 or benchmark equivalent coverage described in subsection (b)(2) of that section.”.

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

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

(iii) by adding at the end the following:

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

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

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

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

“(y) INCREASED FMAP FOR MEDICAL ASSISTANCE FOR NEWLY ELIGIBLE MANDATORY INDIVIDUALS.—

“(1) AMOUNT OF INCREASE.—

“(A) 100 PERCENT FMAP.—During the period that begins on January 1, 2014, and ends on December 31, 2016, notwithstanding subsection (b), the Federal medical assistance percentage determined for a State that is one of the 50 States or the District of Columbia for each fiscal year occurring during that period with respect to amounts expended for medical assistance for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i) shall be equal to 100 percent.

“(B) 2017 AND 2018.—

“(i) IN GENERAL.—During the period that begins on January 1, 2017, and ends on December 31, 2018, notwithstanding subsection (b) and subject to subparagraph (D), the Federal medical assistance percentage determined for a State that is one of the 50 States or the District of Columbia for each fiscal year occurring during that period with respect to amounts expended for medical assistance for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i), shall be increased by the applicable percentage point increase specified in clause (ii) for the quarter and the State.

“(ii) APPLICABLE PERCENTAGE POINT INCREASE.—

“(I) IN GENERAL.—For purposes of clause (i), the applicable percentage point increase for a quarter is the following:

<b>“For any fiscal year quarter occurring in the calendar year:</b>	<b>If the State is an expansion State, the applicable percentage point increase is:</b>	<b>If the State is not an expansion State, the applicable percentage point increase is:</b>
2017	30.3	34.3
2018	31.3	33.3

“(II) EXPANSION STATE DEFINED.—For purposes of the table in subclause (I), a State is an expansion State if, on the date of the enactment of the Patient Protection and Affordable Care Act, the State offers health benefits coverage statewide to parents and nonpregnant, childless adults whose income is at least 100 percent of the poverty line, that is not dependent on access to employer coverage, employer contribution, or employment and is not limited to premium assistance, hospital-only benefits, a high deductible health plan, or alternative benefits under a demonstration program authorized under section 1938. A State that offers health benefits coverage to only parents or only nonpregnant childless adults described in the preceding sentence shall not be considered to be an expansion State.

“(C) 2019 AND SUCCEEDING YEARS.—Beginning January 1, 2019, notwithstanding subsection (b) but subject to subparagraph (D), the Federal medical assistance percentage determined for a State that is one of the 50 States or the District of Columbia for each fiscal year quarter occurring during that period with respect to amounts expended for medical assistance for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i), shall be increased by 32.3 percentage points.

“(D) LIMITATION.—The Federal medical assistance percentage determined for a State under subparagraph (B) or (C) shall in no case be more than 95 percent.

“(2) DEFINITIONS.—In this subsection:

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

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

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

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

“(2) Beginning with the first day of any fiscal year quarter that begins on or after January 1, 2011, and before January 1, 2014, a State may elect through a State plan amendment to provide medical assistance to individuals who would be described in subclause (VIII) of subsection (a)(10)(A)(i) if that subclause were effective before January 1, 2014. A State may elect to phase-in the extension of eligibility for medical assistance to such individuals based on income, so long as the State does not extend such eligibility to individuals described in such subclause with higher income before making individuals described in such subclause with lower income eligible for medical assistance.

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

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

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

(5) CONFORMING AMENDMENTS.—

(A) Section 1902(a)(10) of such Act (42 U.S.C. 1396a(a)(10)) is amended in the matter following subparagraph (G), by striking “and (XIV)” and inserting “(XIV)” and by inserting “and (XV) the medical assistance made available to an individual described in subparagraph (A)(i)(VIII) shall be limited to medical assistance described in subsection (k)(1)” before the semicolon.

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

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

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

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

and

(iii) by inserting after clause (xiii) the following:  
“(xiv) individuals described in section 1902(a)(10)(A)(i)(VIII).”

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

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

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

(1) in subsection (a)—

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

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

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

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

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

“(gg) MAINTENANCE OF EFFORT.—

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

“(2) CONTINUATION OF ELIGIBILITY STANDARDS FOR CHILDREN UNTIL OCTOBER 1, 2019.—The requirement under paragraph (1) shall continue to apply to a State through September 30, 2019, with respect to the eligibility standards, methodologies, and procedures under the State plan under this title or under any waiver of such plan that are applicable to determining the eligibility for medical assistance of any child who is under 19 years of age (or such higher age as the State may have elected).

“(3) NONAPPLICATION.—During the period that begins on January 1, 2011, and ends on December 31, 2013, the requirement under paragraph (1) shall not apply to a State with respect to nonpregnant, nondisabled adults who are eligible

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

“(4) DETERMINATION OF COMPLIANCE.—

“(A) STATES SHALL APPLY MODIFIED GROSS INCOME.—

A State’s determination of income in accordance with subsection (e)(14) shall not be considered to be eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).

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

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

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

(2) in paragraph (2)—

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

(B) in subparagraph (A)—

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

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

“(iv) Coverage of prescription drugs.

“(v) Mental health services.”; and

(C) in subparagraph (C)—

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

(ii) by redesignating clauses (iii) and (iv) as clauses (i) and (ii), respectively; and

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

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

“(6) MENTAL HEALTH SERVICES PARITY.—

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

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

(d) ANNUAL REPORTS ON MEDICAID ENROLLMENT.—

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

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

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

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

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

“(A) the total number of enrolled and newly enrolled individuals in the State plan or under a waiver of the plan for the fiscal year ending on September 30 of the preceding calendar year, disaggregated by population, including children, parents, nonpregnant childless adults, disabled individuals, elderly individuals, and such other

categories or sub-categories of individuals eligible for medical assistance under the State plan or under a waiver of the plan as the Secretary may require;

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

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

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

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

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

(A) in subsection (a)(10)(A)(ii)—

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

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

and

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

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

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

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

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



the term ‘parent’ includes an individual treated as a caretaker relative for purposes of carrying out section 1931.”.

(2) CONFORMING AMENDMENTS.—

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

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

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

and

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

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

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

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

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

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

“(14) INCOME DETERMINED USING MODIFIED GROSS INCOME.—

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

“(B) NO INCOME OR EXPENSE DISREGARDS.—No type of expense, block, or other income disregard shall be applied

by a State to determine income eligibility for medical assistance under the State plan or under any waiver of such plan or for any other purpose applicable under the plan or waiver for which a determination of income is required.

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

“(D) EXCEPTIONS.—

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

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

“(II) Individuals who have attained age 65.

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

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

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

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

“(iii) MEDICARE PRESCRIPTION DRUG SUBSIDIES DETERMINATIONS.—Subparagraphs (A), (B), and (C) shall not apply to any determinations of eligibility for premium and cost-sharing subsidies under and in

accordance with section 1860D–14 made by the State pursuant to section 1935(a)(2).

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

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

“(E) TRANSITION PLANNING AND OVERSIGHT.—Each State shall submit to the Secretary for the Secretary’s approval the income eligibility thresholds proposed to be established using modified gross income and household income, the methodologies and procedures to be used to determine income eligibility using modified gross income and household income and, if applicable, a State plan amendment establishing an optional eligibility category under subsection (a)(10)(A)(ii)(XX). To the extent practicable, the State shall use the same methodologies and procedures for purposes of making such determinations as the State used on the date of enactment of the Patient Protection and Affordable Care Act. The Secretary shall ensure that the income eligibility thresholds proposed to be established using modified gross income and household income, including under the eligibility category established under subsection (a)(10)(A)(ii)(XX), and the methodologies and procedures proposed to be used to determine income eligibility, will not result in children who would have been eligible for medical assistance under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act no longer being eligible for such assistance.

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

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

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

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

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

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

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

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

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

(1) in subsection (a)—

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

(B) by striking “under age 19”; and

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

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

(3) in subsection (d)—

(A) in paragraph (2)—

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

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

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

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

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

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

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

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

- (1) by striking “or” at the end of subclause (VII);
- (2) by adding “or” at the end of subclause (VIII); and
- (3) by inserting after subclause (VIII) the following:

“(IX) who were in foster care under the responsibility of a State for more than 6 months (whether or not consecutive) but are no longer in such care, who are not described in any of subclauses (I) through (VII) of this clause, and who are under 25 years of age.”

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

(c) **CONFORMING AMENDMENTS.**—

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

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

(d) **EFFECTIVE DATE.**—The amendments made by this section take effect on January 1, 2019.

**SEC. 2005. PAYMENTS TO TERRITORIES.**

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

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

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

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

“(5) **FISCAL YEAR 2011 AND THEREAFTER.**—The amounts otherwise determined under this subsection for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa for the second, third, and fourth quarters of fiscal year 2011, and for each fiscal year after fiscal year 2011 (after the application of subsection (f) and the preceding paragraphs of this subsection), shall be increased by 30 percent.”

(b) **DISREGARD OF PAYMENTS FOR MANDATORY EXPANDED ENROLLMENT.**—Section 1108(g)(4) of such Act (42 U.S.C. 1308(g)(4)) is amended—

(1) by striking “to fiscal years beginning” and inserting “to—

“(A) fiscal years beginning”;

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

(3) by adding at the end the following:

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

(c) INCREASED FMAP.—

(1) IN GENERAL.—The first sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended by striking “shall be 50 per centum” and inserting “shall be 55 percent”.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) takes effect on January 1, 2011.

