

111<sup>TH</sup> CONGRESS  
1<sup>ST</sup> SESSION

# H. R. 1200

To provide for health care for every American and to control the cost and enhance the quality of the health care system.

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## IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 25, 2009

Mr. McDERMOTT (for himself, Mr. ENGEL, Mr. FARR, Mr. HINCHEY, Mr. KUCINICH, Mr. DICKS, Ms. LEE of California, and Mr. OLVER) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Oversight and Government Reform, and Armed Services, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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## A BILL

To provide for health care for every American and to control the cost and enhance the quality of the health care system.

1       *Be it enacted by the Senate and House of Representa-*  
2       *tives of the United States of America in Congress assembled,*

3       **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4       (a) **SHORT TITLE.**—This Act may be cited as the  
5       “American Health Security Act of 2009”.

6       (b) **TABLE OF CONTENTS.**—The table of contents of  
7       this Act is as follows:

Sec. 1. Short title; table of contents.

**TITLE I—ESTABLISHMENT OF A STATE-BASED AMERICAN HEALTH SECURITY PROGRAM; UNIVERSAL ENTITLEMENT; ENROLLMENT**

Sec. 101. Establishment of a State-based American Health Security Program.  
 Sec. 102. Universal entitlement.  
 Sec. 103. Enrollment.  
 Sec. 104. Portability of benefits.  
 Sec. 105. Effective date of benefits.  
 Sec. 106. Relationship to existing Federal health programs.

**TITLE II—COMPREHENSIVE BENEFITS, INCLUDING PREVENTIVE BENEFITS AND BENEFITS FOR LONG-TERM CARE**

Sec. 201. Comprehensive benefits.  
 Sec. 202. Definitions relating to services.  
 Sec. 203. Special rules for home and community-based long-term care services.  
 Sec. 204. Exclusions and limitations.  
 Sec. 205. Certification; quality review; plans of care.

**TITLE III—PROVIDER PARTICIPATION**

Sec. 301. Provider participation and standards.  
 Sec. 302. Qualifications for providers.  
 Sec. 303. Qualifications for comprehensive health service organizations.  
 Sec. 304. Limitation on certain physician referrals.

**TITLE IV—ADMINISTRATION**

**Subtitle A—General Administrative Provisions**

Sec. 401. American Health Security Standards Board.  
 Sec. 402. American Health Security Advisory Council.  
 Sec. 403. Consultation with private entities.  
 Sec. 404. State health security programs.  
 Sec. 405. Complementary conduct of related health programs.

**Subtitle B—Control Over Fraud and Abuse**

Sec. 411. Application of Federal sanctions to all fraud and abuse under American Health Security Program.  
 Sec. 412. Requirements for operation of State health care fraud and abuse control units.

**TITLE V—QUALITY ASSESSMENT**

Sec. 501. American Health Security Quality Council.  
 Sec. 502. Development of certain methodologies, guidelines, and standards.  
 Sec. 503. State quality review programs.  
 Sec. 504. Elimination of utilization review programs; transition.

**TITLE VI—HEALTH SECURITY BUDGET; PAYMENTS; COST CONTAINMENT MEASURES**

**Subtitle A—Budgeting and Payments to States**

Sec. 601. National health security budget.

- Sec. 602. Computation of individual and State capitation amounts.
- Sec. 603. State health security budgets.
- Sec. 604. Federal payments to States.
- Sec. 605. Account for health professional education expenditures.

#### Subtitle B—Payments by States to Providers

- Sec. 611. Payments to hospitals and other facility-based services for operating expenses on the basis of approved global budgets.
- Sec. 612. Payments to health care practitioners based on prospective fee schedule.
- Sec. 613. Payments to comprehensive health service organizations.
- Sec. 614. Payments for community-based primary health services.
- Sec. 615. Payments for prescription drugs.
- Sec. 616. Payments for approved devices and equipment.
- Sec. 617. Payments for other items and services.
- Sec. 618. Payment incentives for medically underserved areas.
- Sec. 619. Authority for alternative payment methodologies.

#### Subtitle C—Mandatory Assignment and Administrative Provisions

- Sec. 631. Mandatory assignment.
- Sec. 632. Procedures for reimbursement; appeals.

### TITLE VII—PROMOTION OF PRIMARY HEALTH CARE; DEVELOPMENT OF HEALTH SERVICE CAPACITY; PROGRAMS TO ASSIST THE MEDICALLY UNDERSERVED

#### Subtitle A—Promotion and Expansion of Primary Care Professional Training

- Sec. 701. Role of Board; establishment of primary care professional output goals.
- Sec. 702. Establishment of Advisory Committee on Health Professional Education.
- Sec. 703. Grants for health professions education, nurse education, and the National Health Service Corps.

#### Subtitle B—Direct Health Care Delivery

- Sec. 711. Set-aside for public health.
- Sec. 712. Set-aside for primary health care delivery.
- Sec. 713. Primary care service expansion grants.

#### Subtitle C—Primary Care and Outcomes Research

- Sec. 721. Set-aside for outcomes research.
- Sec. 722. Office of Primary Care and Prevention Research.

#### Subtitle D—School-Related Health Services

- Sec. 731. Authorizations of appropriations.
- Sec. 732. Eligibility for development and operation grants.
- Sec. 733. Preferences.
- Sec. 734. Grants for development of projects.
- Sec. 735. Grants for operation of projects.
- Sec. 736. Federal administrative costs.
- Sec. 737. Definitions.

TITLE VIII—FINANCING PROVISIONS; AMERICAN HEALTH  
SECURITY TRUST FUND

Sec. 800. Amendment of 1986 code; Section 15 not to apply.

Subtitle A—American Health Security Trust Fund

Sec. 801. American Health Security Trust Fund.

Subtitle B—Taxes Based on Income and Wages

Sec. 811. Payroll tax on employers.

Sec. 812. Health care income tax.

TITLE IX—CONFORMING AMENDMENTS TO THE EMPLOYEE  
RETIREMENT INCOME SECURITY ACT OF 1974

Sec. 901. ERISA inapplicable to health coverage arrangements under State health security programs.

Sec. 902. Exemption of State health security programs from ERISA preemption.