**SEC. 2006. SPECIAL ADJUSTMENT TO FMAP DETERMINATION FOR CERTAIN STATES RECOVERING FROM A MAJOR DISASTER.**

Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by sections 2001(a)(3) and 2001(b)(2), is amended—

(1) in subsection (b), in the first sentence, by striking “subsection (y)” and inserting “subsections (y) and (aa)”; and

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

“(aa)(1) Notwithstanding subsection (b), beginning January 1, 2011, the Federal medical assistance percentage for a fiscal year for a disaster-recovery FMAP adjustment State shall be equal to the following:

“(A) In the case of the first fiscal year (or part of a fiscal year) for which this subsection applies to the State, the Federal medical assistance percentage determined for the fiscal year without regard to this subsection and subsection (y), increased by 50 percent of the number of percentage points by which the Federal medical assistance percentage determined for the State for the fiscal year without regard to this subsection and subsection (y), is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year after the application of only subsection (a) of section 5001 of Public Law 111–5 (if applicable to the preceding fiscal year) and without regard to this subsection, subsection (y), and subsections (b) and (c) of section 5001 of Public Law 111–5.

“(B) In the case of the second or any succeeding fiscal year for which this subsection applies to the State, the Federal medical assistance percentage determined for the preceding fiscal year under this subsection for the State, increased by 25 percent of the number of percentage points by which the Federal medical assistance percentage determined for the State

for the fiscal year without regard to this subsection and subsection (y), is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year under this subsection.

“(2) In this subsection, the term ‘disaster-recovery FMAP adjustment State’ means a State that is one of the 50 States or the District of Columbia, for which, at any time during the preceding 7 fiscal years, the President has declared a major disaster under section 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act and determined as a result of such disaster that every county or parish in the State warrant individual and public assistance or public assistance from the Federal Government under such Act and for which—

“(A) in the case of the first fiscal year (or part of a fiscal year) for which this subsection applies to the State, the Federal medical assistance percentage determined for the State for the fiscal year without regard to this subsection and subsection (y), is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year after the application of only subsection (a) of section 5001 of Public Law 111–5 (if applicable to the preceding fiscal year) and without regard to this subsection, subsection (y), and subsections (b) and (c) of section 5001 of Public Law 111–5, by at least 3 percentage points; and

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

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

**SEC. 2007. MEDICAID IMPROVEMENT FUND RESCISSION.**

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

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

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

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

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

### SEC. 2101. ADDITIONAL FEDERAL FINANCIAL PARTICIPATION FOR CHIP.

(a) IN GENERAL.—Section 2105(b) of the Social Security Act (42 U.S.C. 1397ee(b)) is amended by adding at the end the following: “Notwithstanding the preceding sentence, during the period that begins on October 1, 2013, and ends on September 30, 2019, the enhanced FMAP determined for a State for a fiscal year (or for any portion of a fiscal year occurring during such period) shall be increased by 23 percentage points, but in no case shall exceed 100 percent. The increase in the enhanced FMAP under the preceding sentence shall not apply with respect to determining the payment to a State under subsection (a)(1) for expenditures described in subparagraph (D)(iv), paragraphs (8), (9), (11) of subsection (c), or clause (4) of the first sentence of section 1905(b).”.

#### (b) MAINTENANCE OF EFFORT.—

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

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

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

“(i) applying eligibility standards, methodologies, or procedures for children under the State child health plan or under any waiver of the plan that are less restrictive than the eligibility standards, methodologies, or procedures, respectively, for children under the plan or waiver that are in effect on the date of enactment of such Act; or

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

“(B) ASSURANCE OF EXCHANGE COVERAGE FOR TARGETED LOW-INCOME CHILDREN UNABLE TO BE PROVIDED CHILD HEALTH ASSISTANCE AS A RESULT OF FUNDING SHORTFALLS.—In the event that allotments provided under section 2104 are insufficient to provide coverage to all children who are eligible to be targeted low-income children under the State child health plan under this title, a State shall



establish procedures to ensure that such children are provided coverage through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act.”

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

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

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

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

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

(C) by adding at the end the following:

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

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

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

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

“(E) Section 1902(e)(14) (relating to income determined using modified gross income and household income).”

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

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

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

implemented under title XIX or XXI, or both, of the Social Security Act).

**SEC. 2102. TECHNICAL CORRECTIONS.**

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

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

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

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

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

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

(3) Subclauses (I) and (II) of paragraph (3)(C)(i) of section 2105(a) of the Social Security Act (42 U.S.C. 1397ee(a)(3)(ii)), as added by section 104 of CHIPRA, are each amended by striking “, respectively”.

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

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

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

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

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

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

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

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

### **Subtitle C—Medicaid and CHIP Enrollment Simplification**

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

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

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

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

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

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

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

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

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

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

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

Care Act, and any other assistance or subsidies available for coverage obtained through the Exchange;

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

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

“(F) conducting outreach to and enrolling vulnerable and underserved populations eligible for medical assistance under this title XIX or for child health assistance under title XXI, including children, unaccompanied homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS.

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

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

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

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

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

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

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

“(A) at the option of the State;”;

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

(3) by adding at the end the following:

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

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

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

(2) by inserting before the period at the end the following: “, or for medical assistance provided to an individual during a presumptive eligibility period resulting from a determination

of presumptive eligibility made by a hospital that elects under section 1902(a)(47)(B) to be a qualified entity for such purpose”.

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

## **Subtitle D—Improvements to Medicaid Services**

### **SEC. 2301. COVERAGE FOR FREESTANDING BIRTH CENTER SERVICES.**

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

(1) in subsection (a)—

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

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

and

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

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

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

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

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

“(i) that is not a hospital;

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

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

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

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

(b) CONFORMING AMENDMENT.—Section 1902(a)(10)(A) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)), is amended in the

matter preceding clause (i) by striking “and (21)” and inserting “, (21), and (28)”.

(c) EFFECTIVE DATE.—

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

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

**SEC. 2302. CONCURRENT CARE FOR CHILDREN.**

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

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

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

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

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

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

(a) COVERAGE AS OPTIONAL CATEGORICALLY NEEDY GROUP.—

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

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

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

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

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

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

“(ii)(1) Individuals described in this subsection are individuals—  
“(A) whose income does not exceed an income eligibility level established by the State that does not exceed the highest income eligibility level established under the State plan under this title (or under its State child health plan under title XXI) for pregnant women; and  
“(B) who are not pregnant.”

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

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

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

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

(4) CONFORMING AMENDMENTS.—

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

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

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

(b) PRESUMPTIVE ELIGIBILITY.—

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

“PRESUMPTIVE ELIGIBILITY FOR FAMILY PLANNING SERVICES

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



in conjunction with a family planning service in a family planning setting.

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

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

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

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

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

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

“(2) QUALIFIED ENTITY.—

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

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

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

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

“(c) ADMINISTRATION.—

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

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

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

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

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

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

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

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

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

(a)—

“(A) during a presumptive eligibility period; and

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

“(2) is included in the care and services covered by the State plan,

shall be treated as medical assistance provided by such plan for purposes of clause (4) of the first sentence of section 1905(b).”.

(2) CONFORMING AMENDMENTS.—

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

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

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

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

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

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

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

**SEC. 2304. CLARIFICATION OF DEFINITION OF MEDICAL ASSISTANCE.**

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

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

### SEC. 2401. COMMUNITY FIRST CHOICE OPTION.

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

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

“(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, beginning October 1, 2010, a State may provide through a State plan amendment for the provision of medical assistance for home and community-based attendant services and supports for individuals who are eligible for medical assistance under the State plan whose income does not exceed 150 percent of the poverty line (as defined in section 2110(c)(5)) or, if greater, the income level applicable for an individual who has been determined to require an institutional level of care to be eligible for nursing facility services under the State plan and with respect to whom there has been a determination that, but for the provision of such services, the individuals would require the level of care provided in a hospital, a nursing facility, an intermediate care facility for the mentally retarded, or an institution for mental diseases, the cost of which could be reimbursed under the State plan, but only if the individual chooses to receive such home and community-based attendant services and supports, and only if the State meets the following requirements:

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

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

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

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

“(iv) the furnishing of which—

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

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

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

“(B) INCLUDED SERVICES AND SUPPORTS.—In addition to assistance in accomplishing activities of daily living,

instrumental activities of daily living, and health related tasks, the home and community-based attendant services and supports made available include—

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

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

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

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

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

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

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

“(iv) medical supplies and equipment; or

“(v) home modifications.

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

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

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

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

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

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

representatives and consults and collaborates with such individuals;

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

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

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

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

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

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

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

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

“(4) COMPLIANCE WITH CERTAIN LAWS.—A State shall ensure that, regardless of whether the State uses an agency-provider model or other models to provide home and community-based attendant services and supports under a State plan

amendment under this subsection, such services and supports are provided in accordance with the requirements of the Fair Labor Standards Act of 1938 and applicable Federal and State laws regarding—

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

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

“(C) maintenance of general liability insurance; and

“(D) occupational health and safety.

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

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

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

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

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

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

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

“(C) REPORTS.—Not later than—

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

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

“(6) DEFINITIONS.—In this subsection:

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

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

“(C) DELIVERY MODELS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

“(B) 5-YEAR TERM.—

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

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

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

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

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

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

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

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

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

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

and

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

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

(2) CONFORMING AMENDMENTS.—

(A) Section 1903(f)(4) of the Social Security Act (42 U.S.C. 1396b(f)(4)), as amended by section 2304(a)(4)(B), is amended in the matter preceding subparagraph (A),

by inserting “1902(a)(10)(A)(ii)(XXII),” after “1902(a)(10)(A)(ii)(XXI),”.

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

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

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

and

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

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

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

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

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

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

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

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

**SEC. 2403. MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION.**

(a) **EXTENSION OF DEMONSTRATION.**—

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

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

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

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

(b) REDUCTION OF INSTITUTIONAL RESIDENCY PERIOD.—

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

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

(B) by adding at the end the following:

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

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

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

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

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

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

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

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

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

(2) In 1999, under the United States Supreme Court’s decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999), individuals

with disabilities have the right to choose to receive their long-term services and supports in the community, rather than in an institutional setting.

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

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

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

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

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

## Subtitle F—Medicaid Prescription Drug Coverage

### SEC. 2501. PRESCRIPTION DRUG REBATES.

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

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

(A) in clause (i)—

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

(ii) in subclause (V)—

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

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

(iii) by adding at the end the following new sub-

clause:

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

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

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

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

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

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

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

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

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

“(i) IN GENERAL.—In addition to the amounts applied as a reduction under subparagraph (B), for rebate periods beginning on or after January 1, 2010, during a fiscal year, the Secretary shall reduce payments to a State under section 1903(a) in the manner specified in clause (ii), in an amount equal to the product of—

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

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

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

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

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

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

(2) in clause (ii)—

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

(B) by striking the period and inserting “; and”; and  
(3) by adding at the end the following new clause:

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

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

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

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

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

(C) by adding at the end the following:

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

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

(A) in subsection (b)—

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

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

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

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

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

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

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

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

“(C) TREATMENT OF NEW FORMULATIONS.—

“(i) IN GENERAL.—Except as provided in clause (ii), in the case of a drug that is a new formulation, such as an extended-release formulation, of a single source drug or an innovator multiple source drug, the rebate obligation with respect to the drug under this section shall be the amount computed under this section for the new formulation of the drug or, if greater, the product of—

“(I) the average manufacturer price for each dosage form and strength of the new formulation of the single source drug or innovator multiple source drug;

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

“(III) the total number of units of each dosage form and strength of the new formulation paid for under the State plan in the rebate period (as reported by the State).

“(ii) NO APPLICATION TO NEW FORMULATIONS OF ORPHAN DRUGS.—Clause (i) shall not apply to a new formulation of a covered outpatient drug that is or has been designated under section 526 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bb) for a rare disease or condition, without regard to whether the period of market exclusivity for the drug under section 527 of such Act has expired or the specific indication for use of the drug.”.

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

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

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

(f) CONFORMING AMENDMENTS.—

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

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

(B) by striking subsection (c); and

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

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

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

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

(1) in paragraph (2)—

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

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

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

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

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

“(B) Barbiturates.

“(C) Benzodiazepines.”

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

**SEC. 2503. PROVIDING ADEQUATE PHARMACY REIMBURSEMENT.**

(a) **PHARMACY REIMBURSEMENT LIMITS.**—

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

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

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

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

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

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

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

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

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



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

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

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

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

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

“(IV) payments received from, and rebates or discounts provided to, pharmacy benefit managers, managed care organizations, health maintenance organizations, insurers, hospitals, clinics, mail order pharmacies, long term care providers, manufacturers, or any other entity that does not conduct business as a wholesaler or a retail community pharmacy.

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

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

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

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

(B) in subparagraph (C)—

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

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

(iii) by striking clause (iii).

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

“(10) RETAIL COMMUNITY PHARMACY.—The term ‘retail community pharmacy’ means an independent pharmacy, a chain pharmacy, a supermarket pharmacy, or a mass merchandiser pharmacy that is licensed as a pharmacy by the State and that dispenses medications to the general public at retail

prices. Such term does not include a pharmacy that dispenses prescription medications to patients primarily through the mail, nursing home pharmacies, long-term care facility pharmacies, hospital pharmacies, clinics, charitable or not-for-profit pharmacies, government pharmacies, or pharmacy benefit managers.

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

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

(1) in subparagraph (A)—

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

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

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

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

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

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

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

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

## **Subtitle G—Medicaid Disproportionate Share Hospital (DSH) Payments**

### **SEC. 2551. DISPROPORTIONATE SHARE HOSPITAL PAYMENTS.**

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

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

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

(3) by redesignating paragraph (7) as paragraph (8); and  
(4) by inserting after paragraph (6) the following new paragraph:

“(7) REDUCTION OF STATE DSH ALLOTMENTS ONCE REDUCTION IN UNINSURED THRESHOLD REACHED.—

“(A) IN GENERAL.—Subject to subparagraph (E), the DSH allotment for a State for fiscal years beginning with the fiscal year described in subparagraph (C) (with respect to the State), is equal to—

“(i) in the case of the first fiscal year described in subparagraph (C) with respect to a State, the DSH allotment that would be determined under this subsection for the State for the fiscal year without application of this paragraph (but after the application of subparagraph (D)), reduced by the applicable percentage determined for the State for the fiscal year under subparagraph (B)(i); and

“(ii) in the case of any subsequent fiscal year with respect to the State, the DSH allotment determined under this paragraph for the State for the preceding fiscal year, reduced by the applicable percentage determined for the State for the fiscal year under subparagraph (B)(ii).

“(B) APPLICABLE PERCENTAGE.—For purposes of subparagraph (A), the applicable percentage for a State for a fiscal year is the following:

“(i) UNINSURED REDUCTION THRESHOLD FISCAL YEAR.—In the case of the first fiscal year described in subparagraph (C) with respect to the State—

“(I) if the State is a low DSH State described in paragraph (5)(B), the applicable percentage is equal to 25 percent; and

“(II) if the State is any other State, the applicable percentage is 50 percent.

“(ii) SUBSEQUENT FISCAL YEARS IN WHICH THE PERCENTAGE OF UNINSURED DECREASES.—In the case of any fiscal year after the first fiscal year described in subparagraph (C) with respect to a State, if the Secretary determines on the basis of the most recent American Community Survey of the Bureau of the Census, that the percentage of uncovered individuals residing in the State is less than the percentage of such individuals determined for the State for the preceding fiscal year—

“(I) if the State is a low DSH State described in paragraph (5)(B), the applicable percentage is equal to the product of the percentage reduction in uncovered individuals for the fiscal year from the preceding fiscal year and 25 percent; and

“(II) if the State is any other State, the applicable percentage is equal to the product of the percentage reduction in uncovered individuals for the fiscal year from the preceding fiscal year and 50 percent.

“(C) FISCAL YEAR DESCRIBED.—For purposes of subparagraph (A), the fiscal year described in this subparagraph with respect to a State is the first fiscal year that

occurs after fiscal year 2012 for which the Secretary determines, on the basis of the most recent American Community Survey of the Bureau of the Census, that the percentage of uncovered individuals residing in the State is at least 45 percent less than the percentage of such individuals determined for the State for fiscal year 2009.

“(D) EXCLUSION OF PORTIONS DIVERTED FOR COVERAGE EXPANSIONS.—For purposes of applying the applicable percentage reduction under subparagraph (A) to the DSH allotment for a State for a fiscal year, the DSH allotment for a State that would be determined under this subsection for the State for the fiscal year without the application of this paragraph (and prior to any such reduction) shall not include any portion of the allotment for which the Secretary has approved the State’s diversion to the costs of providing medical assistance or other health benefits coverage under a waiver that is in effect on July 2009.

“(E) MINIMUM ALLOTMENT.—In no event shall the DSH allotment determined for a State in accordance with this paragraph for fiscal year 2013 or any succeeding fiscal year be less than the amount equal to 35 percent of the DSH allotment determined for the State for fiscal year 2012 under this subsection (and after the application of this paragraph, if applicable), increased by the percentage change in the consumer price index for all urban consumers (all items, U.S. city average) for each previous fiscal year occurring before the fiscal year.

“(F) UNCOVERED INDIVIDUALS.—In this paragraph, the term ‘uncovered individuals’ means individuals with no health insurance coverage at any time during a year (as determined by the Secretary based on the most recent data available).”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) take effect on October 1, 2011.

## **Subtitle H—Improved Coordination for Dual Eligible Beneficiaries**

### **SEC. 2601. 5-YEAR PERIOD FOR DEMONSTRATION PROJECTS.**

(a) IN GENERAL.—Section 1915(h) of the Social Security Act (42 U.S.C. 1396n(h)) is amended—

- (1) by inserting “(1)” after “(h)”;
- (2) by inserting “, or a waiver described in paragraph (2)” after “(e)”;
- (3) by adding at the end the following new paragraph:

“(2)(A) Notwithstanding subsections (c)(3) and (d) (3), any waiver under subsection (b), (c), or (d), or a waiver under section 1115, that provides medical assistance for dual eligible individuals (including any such waivers under which non dual eligible individuals may be enrolled in addition to dual eligible individuals) may be conducted for a period of 5 years and, upon the request of the State, may be extended for additional 5-year periods unless the Secretary determines that for the previous waiver period the conditions for the waiver have not been met or it would no longer be cost-effective and efficient, or consistent with the purposes of this title, to extend the waiver.

“(B) In this paragraph, the term ‘dual eligible individual’ means an individual who is entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII, and is eligible for medical assistance under the State plan under this title or under a waiver of such plan.”