Sec. 903. Prohibition of employee benefits duplicative of benefits under State health security programs; coordination in case of workers' compensation.

Sec. 904. Repeal of continuation coverage requirements under ERISA and certain other requirements relating to group health plans.

Sec. 905. Effective date of title.

TITLE X—ADDITIONAL CONFORMING AMENDMENTS

Sec. 1001. Repeal of certain provisions in Internal Revenue Code of 1986.

Sec. 1002. Repeal of certain provisions in the Employee Retirement Income Security Act of 1974.

Sec. 1003. Repeal of certain provisions in the Public Health Service Act and related provisions.

Sec. 1004. Effective date of title.

1 **TITLE I—ESTABLISHMENT OF A**  
2 **STATE-BASED AMERICAN**  
3 **HEALTH SECURITY PRO-**  
4 **GRAM; UNIVERSAL ENTITLE-**  
5 **MENT; ENROLLMENT**

6 **SEC. 101. ESTABLISHMENT OF A STATE-BASED AMERICAN**  
7 **HEALTH SECURITY PROGRAM.**

8 (a) IN GENERAL.—There is hereby established in the  
9 United States a State-Based American Health Security  
10 Program to be administered by the individual States in

1 accordance with Federal standards specified in, or estab-  
2 lished under, this Act.

3 (b) STATE HEALTH SECURITY PROGRAMS.—In order  
4 for a State to be eligible to receive payment under section  
5 604, a State must establish a State health security pro-  
6 gram in accordance with this Act.

7 (c) STATE DEFINED.—

8 (1) IN GENERAL.—In this Act, subject to para-  
9 graph (2), the term “State” means each of the 50  
10 States and the District of Columbia.

11 (2) ELECTION.—If the Governor of Puerto  
12 Rico, the Virgin Islands, Guam, American Samoa, or  
13 the Northern Mariana Islands certifies to the Presi-  
14 dent that the legislature of the Commonwealth or  
15 territory has enacted legislation desiring that the  
16 Commonwealth or territory be included as a State  
17 under the provisions of this Act, such Common-  
18 wealth or territory shall be included as a “State”  
19 under this Act beginning January 1 of the first year  
20 beginning 90 days after the President receives the  
21 notification.

22 **SEC. 102. UNIVERSAL ENTITLEMENT.**

23 (a) IN GENERAL.—Every individual who is a resident  
24 of the United States and is a citizen or national of the  
25 United States or lawful resident alien (as defined in sub-

1 section (d)) is entitled to benefits for health care services  
2 under this Act under the appropriate State health security  
3 program. In this section, the term “appropriate State  
4 health security program” means, with respect to an indi-  
5 vidual, the State health security program for the State in  
6 which the individual maintains a primary residence.

7 (b) TREATMENT OF CERTAIN NONIMMIGRANTS.—

8 (1) IN GENERAL.—The American Health Secu-  
9 rity Standards Board (in this Act referred to as the  
10 “Board”) may make eligible for benefits for health  
11 care services under the appropriate State health se-  
12 curity program under this Act such classes of aliens  
13 admitted to the United States as nonimmigrants as  
14 the Board may provide.

15 (2) CONSIDERATION.—In providing for eligi-  
16 bility under paragraph (1), the Board shall consider  
17 reciprocity in health care services offered to United  
18 States citizens who are nonimmigrants in other for-  
19 eign states, and such other factors as the Board de-  
20 termines to be appropriate.

21 (c) TREATMENT OF OTHER INDIVIDUALS.—

22 (1) BY BOARD.—The Board also may make eli-  
23 gible for benefits for health care services under the  
24 appropriate State health security program under this  
25 Act other individuals not described in subsection (a)

1 or (b), and regulate the nature of the eligibility of  
2 such individuals, in order—

3 (A) to preserve the public health of com-  
4 munities;

5 (B) to compensate States for the addi-  
6 tional health care financing burdens created by  
7 such individuals; and

8 (C) to prevent adverse financial and med-  
9 ical consequences of uncompensated care,  
10 while inhibiting travel and immigration to the  
11 United States for the sole purpose of obtaining  
12 health care services.

13 (2) BY STATES.—Any State health security pro-  
14 gram may make individuals described in paragraph  
15 (1) eligible for benefits at the expense of the State.

16 (d) LAWFUL RESIDENT ALIEN DEFINED.—For pur-  
17 poses of this section, the term “lawful resident alien”  
18 means an alien lawfully admitted for permanent residence  
19 and any other alien lawfully residing permanently in the  
20 United States under color of law, including an alien with  
21 lawful temporary resident status under section 210, 210A,  
22 or 234A of the Immigration and Nationality Act (8 U.S.C.  
23 1160, 1161, or 1255a).

1 **SEC. 103. ENROLLMENT.**

2 (a) IN GENERAL.—Each State health security pro-  
3 gram shall provide a mechanism for the enrollment of indi-  
4 viduals entitled or eligible for benefits under this Act. The  
5 mechanism shall—

6 (1) include a process for the automatic enroll-  
7 ment of individuals at the time of birth in the  
8 United States and at the time of immigration into  
9 the United States or other acquisition of lawful resi-  
10 dent status in the United States;

11 (2) provide for the enrollment, as of January 1,  
12 2011, of all individuals who are eligible to be en-  
13 rolled as of such date; and

14 (3) include a process for the enrollment of indi-  
15 viduals made eligible for health care services under  
16 subsections (b) and (c) of section 102.

17 (b) AVAILABILITY OF APPLICATIONS.—Each State  
18 health security program shall make applications for enroll-  
19 ment under the program available—

20 (1) at employment and payroll offices of em-  
21 ployers located in the State;

22 (2) at local offices of the Social Security Ad-  
23 ministration;

24 (3) at social services locations;

25 (4) at out-reach sites (such as provider and  
26 practitioner locations); and



1           (5) at other locations (including post offices  
2           and schools) accessible to a broad cross-section of in-  
3           dividuals eligible to enroll.

4           (c) ISSUANCE OF HEALTH SECURITY CARDS.—In  
5           conjunction with an individual’s enrollment for benefits  
6           under this Act, the State health security program shall  
7           provide for the issuance of a health security card that shall  
8           be used for purposes of identification and processing of  
9           claims for benefits under the program. The State health  
10          security program may provide for issuance of such cards  
11          by employers for purposes of carrying out enrollment pur-  
12          suant to subsection (a)(2).