(b) CONFORMING AMENDMENTS.—

(1) Section 1915 of such Act (42 U.S.C. 1396n) is amended—

(A) in subsection (b), by adding at the end the following new sentence: “Subsection (h)(2) shall apply to a waiver under this subsection.”;

(B) in subsection (c)(3), in the second sentence, by inserting “(other than a waiver described in subsection (h)(2))” after “A waiver under this subsection”;

(C) in subsection (d)(3), in the second sentence, by inserting “(other than a waiver described in subsection (h)(2))” after “A waiver under this subsection”.

(2) Section 1115 of such Act (42 U.S.C. 1315) is amended—

(A) in subsection (e)(2), by inserting “(5 years, in the case of a waiver described in section 1915(h)(2))” after “3 years”; and

(B) in subsection (f)(6), by inserting “(5 years, in the case of a waiver described in section 1915(h)(2))” after “3 years”.

**SEC. 2602. PROVIDING FEDERAL COVERAGE AND PAYMENT COORDINATION FOR DUAL ELIGIBLE BENEFICIARIES.**

(a) ESTABLISHMENT OF FEDERAL COORDINATED HEALTH CARE OFFICE.—

(1) IN GENERAL.—Not later than March 1, 2010, the Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall establish a Federal Coordinated Health Care Office.

(2) ESTABLISHMENT AND REPORTING TO CMS ADMINISTRATOR.—The Federal Coordinated Health Care Office—

(A) shall be established within the Centers for Medicare & Medicaid Services; and

(B) have as the Office a Director who shall be appointed by, and be in direct line of authority to, the Administrator of the Centers for Medicare & Medicaid Services.

(b) PURPOSE.—The purpose of the Federal Coordinated Health Care Office is to bring together officers and employees of the Medicare and Medicaid programs at the Centers for Medicare & Medicaid Services in order to—

(1) more effectively integrate benefits under the Medicare program under title XVIII of the Social Security Act and the Medicaid program under title XIX of such Act; and

(2) improve the coordination between the Federal Government and States for individuals eligible for benefits under both such programs in order to ensure that such individuals get full access to the items and services to which they are entitled under titles XVIII and XIX of the Social Security Act.

(c) GOALS.—The goals of the Federal Coordinated Health Care Office are as follows:

(1) Providing dual eligible individuals full access to the benefits to which such individuals are entitled under the Medicare and Medicaid programs.

(2) Simplifying the processes for dual eligible individuals to access the items and services they are entitled to under the Medicare and Medicaid programs.

(3) Improving the quality of health care and long-term services for dual eligible individuals.

(4) Increasing dual eligible individuals' understanding of and satisfaction with coverage under the Medicare and Medicaid programs.

(5) Eliminating regulatory conflicts between rules under the Medicare and Medicaid programs.

(6) Improving care continuity and ensuring safe and effective care transitions for dual eligible individuals.

(7) Eliminating cost-shifting between the Medicare and Medicaid program and among related health care providers.

(8) Improving the quality of performance of providers of services and suppliers under the Medicare and Medicaid programs.

(d) SPECIFIC RESPONSIBILITIES.—The specific responsibilities of the Federal Coordinated Health Care Office are as follows:

(1) Providing States, specialized MA plans for special needs individuals (as defined in section 1859(b)(6) of the Social Security Act (42 U.S.C. 1395w-28(b)(6))), physicians and other relevant entities or individuals with the education and tools necessary for developing programs that align benefits under the Medicare and Medicaid programs for dual eligible individuals.

(2) Supporting State efforts to coordinate and align acute care and long-term care services for dual eligible individuals with other items and services furnished under the Medicare program.

(3) Providing support for coordination of contracting and oversight by States and the Centers for Medicare & Medicaid Services with respect to the integration of the Medicare and Medicaid programs in a manner that is supportive of the goals described in paragraph (3).

(4) To consult and coordinate with the Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b-6) and the Medicaid and CHIP Payment and Access Commission established under section 1900 of such Act (42 U.S.C. 1396) with respect to policies relating to the enrollment in, and provision of, benefits to dual eligible individuals under the Medicare program under title XVIII of the Social Security Act and the Medicaid program under title XIX of such Act.

(5) To study the provision of drug coverage for new full-benefit dual eligible individuals (as defined in section 1935(c)(6) of the Social Security Act (42 U.S.C. 1396u-5(c)(6))), as well as to monitor and report annual total expenditures, health outcomes, and access to benefits for all dual eligible individuals.

(e) REPORT.—The Secretary shall, as part of the budget transmitted under section 1105(a) of title 31, United States Code, submit to Congress an annual report containing recommendations for legislation that would improve care coordination and benefits for dual eligible individuals.

(f) DUAL ELIGIBLE DEFINED.—In this section, the term “dual eligible individual” means an individual who is entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act, or enrolled for benefits under part B of title XVIII

of such Act, and is eligible for medical assistance under a State plan under title XIX of such Act or under a waiver of such plan.

## **Subtitle I—Improving the Quality of Medicaid for Patients and Providers**

### **SEC. 2701. ADULT HEALTH QUALITY MEASURES.**

Title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by section 401 of the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111-3), is amended by inserting after section 1139A the following new section:

#### **“SEC. 1139B. ADULT HEALTH QUALITY MEASURES.**

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

#### “(b) **DEADLINES.**—

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

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

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

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

#### “(5) **ESTABLISHMENT OF MEDICAID QUALITY MEASUREMENT PROGRAM.**—

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

and innovative evidence-based measures under such program shall equal the aggregate amount awarded by the Secretary for grants under section 1139A(b)(4)(A)

“(B) REVISING, STRENGTHENING, AND IMPROVING INITIAL CORE MEASURES.—Beginning not later than 24 months after the establishment of the Medicaid Quality Measurement Program, and annually thereafter, the Secretary shall publish recommended changes to the initial core set of adult health quality measures that shall reflect the results of the testing, validation, and consensus process for the development of adult health quality measures.

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

“(d) ANNUAL STATE REPORTS REGARDING STATE-SPECIFIC QUALITY OF CARE MEASURES APPLIED UNDER MEDICAID.—

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

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

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

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

“(e) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated for each of fiscal years 2010 through 2014, \$60,000,000 for the purpose of carrying out this section. Funds appropriated under this subsection shall remain available until expended.”.

**SEC. 2702. PAYMENT ADJUSTMENT FOR HEALTH CARE-ACQUIRED CONDITIONS.**

(a) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the “Secretary”) shall identify current State practices that prohibit payment for health care-acquired conditions and shall incorporate the practices identified, or elements of such practices, which the Secretary determines appropriate for application to the Medicaid program in regulations. Such regulations shall be effective as of July 1, 2011, and shall prohibit payments to States under section 1903 of the Social Security Act for any amounts expended for providing medical assistance for health care-acquired conditions specified in the regulations. The regulations shall ensure that the prohibition on payment for health care-acquired conditions shall not result in a loss of access to care or services for Medicaid beneficiaries.

(b) HEALTH CARE-ACQUIRED CONDITION.—In this section, the term “health care-acquired condition” means a medical condition for which an individual was diagnosed that could be identified



by a secondary diagnostic code described in section 1886(d)(4)(D)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(4)(D)(iv)).

(c) **MEDICARE PROVISIONS.**—In carrying out this section, the Secretary shall apply to State plans (or waivers) under title XIX of the Social Security Act the regulations promulgated pursuant to section 1886(d)(4)(D) of such Act (42 U.S.C. 1395ww(d)(4)(D)) relating to the prohibition of payments based on the presence of a secondary diagnosis code specified by the Secretary in such regulations, as appropriate for the Medicaid program. The Secretary may exclude certain conditions identified under title XVIII of the Social Security Act for non-payment under title XIX of such Act when the Secretary finds the inclusion of such conditions to be inapplicable to beneficiaries under title XIX.

**SEC. 2703. STATE OPTION TO PROVIDE HEALTH HOMES FOR ENROLLEES WITH CHRONIC CONDITIONS.**

(a) **STATE PLAN AMENDMENT.**—Title XIX of the Social Security Act (42 U.S.C. 1396a et seq.), as amended by sections 2201 and 2305, is amended by adding at the end the following new section:

“**SEC. 1945. STATE OPTION TO PROVIDE COORDINATED CARE THROUGH A HEALTH HOME FOR INDIVIDUALS WITH CHRONIC CONDITIONS.**—

“(a) **IN GENERAL.**—Notwithstanding section 1902(a)(1) (relating to statewideness), section 1902(a)(10)(B) (relating to comparability), and any other provision of this title for which the Secretary determines it is necessary to waive in order to implement this section, beginning January 1, 2011, a State, at its option as a State plan amendment, may provide for medical assistance under this title to eligible individuals with chronic conditions who select a designated provider (as described under subsection (h)(5)), a team of health care professionals (as described under subsection (h)(6)) operating with such a provider, or a health team (as described under subsection (h)(7)) as the individual’s health home for purposes of providing the individual with health home services.

“(b) **HEALTH HOME QUALIFICATION STANDARDS.**—The Secretary shall establish standards for qualification as a designated provider for the purpose of being eligible to be a health home for purposes of this section.

“(c) **PAYMENTS.**—

“(1) **IN GENERAL.**—A State shall provide a designated provider, a team of health care professionals operating with such a provider, or a health team with payments for the provision of health home services to each eligible individual with chronic conditions that selects such provider, team of health care professionals, or health team as the individual’s health home. Payments made to a designated provider, a team of health care professionals operating with such a provider, or a health team for such services shall be treated as medical assistance for purposes of section 1903(a), except that, during the first 8 fiscal year quarters that the State plan amendment is in effect, the Federal medical assistance percentage applicable to such payments shall be equal to 90 percent.

“(2) **METHODOLOGY.**—

“(A) **IN GENERAL.**—The State shall specify in the State plan amendment the methodology the State will use for determining payment for the provision of health home services. Such methodology for determining payment—

“(i) may be tiered to reflect, with respect to each eligible individual with chronic conditions provided such services by a designated provider, a team of health care professionals operating with such a provider, or a health team, as well as the severity or number of each such individual’s chronic conditions or the specific capabilities of the provider, team of health care professionals, or health team; and

“(ii) shall be established consistent with section 1902(a)(30)(A).

“(B) ALTERNATE MODELS OF PAYMENT.—The methodology for determining payment for provision of health home services under this section shall not be limited to a per-member per-month basis and may provide (as proposed by the State and subject to approval by the Secretary) for alternate models of payment.

“(3) PLANNING GRANTS.—

“(A) IN GENERAL.—Beginning January 1, 2011, the Secretary may award planning grants to States for purposes of developing a State plan amendment under this section. A planning grant awarded to a State under this paragraph shall remain available until expended.

“(B) STATE CONTRIBUTION.—A State awarded a planning grant shall contribute an amount equal to the State percentage determined under section 1905(b) (without regard to section 5001 of Public Law 111–5) for each fiscal year for which the grant is awarded.

“(C) LIMITATION.—The total amount of payments made to States under this paragraph shall not exceed \$25,000,000.

“(d) HOSPITAL REFERRALS.—A State shall include in the State plan amendment a requirement for hospitals that are participating providers under the State plan or a waiver of such plan to establish procedures for referring any eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated providers.

“(e) COORDINATION.—A State shall consult and coordinate, as appropriate, with the Substance Abuse and Mental Health Services Administration in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

“(f) MONITORING.—A State shall include in the State plan amendment—

“(1) a methodology for tracking avoidable hospital readmissions and calculating savings that result from improved chronic care coordination and management under this section; and

“(2) a proposal for use of health information technology in providing health home services under this section and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

“(g) REPORT ON QUALITY MEASURES.—As a condition for receiving payment for health home services provided to an eligible individual with chronic conditions, a designated provider shall report to the State, in accordance with such requirements as the Secretary shall specify, on all applicable measures for determining

the quality of such services. When appropriate and feasible, a designated provider shall use health information technology in providing the State with such information.

“(h) DEFINITIONS.—In this section:

“(1) ELIGIBLE INDIVIDUAL WITH CHRONIC CONDITIONS.—

“(A) IN GENERAL.—Subject to subparagraph (B), the term ‘eligible individual with chronic conditions’ means an individual who—

“(i) is eligible for medical assistance under the State plan or under a waiver of such plan; and

“(ii) has at least—

“(I) 2 chronic conditions;

“(II) 1 chronic condition and is at risk of having a second chronic condition; or

“(III) 1 serious and persistent mental health condition.

“(B) RULE OF CONSTRUCTION.—Nothing in this paragraph shall prevent the Secretary from establishing higher levels as to the number or severity of chronic or mental health conditions for purposes of determining eligibility for receipt of health home services under this section.

“(2) CHRONIC CONDITION.—The term ‘chronic condition’ has the meaning given that term by the Secretary and shall include, but is not limited to, the following:

“(A) A mental health condition.

“(B) Substance use disorder.

“(C) Asthma.

“(D) Diabetes.

“(E) Heart disease.

“(F) Being overweight, as evidenced by having a Body Mass Index (BMI) over 25.

“(3) HEALTH HOME.—The term ‘health home’ means a designated provider (including a provider that operates in coordination with a team of health care professionals) or a health team selected by an eligible individual with chronic conditions to provide health home services.

“(4) HEALTH HOME SERVICES.—

“(A) IN GENERAL.—The term ‘health home services’ means comprehensive and timely high-quality services described in subparagraph (B) that are provided by a designated provider, a team of health care professionals operating with such a provider, or a health team.

“(B) SERVICES DESCRIBED.—The services described in this subparagraph are—

“(i) comprehensive care management;

“(ii) care coordination and health promotion;

“(iii) comprehensive transitional care, including appropriate follow-up, from inpatient to other settings;

“(iv) patient and family support (including authorized representatives);

“(v) referral to community and social support services, if relevant; and

“(vi) use of health information technology to link services, as feasible and appropriate.

“(5) DESIGNATED PROVIDER.—The term ‘designated provider’ means a physician, clinical practice or clinical group practice, rural clinic, community health center, community mental health

center, home health agency, or any other entity or provider (including pediatricians, gynecologists, and obstetricians) that is determined by the State and approved by the Secretary to be qualified to be a health home for eligible individuals with chronic conditions on the basis of documentation evidencing that the physician, practice, or clinic—

“(A) has the systems and infrastructure in place to provide health home services; and

“(B) satisfies the qualification standards established by the Secretary under subsection (b).

“(6) TEAM OF HEALTH CARE PROFESSIONALS.—The term ‘team of health care professionals’ means a team of health professionals (as described in the State plan amendment) that may—

“(A) include physicians and other professionals, such as a nurse care coordinator, nutritionist, social worker, behavioral health professional, or any professionals deemed appropriate by the State; and

“(B) be free standing, virtual, or based at a hospital, community health center, community mental health center, rural clinic, clinical practice or clinical group practice, academic health center, or any entity deemed appropriate by the State and approved by the Secretary.

“(7) HEALTH TEAM.—The term ‘health team’ has the meaning given such term for purposes of section 3502 of the Patient Protection and Affordable Care Act.”.

(b) EVALUATION.—

(1) INDEPENDENT EVALUATION.—

(A) IN GENERAL.—The Secretary shall enter into a contract with an independent entity or organization to conduct an evaluation and assessment of the States that have elected the option to provide coordinated care through a health home for Medicaid beneficiaries with chronic conditions under section 1945 of the Social Security Act (as added by subsection (a)) for the purpose of determining the effect of such option on reducing hospital admissions, emergency room visits, and admissions to skilled nursing facilities.

(B) EVALUATION REPORT.—Not later than January 1, 2017, the Secretary shall report to Congress on the evaluation and assessment conducted under subparagraph (A).

(2) SURVEY AND INTERIM REPORT.—

(A) IN GENERAL.—Not later than January 1, 2014, the Secretary of Health and Human Services shall survey States that have elected the option under section 1945 of the Social Security Act (as added by subsection (a)) and report to Congress on the nature, extent, and use of such option, particularly as it pertains to—

- (i) hospital admission rates;
- (ii) chronic disease management;
- (iii) coordination of care for individuals with chronic conditions;
- (iv) assessment of program implementation;
- (v) processes and lessons learned (as described in subparagraph (B));
- (vi) assessment of quality improvements and clinical outcomes under such option; and

(vii) estimates of cost savings.

(B) IMPLEMENTATION REPORTING.—A State that has elected the option under section 1945 of the Social Security Act (as added by subsection (a)) shall report to the Secretary, as necessary, on processes that have been developed and lessons learned regarding provision of coordinated care through a health home for Medicaid beneficiaries with chronic conditions under such option.

**SEC. 2704. DEMONSTRATION PROJECT TO EVALUATE INTEGRATED CARE AROUND A HOSPITALIZATION.**

(a) AUTHORITY TO CONDUCT PROJECT.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall establish a demonstration project under title XIX of the Social Security Act to evaluate the use of bundled payments for the provision of integrated care for a Medicaid beneficiary—

(A) with respect to an episode of care that includes a hospitalization; and

(B) for concurrent physicians services provided during a hospitalization.

(2) DURATION.—The demonstration project shall begin on January 1, 2012, and shall end on December 31, 2016.

(b) REQUIREMENTS.—The demonstration project shall be conducted in accordance with the following:

(1) The demonstration project shall be conducted in up to 8 States, determined by the Secretary based on consideration of the potential to lower costs under the Medicaid program while improving care for Medicaid beneficiaries. A State selected to participate in the demonstration project may target the demonstration project to particular categories of beneficiaries, beneficiaries with particular diagnoses, or particular geographic regions of the State, but the Secretary shall insure that, as a whole, the demonstration project is, to the greatest extent possible, representative of the demographic and geographic composition of Medicaid beneficiaries nationally.

(2) The demonstration project shall focus on conditions where there is evidence of an opportunity for providers of services and suppliers to improve the quality of care furnished to Medicaid beneficiaries while reducing total expenditures under the State Medicaid programs selected to participate, as determined by the Secretary.

(3) A State selected to participate in the demonstration project shall specify the 1 or more episodes of care the State proposes to address in the project, the services to be included in the bundled payments, and the rationale for the selection of such episodes of care and services. The Secretary may modify the episodes of care as well as the services to be included in the bundled payments prior to or after approving the project. The Secretary may also vary such factors among the different States participating in the demonstration project.

(4) The Secretary shall ensure that payments made under the demonstration project are adjusted for severity of illness and other characteristics of Medicaid beneficiaries within a category or having a diagnosis targeted as part of the demonstration project. States shall ensure that Medicaid beneficiaries are not liable for any additional cost sharing than

if their care had not been subject to payment under the demonstration project.

(5) Hospitals participating in the demonstration project shall have or establish robust discharge planning programs to ensure that Medicaid beneficiaries requiring post-acute care are appropriately placed in, or have ready access to, post-acute care settings.

(6) The Secretary and each State selected to participate in the demonstration project shall ensure that the demonstration project does not result in the Medicaid beneficiaries whose care is subject to payment under the demonstration project being provided with less items and services for which medical assistance is provided under the State Medicaid program than the items and services for which medical assistance would have been provided to such beneficiaries under the State Medicaid program in the absence of the demonstration project.