13       **SEC. 104. PORTABILITY OF BENEFITS.**

14          (a) IN GENERAL.—To ensure continuous access to  
15          benefits for health care services covered under this Act,  
16          each State health security program—

17               (1) shall not impose any minimum period of  
18               residence in the State, or waiting period, in excess  
19               of 3 months before residents of the State are enti-  
20               tled to, or eligible for, such benefits under the pro-  
21               gram;

22               (2) shall provide continuation of payment for  
23               covered health care services to individuals who have  
24               terminated their residence in the State and estab-  
25               lished their residence in another State, for the dura-

1       tion of any waiting period imposed in the State of  
2       new residency for establishing entitlement to, or eli-  
3       gibility for, such services; and

4               (3) shall provide for the payment for health  
5       care services covered under this Act provided to indi-  
6       viduals while temporarily absent from the State  
7       based on the following principles:

8               (A) Payment for such health care services  
9       is at the rate that is approved by the State  
10      health security program in the State in which  
11      the services are provided, unless the States con-  
12      cerned agree to apportion the cost between  
13      them in a different manner.

14              (B) Payment for such health care services  
15      provided outside the United States is made on  
16      the basis of the amount that would have been  
17      paid by the State health security program for  
18      similar services rendered in the State, with due  
19      regard, in the case of hospital services, to the  
20      size of the hospital, standards of service, and  
21      other relevant factors.

22      (b) CROSS-BORDER ARRANGEMENTS.—A State  
23      health security program for a State may negotiate with  
24      such a program in an adjacent State a reciprocal arrange-

1 ment for the coverage under such other program of health  
2 care services to enrollees residing in the border region.

3 **SEC. 105. EFFECTIVE DATE OF BENEFITS.**

4 Benefits shall first be available under this Act for  
5 items and services furnished on or after January 1, 2011.

6 **SEC. 106. RELATIONSHIP TO EXISTING FEDERAL HEALTH  
7 PROGRAMS.**

8 (a) MEDICARE, MEDICAID AND STATE CHILDREN'S  
9 HEALTH INSURANCE PROGRAM (SCHIP).—

10 (1) IN GENERAL.—Notwithstanding any other  
11 provision of law, subject to paragraph (2)—

12 (A) no benefits shall be available under  
13 title XVIII of the Social Security Act for any  
14 item or service furnished after December 31,  
15 2010;

16 (B) no individual is entitled to medical as-  
17 sistance under a State plan approved under  
18 title XIX of such Act for any item or service  
19 furnished after such date;

20 (C) no individual is entitled to medical as-  
21 sistance under an SCHIP plan under title XXI  
22 of such Act for any item or service furnished  
23 after such date; and

24 (D) no payment shall be made to a State  
25 under section 1903(a) or 2105(a) of such Act

1 with respect to medical assistance or child  
2 health assistance for any item or service fur-  
3 nished after such date.

4 (2) TRANSITION.—In the case of inpatient hos-  
5 pital services and extended care services during a  
6 continuous period of stay which began before Janu-  
7 ary 1, 2011, and which had not ended as of such  
8 date, for which benefits are provided under title  
9 XVIII, under a State plan under title XIX, or a  
10 State child health plan under title XXI, of the Social  
11 Security Act, the Secretary of Health and Human  
12 Services and each State plan, respectively, shall pro-  
13 vide for continuation of benefits under such title or  
14 plan until the end of the period of stay.

15 (b) FEDERAL EMPLOYEES HEALTH BENEFITS PRO-  
16 GRAM.—No benefits shall be made available under chapter  
17 89 of title 5, United States Code, for any part of a cov-  
18 erage period occurring after December 31, 2010.

19 (c) CHAMPUS.—No benefits shall be made available  
20 under sections 1079 and 1086 of title 10, United States  
21 Code, for items or services furnished after December 31,  
22 2010.

23 (d) TREATMENT OF BENEFITS FOR VETERANS AND  
24 NATIVE AMERICANS.—Nothing in this Act shall affect the  
25 eligibility of veterans for the medical benefits and services

1 provided under title 38, United States Code, or of Indians  
2 for the medical benefits and services provided by or  
3 through the Indian Health Service.

4 **TITLE II—COMPREHENSIVE BEN-**  
5 **EFITS, INCLUDING PREVEN-**  
6 **TIVE BENEFITS AND BENE-**  
7 **FITS FOR LONG-TERM CARE**

8 **SEC. 201. COMPREHENSIVE BENEFITS.**

9 (a) IN GENERAL.—Subject to the succeeding provi-  
10 sions of this title, individuals enrolled for benefits under  
11 this Act are entitled to have payment made under a State  
12 health security program for the following items and serv-  
13 ices if medically necessary or appropriate for the mainte-  
14 nance of health or for the diagnosis, treatment, or rehabili-  
15 tation of a health condition:

16 (1) HOSPITAL SERVICES.—Inpatient and out-  
17 patient hospital care, including 24-hour-a-day emer-  
18 gency services.

19 (2) PROFESSIONAL SERVICES.—Professional  
20 services of health care practitioners authorized to  
21 provide health care services under State law, includ-  
22 ing patient education and training in self-manage-  
23 ment techniques.

1           (3) COMMUNITY-BASED PRIMARY HEALTH  
2 SERVICES.—Community-based primary health serv-  
3 ices (as defined in section 202(a)).

4           (4) PREVENTIVE SERVICES.—Preventive serv-  
5 ices (as defined in section 202(b)).

6           (5) LONG-TERM, ACUTE, AND CHRONIC CARE  
7 SERVICES.—

8                 (A) Nursing facility services.

9                 (B) Home health services.

10                (C) Home and community-based long-term  
11 care services (as defined in section 202(c)) for  
12 individuals described in section 203(a).

13                (D) Hospice care.

14                (E) Services in intermediate care facilities  
15 for individuals with mental retardation.