(c) **WAIVER OF PROVISIONS.**—Notwithstanding section 1115(a) of the Social Security Act (42 U.S.C. 1315(a)), the Secretary may waive such provisions of titles XIX, XVIII, and XI of that Act as may be necessary to accomplish the goals of the demonstration, ensure beneficiary access to acute and post-acute care, and maintain quality of care.

(d) **EVALUATION AND REPORT.**—

(1) **DATA.**—Each State selected to participate in the demonstration project under this section shall provide to the Secretary, in such form and manner as the Secretary shall specify, relevant data necessary to monitor outcomes, costs, and quality, and evaluate the rationales for selection of the episodes of care and services specified by States under subsection (b)(3).

(2) **REPORT.**—Not later than 1 year after the conclusion of the demonstration project, the Secretary shall submit a report to Congress on the results of the demonstration project.

**SEC. 2705. MEDICAID GLOBAL PAYMENT SYSTEM DEMONSTRATION PROJECT.**

(a) **IN GENERAL.**—The Secretary of Health and Human Services (referred to in this section as the “Secretary”) shall, in coordination with the Center for Medicare and Medicaid Innovation (as established under section 1115A of the Social Security Act, as added by section 3021 of this Act), establish the Medicaid Global Payment System Demonstration Project under which a participating State shall adjust the payments made to an eligible safety net hospital system or network from a fee-for-service payment structure to a global capitated payment model.

(b) **DURATION AND SCOPE.**—The demonstration project conducted under this section shall operate during a period of fiscal years 2010 through 2012. The Secretary shall select not more than 5 States to participate in the demonstration project.

(c) **ELIGIBLE SAFETY NET HOSPITAL SYSTEM OR NETWORK.**—For purposes of this section, the term “eligible safety net hospital system or network” means a large, safety net hospital system or network (as defined by the Secretary) that operates within a State selected by the Secretary under subsection (b).

(d) **EVALUATION.**—

(1) **TESTING.**—The Innovation Center shall test and evaluate the demonstration project conducted under this section

to examine any changes in health care quality outcomes and spending by the eligible safety net hospital systems or networks.

(2) BUDGET NEUTRALITY.—During the testing period under paragraph (1), any budget neutrality requirements under section 1115A(b)(3) of the Social Security Act (as so added) shall not be applicable.

(3) MODIFICATION.—During the testing period under paragraph (1), the Secretary may, in the Secretary's discretion, modify or terminate the demonstration project conducted under this section.

(e) REPORT.—Not later than 12 months after the date of completion of the demonstration project under this section, the Secretary shall submit to Congress a report containing the results of the evaluation and testing conducted under subsection (d), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.

**SEC. 2706. PEDIATRIC ACCOUNTABLE CARE ORGANIZATION DEMONSTRATION PROJECT.**

(a) AUTHORITY TO CONDUCT DEMONSTRATION.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the "Secretary") shall establish the Pediatric Accountable Care Organization Demonstration Project to authorize a participating State to allow pediatric medical providers that meet specified requirements to be recognized as an accountable care organization for purposes of receiving incentive payments (as described under subsection (d)), in the same manner as an accountable care organization is recognized and provided with incentive payments under section 1899 of the Social Security Act (as added by section 3022).

(2) DURATION.—The demonstration project shall begin on January 1, 2012, and shall end on December 31, 2016.

(b) APPLICATION.—A State that desires to participate in the demonstration project under this section shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(c) REQUIREMENTS.—

(1) PERFORMANCE GUIDELINES.—The Secretary, in consultation with the States and pediatric providers, shall establish guidelines to ensure that the quality of care delivered to individuals by a provider recognized as an accountable care organization under this section is not less than the quality of care that would have otherwise been provided to such individuals.

(2) SAVINGS REQUIREMENT.—A participating State, in consultation with the Secretary, shall establish an annual minimal level of savings in expenditures for items and services covered under the Medicaid program under title XIX of the Social Security Act and the CHIP program under title XXI of such Act that must be reached by an accountable care organization in order for such organization to receive an incentive payment under subsection (d).

(3) MINIMUM PARTICIPATION PERIOD.—A provider desiring to be recognized as an accountable care organization under

the demonstration project shall enter into an agreement with the State to participate in the project for not less than a 3-year period.

(d) INCENTIVE PAYMENT.—An accountable care organization that meets the performance guidelines established by the Secretary under subsection (c)(1) and achieves savings greater than the annual minimal savings level established by the State under subsection (c)(2) shall receive an incentive payment for such year equal to a portion (as determined appropriate by the Secretary) of the amount of such excess savings. The Secretary may establish an annual cap on incentive payments for an accountable care organization.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.

**SEC. 2707. MEDICAID EMERGENCY PSYCHIATRIC DEMONSTRATION PROJECT.**

(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECT.—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall establish a demonstration project under which an eligible State (as described in subsection (c)) shall provide payment under the State Medicaid plan under title XIX of the Social Security Act to an institution for mental diseases that is not publicly owned or operated and that is subject to the requirements of section 1867 of the Social Security Act (42 U.S.C. 1395dd) for the provision of medical assistance available under such plan to individuals who—

- (1) have attained age 21, but have not attained age 65;
- (2) are eligible for medical assistance under such plan;

and

- (3) require such medical assistance to stabilize an emergency medical condition.

(b) STABILIZATION REVIEW.—A State shall specify in its application described in subsection (c)(1) establish a mechanism for how it will ensure that institutions participating in the demonstration will determine whether or not such individuals have been stabilized (as defined in subsection (h)(5)). This mechanism shall commence before the third day of the inpatient stay. States participating in the demonstration project may manage the provision of services for the stabilization of medical emergency conditions through utilization review, authorization, or management practices, or the application of medical necessity and appropriateness criteria applicable to behavioral health.

(c) ELIGIBLE STATE DEFINED.—

(1) IN GENERAL.—An eligible State is a State that has made an application and has been selected pursuant to paragraphs (2) and (3).

(2) APPLICATION.—A State seeking to participate in the demonstration project under this section shall submit to the Secretary, at such time and in such format as the Secretary requires, an application that includes such information, provisions, and assurances, as the Secretary may require.

(3) SELECTION.—A State shall be determined eligible for the demonstration by the Secretary on a competitive basis among States with applications meeting the requirements of



paragraph (1). In selecting State applications for the demonstration project, the Secretary shall seek to achieve an appropriate national balance in the geographic distribution of such projects.

(d) LENGTH OF DEMONSTRATION PROJECT.—The demonstration project established under this section shall be conducted for a period of 3 consecutive years.

(e) LIMITATIONS ON FEDERAL FUNDING.—

(1) APPROPRIATION.—

(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this section, \$75,000,000 for fiscal year 2011.

(B) BUDGET AUTHORITY.—Subparagraph (A) constitutes budget authority in advance of appropriations Act and represents the obligation of the Federal Government to provide for the payment of the amounts appropriated under that subparagraph.

(2) 5-YEAR AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available for obligation through December 31, 2015.

(3) LIMITATION ON PAYMENTS.—In no case may—

(A) the aggregate amount of payments made by the Secretary to eligible States under this section exceed \$75,000,000; or

(B) payments be provided by the Secretary under this section after December 31, 2015.

(4) FUNDS ALLOCATED TO STATES.—Funds shall be allocated to eligible States on the basis of criteria, including a State's application and the availability of funds, as determined by the Secretary.

(5) PAYMENTS TO STATES.—The Secretary shall pay to each eligible State, from its allocation under paragraph (4), an amount each quarter equal to the Federal medical assistance percentage of expenditures in the quarter for medical assistance described in subsection (a). As a condition of receiving payment, a State shall collect and report information, as determined necessary by the Secretary, for the purposes of providing Federal oversight and conducting an evaluation under subsection (f)(1).

(f) EVALUATION AND REPORT TO CONGRESS.—

(1) EVALUATION.—The Secretary shall conduct an evaluation of the demonstration project in order to determine the impact on the functioning of the health and mental health service system and on individuals enrolled in the Medicaid program and shall include the following:

(A) An assessment of access to inpatient mental health services under the Medicaid program; average lengths of inpatient stays; and emergency room visits.

(B) An assessment of discharge planning by participating hospitals.

(C) An assessment of the impact of the demonstration project on the costs of the full range of mental health services (including inpatient, emergency and ambulatory care).

(D) An analysis of the percentage of consumers with Medicaid coverage who are admitted to inpatient facilities as a result of the demonstration project as compared to

those admitted to these same facilities through other means.

(E) A recommendation regarding whether the demonstration project should be continued after December 31, 2013, and expanded on a national basis.

(2) REPORT.—Not later than December 31, 2013, the Secretary shall submit to Congress and make available to the public a report on the findings of the evaluation under paragraph (1).

(g) WAIVER AUTHORITY.—

(1) IN GENERAL.—The Secretary shall waive the limitation of subdivision (B) following paragraph (28) of section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) (relating to limitations on payments for care or services for individuals under 65 years of age who are patients in an institution for mental diseases) for purposes of carrying out the demonstration project under this section.

(2) LIMITED OTHER WAIVER AUTHORITY.—The Secretary may waive other requirements of titles XI and XIX of the Social Security Act (including the requirements of sections 1902(a)(1) (relating to statewideness) and 1902(1)(10)(B) (relating to comparability)) only to extent necessary to carry out the demonstration project under this section.

(h) DEFINITIONS.—In this section:

(1) EMERGENCY MEDICAL CONDITION.—The term “emergency medical condition” means, with respect to an individual, an individual who expresses suicidal or homicidal thoughts or gestures, if determined dangerous to self or others.

(2) FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—The term “Federal medical assistance percentage” has the meaning given that term with respect to a State under section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)).

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

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

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

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

## **Subtitle J—Improvements to the Medicaid and CHIP Payment and Access Commission (MACPAC)**

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

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

(1) in subsection (b)—

(A) in paragraph (1)—

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

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

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

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

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

(B) in paragraph (2)—

(i) in subparagraph (A)—

(I) in clause (i)—

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

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

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

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

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

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

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

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

“(E) QUALITY OF CARE.—Medicaid and CHIP policies as they relate to the quality of care provided under those programs, including a determination of the degree to which Federal and State policies achieve their stated goals and

interact with similar goals established by other purchasers of health care services.”;

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

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

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

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

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

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

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

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

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

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

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

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

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

(iv) by adding at the end the following:

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

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

(H) by adding at the end the following:

“(11) CONSULTATION AND COORDINATION WITH MEDPAC.—

“(A) IN GENERAL.—MACPAC shall consult with the Medicare Payment Advisory Commission (in this paragraph referred to as ‘MedPAC’) established under section 1805 in carrying out its duties under this section, as appropriate and particularly with respect to the issues specified in

paragraph (2) as they relate to those Medicaid beneficiaries who are dually eligible for Medicaid and the Medicare program under title XVIII, adult Medicaid beneficiaries (who are not dually eligible for Medicare), and beneficiaries under Medicare. Responsibility for analysis of and recommendations to change Medicare policy regarding Medicare beneficiaries, including Medicare beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with MedPAC.

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

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

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

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

(2) in subsection (c)(2)—

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

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

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

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

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

(5) in subsection (f)—

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

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

(C) by adding at the end the following:

“(3) FUNDING FOR FISCAL YEAR 2010.—

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

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

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

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

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

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

(3) by adding at the end the following:

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

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

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

shall rest with the Commission. Responsibility for analysis of and recommendations to change Medicaid policy regarding Medicaid beneficiaries, including Medicaid beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with MACPAC.”.

## **Subtitle K—Protections for American Indians and Alaska Natives**

### **SEC. 2901. SPECIAL RULES RELATING TO INDIANS.**

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

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

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

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

(2) by adding at the end the following:

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

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

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

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

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

## Subtitle L—Maternal and Child Health Services

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

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

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

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

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

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

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

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

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

“(A) communities with concentrations of—

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

“(ii) poverty;

“(iii) crime;

“(iv) domestic violence;

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

“(vi) substance abuse;

“(vii) unemployment; or

“(viii) child maltreatment;

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

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

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

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

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

“(2) COORDINATION WITH OTHER ASSESSMENTS.—In conducting the statewide needs assessment required under paragraph (1), the State shall coordinate with, and take into account, other appropriate needs assessments conducted by



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

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

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

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

“(c) GRANTS FOR EARLY CHILDHOOD HOME VISITATION PROGRAMS.—

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

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

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

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

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

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

“(A) IN GENERAL.—The eligible entity establishes, subject to the approval of the Secretary, quantifiable, measurable 3- and 5-year benchmarks for demonstrating that the

program results in improvements for the eligible families participating in the program in each of the following areas:

- “(i) Improved maternal and newborn health.
- “(ii) Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits.
- “(iii) Improvement in school readiness and achievement.
- “(iv) Reduction in crime or domestic violence.
- “(v) Improvements in family economic self-sufficiency.
- “(vi) Improvements in the coordination and referrals for other community resources and supports.

“(B) DEMONSTRATION OF IMPROVEMENTS AFTER 3 YEARS.—

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

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

“(iii) TECHNICAL ASSISTANCE.—

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

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

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

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

“(2) IMPROVEMENTS IN OUTCOMES FOR INDIVIDUAL FAMILIES.—

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

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

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

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

“(iii) Improvements in parenting skills.

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

“(v) Reductions in crime or domestic violence.

“(vi) Improvements in family economic self-sufficiency.

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

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

“(A) SERVICE DELIVERY MODEL OR MODELS.—

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

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

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

“(bb) quasi-experimental research designs.

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

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

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

“(B) ADDITIONAL REQUIREMENTS.—

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

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

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

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

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

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

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

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

“(B) Low-income eligible families.

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

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

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

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

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

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

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

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

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

“(2) An assurance that the entity will give priority to serving low-income eligible families and eligible families who reside in at risk communities identified in the statewide needs assessment required under subsection (b)(1)(A).

“(3) The service delivery model or models described in subsection (d)(3)(A) that the entity will use under the program and the basis for the selection of the model or models.

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

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

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

“(7) Assurances that the entity will establish procedures to ensure that—

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

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

“(8) Assurances that the entity will—

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

“(B) participate in, and cooperate with, data and information collection necessary for the evaluation required

under subsection (g)(2) and other research and evaluation activities carried out under subsection (h)(3).

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

“(10) Other information as required by the Secretary.

“(f) MAINTENANCE OF EFFORT.—Funds provided to an eligible entity receiving a grant under this section shall supplement, and not supplant, funds from other sources for early childhood home visitation programs or initiatives.

“(g) EVALUATION.—

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

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

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

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

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

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

“(B) an assessment of—

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

“(ii) the effectiveness of such programs on different populations, including the extent to which the ability of programs to improve participant outcomes varies across programs and populations; and

“(iii) the potential for the activities conducted under such programs, if scaled broadly, to improve health care practices, eliminate health disparities, and improve health care system quality, efficiencies, and reduce costs.

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

“(h) OTHER PROVISIONS.—

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

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

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

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

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

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

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

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

to eligible entities that are States and shall require the organization to—

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

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

“(3) RESEARCH AND OTHER EVALUATION ACTIVITIES.—

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

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

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

“(ii) the conduct of research and evaluation activities includes consultation with independent researchers, State officials, and developers and providers of home visiting programs on topics including research design and administrative data matching.

“(4) REPORT AND RECOMMENDATION.—Not later than December 31, 2015, the Secretary shall submit a report to Congress regarding the programs conducted with grants under this section. The report required under this paragraph shall include—

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

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

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

“(i) APPLICATION OF OTHER PROVISIONS OF TITLE.—

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

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

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

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

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

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



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

“(F) Section 508 (relating to nondiscrimination).

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

“(j) APPROPRIATIONS.—

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

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

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

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

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

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

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

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

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

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

“(k) DEFINITIONS.—In this section:

“(1) ELIGIBLE ENTITY.—

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

“(B) NONPROFIT ORGANIZATIONS.—Only for purposes of awarding grants under subsection (h)(2)(B), such term shall include a nonprofit organization with an established record of providing early childhood home visitation programs or initiatives in a State or several States.

“(2) ELIGIBLE FAMILY.—The term ‘eligible family’ means—

“(A) a woman who is pregnant, and the father of the child if the father is available; or

“(B) a parent or primary caregiver of a child, including grandparents or other relatives of the child, and foster parents, who are serving as the child’s primary caregiver from birth to kindergarten entry, and including a noncustodial parent who has an ongoing relationship with, and at times provides physical care for, the child.

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

**SEC. 2952. SUPPORT, EDUCATION, AND RESEARCH FOR POSTPARTUM DEPRESSION.**

(a) **RESEARCH ON POSTPARTUM CONDITIONS.—**

(1) **EXPANSION AND INTENSIFICATION OF ACTIVITIES.—**The Secretary of Health and Human Services (in this subsection and subsection (c) referred to as the “Secretary”) is encouraged to continue activities on postpartum depression or postpartum psychosis (in this subsection and subsection (c) referred to as “postpartum conditions”), including research to expand the understanding of the causes of, and treatments for, postpartum conditions. Activities under this paragraph shall include conducting and supporting the following:

(A) Basic research concerning the etiology and causes of the conditions.

(B) Epidemiological studies to address the frequency and natural history of the conditions and the differences among racial and ethnic groups with respect to the conditions.

(C) The development of improved screening and diagnostic techniques.

(D) Clinical research for the development and evaluation of new treatments.

(E) Information and education programs for health care professionals and the public, which may include a coordinated national campaign to increase the awareness and knowledge of postpartum conditions. Activities under such a national campaign may—

(i) include public service announcements through television, radio, and other means; and

(ii) focus on—

(I) raising awareness about screening;

(II) educating new mothers and their families about postpartum conditions to promote earlier diagnosis and treatment; and

(III) ensuring that such education includes complete information concerning postpartum conditions, including its symptoms, methods of coping with the illness, and treatment resources.

(2) **SENSE OF CONGRESS REGARDING LONGITUDINAL STUDY OF RELATIVE MENTAL HEALTH CONSEQUENCES FOR WOMEN OF RESOLVING A PREGNANCY.—**

(A) **SENSE OF CONGRESS.—**It is the sense of Congress that the Director of the National Institute of Mental Health may conduct a nationally representative longitudinal study (during the period of fiscal years 2010 through 2019) of the relative mental health consequences for women of resolving a pregnancy (intended and unintended) in various ways, including carrying the pregnancy to term and parenting the child, carrying the pregnancy to term and placing the child for adoption, miscarriage, and having an abortion. This study may assess the incidence, timing, magnitude, and duration of the immediate and long-term mental health consequences (positive or negative) of these pregnancy outcomes.