16           (6) PRESCRIPTION DRUGS, BIOLOGICALS, INSU-  
17 LIN, MEDICAL FOODS.—

18                 (A) Outpatient prescription drugs and bio-  
19 logics, as specified by the Board consistent with  
20 section 615.

21                 (B) Insulin.

22                 (C) Medical foods (as defined in section  
23 202(e)).

24           (7) DENTAL SERVICES.—Dental services (as de-  
25 fined in section 202(h)).

1           (8) MENTAL HEALTH AND SUBSTANCE ABUSE  
2 TREATMENT SERVICES.—Mental health and sub-  
3 stance abuse treatment services (as defined in sec-  
4 tion 202(f)).

5           (9) DIAGNOSTIC TESTS.—Diagnostic tests.

6           (10) OTHER ITEMS AND SERVICES.—

7           (A) OUTPATIENT THERAPY.—Outpatient  
8 physical therapy services, outpatient speech pa-  
9 thology services, and outpatient occupational  
10 therapy services in all settings.

11           (B) DURABLE MEDICAL EQUIPMENT.—Du-  
12 rable medical equipment.

13           (C) HOME DIALYSIS.—Home dialysis sup-  
14 plies and equipment.

15           (D) AMBULANCE.—Emergency ambulance  
16 service.

17           (E) PROSTHETIC DEVICES.—Prosthetic de-  
18 vices, including replacements of such devices.

19           (F) ADDITIONAL ITEMS AND SERVICES.—  
20 Such other medical or health care items or serv-  
21 ices as the Board may specify.

22 (b) COST-SHARING.—

23           (1) IN GENERAL.—Except as provided in this  
24 subsection, there are no deductibles, coinsurance, or

1 copayments applicable to acute care and preventive  
2 benefits provided under this title.

3 (2) COST-SHARING FOR LONG-TERM CARE  
4 SERVICES.—

5 (A) IN GENERAL.—

6 (i) payments for home and commu-  
7 nity-based long-term care services are sub-  
8 ject to coinsurance of 20 percent; and

9 (ii) payments for nursing facility serv-  
10 ices are subject to coinsurance of 35 per-  
11 cent.

12 (B) EXCEPTION.—With respect to the co-  
13 insurance established under subparagraph  
14 (A)—

15 (i) such coinsurance shall not apply to  
16 an individual with income (as defined by  
17 the Secretary) of not more than 100 per-  
18 cent of the income official poverty line ap-  
19 plicable to a family of the size involved;  
20 and

21 (ii) in the case of an individual with  
22 such income that exceeds 100 percent, but  
23 is less than 200 percent, of such applicable  
24 poverty line, the coinsurance shall be re-  
25 duced in the same proportion as the pro-



1                   portion of such income is less than 200  
2                   percent of such applicable poverty line.

3           (c) PROHIBITION OF BALANCE BILLING.—As pro-  
4 vided in section 531, no person may impose a charge for  
5 covered services for which benefits are provided under this  
6 Act.

7           (d) NO DUPLICATE HEALTH INSURANCE.—Each  
8 State health security program shall prohibit the sale of  
9 health insurance in the State if payment under the insur-  
10 ance duplicates payment for any items or services for  
11 which payment may be made under such a program.

12          (e) STATE PROGRAM MAY PROVIDE ADDITIONAL  
13 BENEFITS.—Nothing in this Act shall be construed as  
14 limiting the benefits that may be made available under a  
15 State health security program to residents of the State  
16 at the expense of the State.

17          (f) EMPLOYERS MAY PROVIDE ADDITIONAL BENE-  
18 FITS.—Nothing in this Act shall be construed as limiting  
19 the additional benefits that an employer may provide to  
20 employees or their dependents, or to former employees or  
21 their dependents.

22 **SEC. 202. DEFINITIONS RELATING TO SERVICES.**

23          (a) COMMUNITY-BASED PRIMARY HEALTH SERV-  
24 ICES.—In this title, the term “community-based primary

1 health services” means ambulatory health services fur-  
2 nished—

3 (1) by a rural health clinic;

4 (2) by a federally qualified health center (as de-  
5 fined in section 1905(l)(2)(B) of the Social Security  
6 Act), and which, for purposes of this Act, include  
7 services furnished by State and local health agencies;

8 (3) in a school-based setting;

9 (4) by public educational agencies and other  
10 providers of services to children entitled to assist-  
11 ance under the Individuals with Disabilities Edu-  
12 cation Act for services furnished pursuant to a writ-  
13 ten Individualized Family Services Plan or Indi-  
14 vidual Education Plan under such Act; and

15 (5) public and private nonprofit entities receiv-  
16 ing Federal assistance under the Public Health  
17 Service Act.

18 (b) PREVENTIVE SERVICES.—

19 (1) IN GENERAL.—In this title, the term “pre-  
20 ventive services” means items and services—

21 (A) which—

22 (i) are specified in paragraph (2); or

23 (ii) the Board determines to be effec-  
24 tive in the maintenance and promotion of

1 health or minimizing the effect of illness,  
2 disease, or medical condition; and

3 (B) which are provided consistent with the  
4 periodicity schedule established under para-  
5 graph (3).

6 (2) SPECIFIED PREVENTIVE SERVICES.—The  
7 services specified in this paragraph are as follows:

8 (A) Basic immunizations.

9 (B) Prenatal and well-baby care (for in-  
10 fants under 1 year of age).

11 (C) Well-child care (including periodic  
12 physical examinations, hearing and vision  
13 screening, and developmental screening and ex-  
14 aminations) for individuals under 18 years of  
15 age.

16 (D) Periodic screening mammography, Pap  
17 smears, and colorectal examinations and exami-  
18 nations for prostate cancer.

19 (E) Physical examinations.

20 (F) Family planning services.

21 (G) Routine eye examinations, eyeglasses,  
22 and contact lenses.

23 (H) Hearing aids, but only upon a deter-  
24 mination of a certified audiologist or physician  
25 that a hearing problem exists and is caused by

1 a condition that can be corrected by use of a  
2 hearing aid.

3 (3) SCHEDULE.—The Board shall establish, in  
4 consultation with experts in preventive medicine and  
5 public health and taking into consideration those  
6 preventive services recommended by the Preventive  
7 Services Task Force and published as the Guide to  
8 Clinical Preventive Services, a periodicity schedule  
9 for the coverage of preventive services under para-  
10 graph (1). Such schedule shall take into consider-  
11 ation the cost-effectiveness of appropriate preventive  
12 care and shall be revised not less frequently than  
13 once every 5 years, in consultation with experts in  
14 preventive medicine and public health.

15 (c) HOME AND COMMUNITY-BASED LONG-TERM  
16 CARE SERVICES.—In this title, the term “home and com-  
17 munity-based long-term care services” means the following  
18 services provided to an individual to enable the individual  
19 to remain in such individual’s place of residence within  
20 the community:

21 (1) Home health aide services.

22 (2) Adult day health care, social day care or  
23 psychiatric day care.

24 (3) Medical social work services.

1           (4) Care coordination services, as defined in  
2 subsection (g)(1).

3           (5) Respite care, including training for informal  
4 caregivers.

5           (6) Personal assistance services, and home-  
6 maker services (including meals) incidental to the  
7 provision of personal assistance services.

8 (d) HOME HEALTH SERVICES.—

9           (1) IN GENERAL.—The term “home health  
10 services” means items and services described in sec-  
11 tion 1861(m) of the Social Security Act and includes  
12 home infusion services.

13           (2) HOME INFUSION SERVICES.—The term  
14 “home infusion services” includes the nursing, phar-  
15 macy, and related services that are necessary to con-  
16 duct the home infusion of a drug regimen safely and  
17 effectively under a plan established and periodically  
18 reviewed by a physician and that are provided in  
19 compliance with quality assurance requirements es-  
20 tablished by the Secretary.

21           (e) MEDICAL FOODS.—In this title, the term “med-  
22 ical foods” means foods which are formulated to be con-  
23 sumed or administered enterally under the supervision of  
24 a physician and which are intended for the specific dietary  
25 management of a disease or condition for which distinctive

1 nutritional requirements, based on recognized scientific  
2 principles, are established by medical evaluation.

3 (f) MENTAL HEALTH AND SUBSTANCE ABUSE  
4 TREATMENT SERVICES.—

5 (1) SERVICES DESCRIBED.—In this title, the  
6 term “mental health and substance abuse treatment  
7 services” means the following services related to the  
8 prevention, diagnosis, treatment, and rehabilitation  
9 of mental illness and promotion of mental health:

10 (A) INPATIENT HOSPITAL SERVICES.—In-  
11 patient hospital services furnished primarily for  
12 the diagnosis or treatment of mental illness or  
13 substance abuse for up to 60 days during a  
14 year, reduced by a number of days determined  
15 by the Secretary so that the actuarial value of  
16 providing such number of days of services  
17 under this paragraph to the individual is equal  
18 to the actuarial value of the days of inpatient  
19 residential services furnished to the individual  
20 under subparagraph (B) during the year after  
21 such services have been furnished to the indi-  
22 vidual for 120 days during the year (rounded to  
23 the nearest day), but only if (with respect to  
24 services furnished to an individual described in  
25 section 204(b)(1)) such services are furnished

1 in conformity with the plan of an organized sys-  
2 tem of care for mental health and substance  
3 abuse services in accordance with section  
4 204(b)(2).

5 (B) INTENSIVE RESIDENTIAL SERVICES.—

6 Intensive residential services (as defined in  
7 paragraph (2)) furnished to an individual for  
8 up to 120 days during any calendar year, ex-  
9 cept that—

10 (i) such services may be furnished to  
11 the individual for additional days during  
12 the year if necessary for the individual to  
13 complete a course of treatment to the ex-  
14 tent that the number of days of inpatient  
15 hospital services described in subparagraph  
16 (A) that may be furnished to the individual  
17 during the year (as reduced under such  
18 subparagraph) is not less than 15; and

19 (ii) reduced by a number of days de-  
20 termined by the Secretary so that the actu-  
21 arial value of providing such number of  
22 days of services under this paragraph to  
23 the individual is equal to the actuarial  
24 value of the days of intensive community-  
25 based services furnished to the individual

1 under subparagraph (D) during the year  
2 after such services have been furnished to  
3 the individual for 90 days (or, in the case  
4 of services described in subparagraph  
5 (D)(ii), for 180 days) during the year  
6 (rounded to the nearest day).

7 (C) OUTPATIENT SERVICES.—Outpatient  
8 treatment services of mental illness or sub-  
9 stance abuse (other than intensive community-  
10 based services under subparagraph (D)) for an  
11 unlimited number of days during any calendar  
12 year furnished in accordance with standards es-  
13 tablished by the Secretary for the management  
14 of such services, and, in the case of services fur-  
15 nished to an individual described in section  
16 204(b)(1) who is not an inpatient of a hospital,  
17 in conformity with the plan of an organized sys-  
18 tem of care for mental health and substance  
19 abuse services in accordance with section  
20 204(b)(2).

21 (D) INTENSIVE COMMUNITY-BASED SERV-  
22 ICES.—Intensive community-based services (as  
23 described in paragraph (3))—

24 (i) for an unlimited number of days  
25 during any calendar year, in the case of



1 services described in section 1861(ff)(2)(E)  
2 that are furnished to an individual who is  
3 a seriously mentally ill adult, a seriously  
4 emotionally disturbed child, or an adult or  
5 child with serious substance abuse disorder  
6 (as determined in accordance with criteria  
7 established by the Secretary);

8 (ii) in the case of services described in  
9 section 1861(ff)(2)(C), for up to 180 days  
10 during any calendar year, except that such  
11 services may be furnished to the individual  
12 for a number of additional days during the  
13 year equal to the difference between the  
14 total number of days of intensive residen-  
15 tial services which the individual may re-  
16 ceive during the year under part A (as de-  
17 termined under subparagraph (B)) and the  
18 number of days of such services which the  
19 individual has received during the year; or

20 (iii) in the case of any other such  
21 services, for up to 90 days during any cal-  
22 endar year, except that such services may  
23 be furnished to the individual for the num-  
24 ber of additional days during the year de-  
25 scribed in clause (ii).