(B) **REPORT.—**Subject to the completion of the study under subsection (a), beginning not later than 5 years after the date of the enactment of this Act, and periodically

thereafter for the duration of the study, such Director may prepare and submit to the Congress reports on the findings of the study.

(b) GRANTS TO PROVIDE SERVICES TO INDIVIDUALS WITH A POSTPARTUM CONDITION AND THEIR FAMILIES.—Title V of the Social Security Act (42 U.S.C. 701 et seq.), as amended by section 2951, is amended by adding at the end the following new section:

**“SEC. 512. SERVICES TO INDIVIDUALS WITH A POSTPARTUM CONDITION AND THEIR FAMILIES.**

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

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

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

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

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

“(4) Providing education about postpartum conditions to promote earlier diagnosis and treatment. Such education may include—

“(A) providing complete information on postpartum conditions, symptoms, methods of coping with the illness, and treatment resources; and

“(B) in the case of a grantee that is a State, hospital, or birthing facility—

“(i) providing education to new mothers and fathers, and other family members as appropriate, concerning postpartum conditions before new mothers leave the health facility; and

“(ii) ensuring that training programs regarding such education are carried out at the health facility.

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

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

each grant period, a report to the Secretary that describes how grant funds were used during such period.

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

“(f) APPLICATION OF OTHER PROVISIONS OF TITLE.—

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

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

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

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

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

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

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

“(F) Section 508 (relating to nondiscrimination).

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

“(g) DEFINITIONS.—In this section:

“(1) The term ‘eligible entity’—

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

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

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

(c) GENERAL PROVISIONS.—

(1) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section and the amendment made by subsection (b), there are authorized to be appropriated, in addition to such other sums as may be available for such purpose—

(A) \$3,000,000 for fiscal year 2010; and

(B) such sums as may be necessary for fiscal years 2011 and 2012.

(2) REPORT BY THE SECRETARY.—

(A) STUDY.—The Secretary shall conduct a study on the benefits of screening for postpartum conditions.

(B) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall complete the study required by subparagraph (A) and submit a report to the Congress on the results of such study.

**SEC. 2953. PERSONAL RESPONSIBILITY EDUCATION.**

Title V of the Social Security Act (42 U.S.C. 701 et seq.), as amended by sections 2951 and 2952(c), is amended by adding at the end the following:

**“SEC. 513. PERSONAL RESPONSIBILITY EDUCATION.**

“(a) ALLOTMENTS TO STATES.—

“(1) AMOUNT.—

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

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

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

“(B) MINIMUM ALLOTMENT.—

“(i) IN GENERAL.—Each State allotment under this paragraph for a fiscal year shall be at least \$250,000.

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

“(C) APPLICATION REQUIRED TO ACCESS ALLOTMENTS.—

“(i) IN GENERAL.—A State shall not be paid from its allotment for a fiscal year unless the State submits an application to the Secretary for the fiscal year and the Secretary approves the application (or requires changes to the application that the State satisfies) and meets such additional requirements as the Secretary may specify.

“(ii) REQUIREMENTS.—The State application shall contain an assurance that the State has complied with the requirements of this section in preparing and submitting the application and shall include the following as well as such additional information as the Secretary may require:

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

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

“(III) A description of the State’s plan for using the State allotments provided under this section to achieve such goals, especially among youth

populations that are the most high-risk or vulnerable for pregnancies or otherwise have special circumstances, including youth in foster care, homeless youth, youth with HIV/AIDS, pregnant youth who are under 21 years of age, mothers who are under 21 years of age, and youth residing in areas with high birth rates for youth.

“(2) STATE YOUTH POPULATION PERCENTAGE.—

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

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

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

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

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

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

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

“(B) 3-YEAR GRANTS.—

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

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

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

“(5) MAINTENANCE OF EFFORT.—No payment shall be made to a State from the allotment determined for the State under this subsection or to a local organization or entity awarded

a grant under paragraph (4), if the expenditure of non-federal funds by the State, organization, or entity for activities, programs, or initiatives for which amounts from allotments and grants under this subsection may be expended is less than the amount expended by the State, organization, or entity for such programs or initiatives for fiscal year 2009.

“(6) DATA COLLECTION AND REPORTING.—A State or local organization or entity receiving funds under this section shall cooperate with such requirements relating to the collection of data and information and reporting on outcomes regarding the programs and activities carried out with such funds, as the Secretary shall specify.

“(b) PURPOSE.—

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

“(2) PERSONAL RESPONSIBILITY EDUCATION PROGRAMS.—

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

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

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

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

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

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

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

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

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

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

“(C) ADULTHOOD PREPARATION SUBJECTS.—The adulthood preparation subjects described in this subparagraph are the following:

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

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

“(iii) Financial literacy.

“(iv) Parent-child communication.

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

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

“(c) RESERVATIONS OF FUNDS.—

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

“(2) OTHER RESERVATIONS.—From the amount appropriated under subsection (f) for the fiscal year that remains after the application of paragraph (1), the Secretary shall reserve the following amounts:

“(A) GRANTS FOR INDIAN TRIBES OR TRIBAL ORGANIZATIONS.—The Secretary shall reserve 5 percent of such remainder for purposes of awarding grants to Indian tribes and tribal organizations in such manner, and subject to such requirements, as the Secretary, in consultation with Indian tribes and tribal organizations, determines appropriate.

“(B) SECRETARIAL RESPONSIBILITIES.—

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

“(ii) PROGRAM SUPPORT.—The Secretary shall provide, directly or through a competitive grant process, research, training and technical assistance, including dissemination of research and information regarding effective and promising practices, providing consultation and resources on a broad array of teen pregnancy prevention strategies, including abstinence and contraception, and developing resources and materials to support the activities of recipients of grants and other State, tribal, and community organizations working



to reduce teen pregnancy. In carrying out such functions, the Secretary shall collaborate with a variety of entities that have expertise in the prevention of teen pregnancy, HIV and sexually transmitted infections, healthy relationships, financial literacy, and other topics addressed through the personal responsibility education programs.

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

“(d) ADMINISTRATION.—

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

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

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

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

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

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

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

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

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

“(vi) Section 508 (relating to nondiscrimination).

“(e) DEFINITIONS.—In this section:

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

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

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

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

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

“(4) YOUTH.—The term ‘youth’ means an individual who has attained age 10 but has not attained age 20.

“(f) APPROPRIATION.—For the purpose of carrying out this section, there is appropriated, out of any money in the Treasury not otherwise appropriated, \$75,000,000 for each of fiscal years 2010 through 2014. Amounts appropriated under this subsection shall remain available until expended.”.

**SEC. 2954. RESTORATION OF FUNDING FOR ABSTINENCE EDUCATION.**

Section 510 of the Social Security Act (42 U.S.C. 710) is amended—

(1) in subsection (a), by striking “fiscal year 1998 and each subsequent fiscal year” and inserting “each of fiscal years 2010 through 2014”; and

(2) in subsection (d)—

(A) in the first sentence, by striking “1998 through 2003” and inserting “2010 through 2014”; and

(B) in the second sentence, by inserting “(except that such appropriation shall be made on the date of enactment of the Patient Protection and Affordable Care Act in the case of fiscal year 2010)” before the period.

**SEC. 2955. INCLUSION OF INFORMATION ABOUT THE IMPORTANCE OF HAVING A HEALTH CARE POWER OF ATTORNEY IN TRANSITION PLANNING FOR CHILDREN AGING OUT OF FOSTER CARE AND INDEPENDENT LIVING PROGRAMS.**

(a) TRANSITION PLANNING.—Section 475(5)(H) of the Social Security Act (42 U.S.C. 675(5)(H)) is amended by inserting “includes information about the importance of designating another individual to make health care treatment decisions on behalf of the child if the child becomes unable to participate in such decisions and the child does not have, or does not want, a relative who would otherwise be authorized under State law to make such decisions, and provides the child with the option to execute a health care power of attorney, health care proxy, or other similar document recognized under State law,” after “employment services,”.

(b) INDEPENDENT LIVING EDUCATION.—Section 477(b)(3) of such Act (42 U.S.C. 677(b)(3)) is amended by adding at the end the following:

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

(c) HEALTH OVERSIGHT AND COORDINATION PLAN.—Section 422(b)(15)(A) of such Act (42 U.S.C. 622(b)(15)(A)) is amended—

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

(2) by adding at the end the following:

“(vii) steps to ensure that the components of the transition plan development process required under

section 475(5)(H) that relate to the health care needs of children aging out of foster care, including the requirements to include options for health insurance, information about a health care power of attorney, health care proxy, or other similar document recognized under State law, and to provide the child with the option to execute such a document, are met; and”.

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

## **TITLE III—IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE**

### **Subtitle A—Transforming the Health Care Delivery System**

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

##### **SEC. 3001. HOSPITAL VALUE-BASED PURCHASING PROGRAM.**

(a) PROGRAM.—

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

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

“(1) ESTABLISHMENT.—

“(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall establish a hospital value-based purchasing program (in this subsection referred to as the ‘Program’) under which value-based incentive payments are made in a fiscal year to hospitals that meet the performance standards under paragraph (3) for the performance period for such fiscal year (as established under paragraph (4)).

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

“(C) APPLICABILITY OF PROGRAM TO HOSPITALS.—

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

“(ii) EXCLUSIONS.—The term ‘hospital’ shall not include, with respect to a fiscal year, a hospital—

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

“(II) for which, during the performance period for such fiscal year, the Secretary has cited deficiencies that pose immediate jeopardy to the health or safety of patients;