1           (2) INTENSIVE RESIDENTIAL SERVICES DE-  
2 FINED.—

3           (A) IN GENERAL.—Subject to subpara-  
4 graphs (B) and (C), the term “intensive resi-  
5 dential services” means inpatient services pro-  
6 vided in any of the following facilities:

7                   (i) Residential detoxification centers.

8                   (ii) Crisis residential programs or  
9 mental illness residential treatment pro-  
10 grams.

11                  (iii) Therapeutic family or group  
12 treatment homes.

13                  (iv) Residential centers for substance  
14 abuse treatment.

15           (B) REQUIREMENTS FOR FACILITIES.—No  
16 service may be treated as an intensive residen-  
17 tial service under subparagraph (A) unless the  
18 facility at which the service is provided—

19                   (i) is legally authorized to provide  
20 such service under the law of the State (or  
21 under a State regulatory mechanism pro-  
22 vided by State law) in which the facility is  
23 located or is certified to provide such serv-  
24 ice by an appropriate accreditation entity

1 approved by the State in consultation with  
2 the Secretary; and

3 (ii) meets such other requirements as  
4 the Secretary may impose to assure the  
5 quality of the intensive residential services  
6 provided.

7 (C) SERVICES FURNISHED TO AT-RISK  
8 CHILDREN.—In the case of services furnished  
9 to an individual described in section 204(b)(1),  
10 no service may be treated as an intensive resi-  
11 dential service under this subsection unless the  
12 service is furnished in conformity with the plan  
13 of an organized system of care for mental  
14 health and substance abuse services in accord-  
15 ance with section 204(b)(2).

16 (D) MANAGEMENT STANDARDS.—No serv-  
17 ice may be treated as an intensive residential  
18 service under subparagraph (A) unless the serv-  
19 ice is furnished in accordance with standards  
20 established by the Secretary for the manage-  
21 ment of such services.

22 (3) INTENSIVE COMMUNITY-BASED SERVICES  
23 DEFINED.—

24 (A) IN GENERAL.—The term “intensive  
25 community-based services” means the items

1 and services described in subparagraph (B) pre-  
2 scribed by a physician (or, in the case of serv-  
3 ices furnished to an individual described in sec-  
4 tion 204(b)(1), by an organized system of care  
5 for mental health and substance abuse services  
6 in accordance with such section) and provided  
7 under a program described in subparagraph  
8 (D) under the supervision of a physician (or, to  
9 the extent permitted under the law of the State  
10 in which the services are furnished, a non-phy-  
11 sician mental health professional) pursuant to  
12 an individualized, written plan of treatment es-  
13 tablished and periodically reviewed by a physi-  
14 cian (in consultation with appropriate staff par-  
15 ticipating in such program) which sets forth the  
16 physician's diagnosis, the type, amount, fre-  
17 quency, and duration of the items and services  
18 provided under the plan, and the goals for  
19 treatment under the plan, but does not include  
20 any item or service that is not furnished in ac-  
21 cordance with standards established by the Sec-  
22 retary for the management of such services.

23 (B) ITEMS AND SERVICES DESCRIBED.—

24 The items and services described in this sub-  
25 paragraph are—

- 1 (i) partial hospitalization services con-  
2 sisting of the items and services described  
3 in subparagraph (C);
- 4 (ii) psychiatric rehabilitation services;
- 5 (iii) day treatment services for indi-  
6 viduals under 19 years of age;
- 7 (iv) in-home services;
- 8 (v) case management services, includ-  
9 ing collateral services designated as such  
10 case management services by the Sec-  
11 retary;
- 12 (vi) ambulatory detoxification services;
- 13 and
- 14 (vii) such other items and services as  
15 the Secretary may provide (but in no event  
16 to include meals and transportation),  
17 that are reasonable and necessary for the diag-  
18 nosis or active treatment of the individual's  
19 condition, reasonably expected to improve or  
20 maintain the individual's condition and func-  
21 tional level and to prevent relapse or hos-  
22 pitalization, and furnished pursuant to such  
23 guidelines relating to frequency and duration of  
24 services as the Secretary shall by regulation es-  
25 tablish (taking into account accepted norms of

1 medical practice and the reasonable expectation  
2 of patient improvement).

3 (C) ITEMS AND SERVICES INCLUDED AS  
4 PARTIAL HOSPITALIZATION SERVICES.—For  
5 purposes of subparagraph (B)(i), partial hos-  
6 pitalization services consist of the following:

7 (i) Individual and group therapy with  
8 physicians or psychologists (or other men-  
9 tal health professionals to the extent au-  
10 thorized under State law).

11 (ii) Occupational therapy requiring  
12 the skills of a qualified occupational thera-  
13 pist.

14 (iii) Services of social workers, trained  
15 psychiatric nurses, behavioral aides, and  
16 other staff trained to work with psychiatric  
17 patients (to the extent authorized under  
18 State law).

19 (iv) Drugs and biologicals furnished  
20 for therapeutic purposes (which cannot, as  
21 determined in accordance with regulations,  
22 be self-administered).

23 (v) Individualized activity therapies  
24 that are not primarily recreational or di-  
25 versionary.

1 (vi) Family counseling (the primary  
2 purpose of which is treatment of the indi-  
3 vidual's condition).

4 (vii) Patient training and education  
5 (to the extent that training and edu-  
6 cational activities are closely and clearly  
7 related to the individual's care and treat-  
8 ment).

9 (viii) Diagnostic services.

10 (D) PROGRAMS DESCRIBED.—A program  
11 described in this subparagraph is a program  
12 (whether facility-based or freestanding) which is  
13 furnished by an entity—

14 (i) legally authorized to furnish such a  
15 program under State law (or the State reg-  
16 ulatory mechanism provided by State law)  
17 or certified to furnish such a program by  
18 an appropriate accreditation entity ap-  
19 proved by the State in consultation with  
20 the Secretary; and

21 (ii) meeting such other requirements  
22 as the Secretary may impose to assure the  
23 quality of the intensive community-based  
24 services provided.

25 (g) CARE COORDINATION SERVICES.—

1           (1) IN GENERAL.—In this title, the term “care  
2 coordination services” means services provided by  
3 care coordinators (as defined in paragraph (2)) to  
4 individuals described in paragraph (3) for the co-  
5 ordination and monitoring of home and community-  
6 based long term care services to ensure appropriate,  
7 cost-effective utilization of such services in a com-  
8 prehensive and continuous manner, and includes—

9           (A) transition management between inpa-  
10 tient facilities and community-based services,  
11 including assisting patients in identifying and  
12 gaining access to appropriate ancillary services;  
13 and

14           (B) evaluating and recommending appro-  
15 priate treatment services, in cooperation with  
16 patients and other providers and in conjunction  
17 with any quality review program or plan of care  
18 under section 205.

19           (2) CARE COORDINATOR.—

20           (A) IN GENERAL.—In this title, the term  
21 “care coordinator” means an individual or non-  
22 profit or public agency or organization which  
23 the State health security program determines—

24           (i) is capable of performing directly,  
25           efficiently, and effectively the duties of a



1 care coordinator described in paragraph  
2 (1); and

3 (ii) demonstrates capability in estab-  
4 lishing and periodically reviewing and re-  
5 vising plans of care, and in arranging for  
6 and monitoring the provision and quality  
7 of services under any plan.

8 (B) INDEPENDENCE.—State health secu-  
9 rity programs shall establish safeguards to as-  
10 sure that care coordinators have no financial in-  
11 terest in treatment decisions or placements.  
12 Care coordination may not be provided through  
13 any structure or mechanism through which  
14 quality review is performed.

15 (3) ELIGIBLE INDIVIDUALS.—An individual de-  
16 scribed in this paragraph is an individual described  
17 in section 203 (relating to individuals qualifying for  
18 long term and chronic care services).

19 (h) DENTAL SERVICES.—

20 (1) IN GENERAL.—In this title, subject to sub-  
21 section (b), the term “dental services” means the  
22 following:

23 (A) Emergency dental treatment, including  
24 extractions, for bleeding, pain, acute infections,  
25 and injuries to the maxillofacial region.

1           (B) Prevention and diagnosis of dental dis-  
2           ease, including examinations of the hard and  
3           soft tissues of the oral cavity and related struc-  
4           tures, radiographs, dental sealants, fluorides,  
5           and dental prophylaxis.

6           (C) Treatment of dental disease, including  
7           non-cast fillings, periodontal maintenance serv-  
8           ices, and endodontic services.

9           (D) Space maintenance procedures to pre-  
10          vent orthodontic complications.

11          (E) Orthodontic treatment to prevent se-  
12          vere malocclusions.

13          (F) Full dentures.

14          (G) Medically necessary oral health care.

15          (H) Any items and services for special  
16          needs patients that are not described in sub-  
17          paragraphs (A) through (G) and that—

18                 (i) are required to provide such pa-  
19                 tients the items and services described in  
20                 subparagraphs (A) through (G);

21                 (ii) are required to establish oral func-  
22                 tion (including general anesthesia for indi-  
23                 viduals with physical or emotional limita-  
24                 tions that prevent the provision of dental  
25                 care without such anesthesia);

1 (iii) consist of orthodontic care for se-  
2 vere dentofacial abnormalities; or

3 (iv) consist of prosthetic dental de-  
4 vices for genetic or birth defects or fitting  
5 for such devices.

6 (I) Any dental care for individuals with a  
7 seizure disorder that is not described in sub-  
8 paragraphs (A) through (H) and that is re-  
9 quired because of an illness, injury, disorder, or  
10 other health condition that results from such  
11 seizure disorder.

12 (2) LIMITATIONS.—Dental services are subject  
13 to the following limitations:

14 (A) PREVENTION AND DIAGNOSIS.—

15 (i) EXAMINATIONS AND PROPHY-  
16 LAXIS.—The examinations and prophylaxis  
17 described in paragraph (1)(B) are covered  
18 only consistent with a periodicity schedule  
19 established by the Board, which schedule  
20 may provide for special treatment of indi-  
21 viduals less than 18 years of age and of  
22 special needs patients.

23 (ii) DENTAL SEALANTS.—The dental  
24 sealants described in such paragraph are  
25 not covered for individuals 18 years of age

1 or older. Such sealants are covered for in-  
2 dividuals less than 10 years of age for pro-  
3 tection of the 1st permanent molars. Such  
4 sealants are covered for individuals 10  
5 years of age or older for protection of the  
6 2d permanent molars.

7 (B) TREATMENT OF DENTAL DISEASE.—

8 Prior to January 1, 2016, the items and serv-  
9 ices described in paragraph (1)(C) are covered  
10 only for individuals less than 18 years of age  
11 and special needs patients. On or after such  
12 date, such items and services are covered for all  
13 individuals enrolled for benefits under this Act,  
14 except that endodontic services are not covered  
15 for individuals 18 years of age or older.

16 (C) SPACE MAINTENANCE.—The items and  
17 services described in paragraph (1)(D) are cov-  
18 ered only for individuals at least 3 years of age,  
19 but less than 13 years of age and—

20 (i) are limited to posterior teeth;

21 (ii) involve maintenance of a space or  
22 spaces for permanent posterior teeth that  
23 would otherwise be prevented from normal  
24 eruption if the space were not maintained;  
25 and

1 (iii) do not include a space maintainer  
2 that is placed within 6 months of the ex-  
3 pected eruption of the permanent posterior  
4 tooth concerned.

5 (D) ORTHODONTIC TREATMENT.—Prior to  
6 January 1, 2016, the items and services de-  
7 scribed in paragraph (1)(E) are covered only  
8 for individuals at least 6 years of age, but less  
9 than 12 years of age, who have severe  
10 dentofacial abnormalities. On or after such  
11 date, such items and services are covered only  
12 for individuals at least 6 years of age, but less  
13 than 12 years of age.

14 (E) DENTURES.—Prior to January 1,  
15 2016, the dentures described in paragraph  
16 (1)(F) are not covered, except for special needs  
17 patients. On or after such date, dentures are  
18 covered for an individual consistent with a peri-  
19 odicity schedule established by the Board, ex-  
20 cept that the limitation of periodicity provided  
21 in such schedule shall not apply to a special  
22 needs patient.

23 (3) DEFINITIONS.—For purposes of this title:

24 (A) MEDICALLY NECESSARY ORAL HEALTH  
25 CARE.—The term “medically necessary oral

1 health care” means oral health care that is re-  
2 quired as a direct result of, or would have a di-  
3 rect impact on, an underlying medical condi-  
4 tion. Such term includes oral health care di-  
5 rected toward control or elimination of pain, in-  
6 fection, or reestablishment of oral function.

7 (B) SPECIAL NEEDS PATIENT.—The term  
8 “special needs patient” includes an individual  
9 with a genetic or birth defect, a developmental  
10 disability, or an acquired medical disability.

11 (i) NURSING FACILITY; NURSING FACILITY SERV-  
12 ICES.—Except as may be provided by the Board, the  
13 terms “nursing facility” and “nursing facility services”  
14 have the meanings given such terms in sections 1919(a)  
15 and 1905(f), respectively, of the Social Security Act.

16 (j) SERVICES IN INTERMEDIATE CARE FACILITIES  
17 FOR INDIVIDUALS WITH MENTAL RETARDATION.—Ex-  
18 cept as may be provided by the Board—

19 (1) the term “intermediate care facility for indi-  
20 viduals with mental retardation” has the meaning  
21 specified in section 1905(d) of the Social Security  
22 Act (as in effect before the enactment of this Act);  
23 and

24 (2) the term “services in intermediate care fa-  
25 cilities for individuals with mental retardation”

1 means services described in section 1905(a)(15) of  
2 such Act (as so in effect) in an intermediate care fa-  
3 cility for individuals with mental retardation to an  
4 individual determined to require such services in ac-  
5 cordance with standards specified by the Board and  
6 comparable to the standards described in section  
7 1902(a)(31)(A) of such Act (as so in effect).

8 (k) OTHER TERMS.—Except as may be provided by  
9 the Board, the definitions contained in section 1861 of the  
10 Social Security Act shall apply.

11 **SEC. 203. SPECIAL RULES FOR HOME AND COMMUNITY-**  
12 **BASED LONG-TERM CARE SERVICES.**

13 (a) QUALIFYING INDIVIDUALS.—For purposes of sec-  
14 tion 201(a)(5)(C), individuals described in this subsection  
15 are the following individuals:

16 (1) ADULTS.—Individuals 18 years of age or  
17 older determined (in a manner specified by the  
18 Board)—

19 (A) to be unable to perform, without the  
20 assistance of an individual, at least 2 of the fol-  
21 lowing 5 activities of daily living (or who has a  
22 similar level of disability due to cognitive im-  
23 pairment)—

24 (i) bathing;

25 (ii) eating;

- 1 (iii) dressing;  
2 (iv) toileting; and  
3 (v) transferring in and out of a bed or  
4 in and out of a chair;

5 (B) due to cognitive or mental impair-  
6 ments, to require supervision because the indi-  
7 vidual behaves in a manner that poses health or  
8 safety hazards to himself or herself or others;  
9 or

10 (C) due to cognitive or mental impair-  
11 ments, to require queuing to perform activities  
12 of daily living.

13 (2) CHILDREN.—Individuals under 18 years of  
14 age determined (in a manner specified by the Board)  
15 to meet such alternative standard of disability for  
16 children as the Board develops. Such alternative  
17 standard shall be comparable to the standard for  
18 adults and appropriate for children.

19 (b) LIMIT ON SERVICES.—

20 (1) IN GENERAL.—The aggregate expenditures  
21 by a State health security program with respect to  
22 home and community-based long-term care services  
23 in a period (specified by the Board) may not exceed  
24 65 percent (or such alternative ratio as the Board  
25 establishes under paragraph (2)) of the average of



1 the amount of payment that would have been made  
2 under the program during the period if all the home-  
3 based long-term care beneficiaries had been resi-  
4 dents of nursing facilities in the same area in which  
5 the services were provided.

6 (2) ALTERNATIVE RATIO.—The Board may es-  
7 tablish for purposes of paragraph (1) an alternative  
8 ratio (of payments for home and community-based  
9 long term care services to payments for nursing fa-  
10 cility services) as the Board determines to be more  
11 consistent with the goal of providing cost-effective  
12 long-term care in the most appropriate and least re-  
13 strictive setting.

14 **SEC. 204. EXCLUSIONS AND LIMITATIONS.**

15 (a) IN GENERAL.—Subject to section 201(e), benefits  
16 for service are not available under this Act unless the serv-  
17 ices meet the standards specified in section 201(a).

18 (b) SPECIAL DELIVERY REQUIREMENTS FOR MEN-  
19 TAL HEALTH AND SUBSTANCE ABUSE TREATMENT SERV-  
20 ICES PROVIDED TO AT-RISK CHILDREN.—

21 (1) REQUIRING SERVICES TO BE PROVIDED  
22 THROUGH ORGANIZED SYSTEMS OF CARE.—A State  
23 health security program shall ensure that mental  
24 health services and substance abuse treatment serv-

1       ices are furnished through an organized system of  
2       care, as described in paragraph (2), if—

3               (A) the services are provided to an indi-  
4       vidual less than 22 years of age;

5               (B) the individual has a serious emotional  
6       disturbance or a substance abuse disorder; and

7               (C) the individual is, or is at imminent risk  
8       of being, subject to the authority of, or in need  
9       of the services of, at least 1 public agency that  
10      serves the needs of children, including an agen-  
11      cy involved with child welfare, special education,  
12      juvenile justice, or criminal justice.

13           (2) REQUIREMENTS FOR SYSTEM OF CARE.—In  
14      this subsection, an “organized system of care” is a  
15      community-based service delivery network, which  
16      may consist of public and private providers, that  
17      meets the following requirements:

18               (A) The system has established linkages  
19      with existing mental health services and sub-  
20      stance abuse treatment service delivery pro-  
21      grams in the plan service area (or is in the  
22      process of developing or operating a system  
23      with appropriate public agencies in the area to  
24      coordinate the delivery of such services to indi-  
25      viduals in the area).

1           (B) The system provides for the participa-  
2           tion and coordination of multiple agencies and  
3           providers that serve the needs of children in the  
4           area, including agencies and providers involved  
5           with child welfare, education, juvenile justice,  
6           criminal justice, health care, mental health, and  
7           substance abuse prevention and treatment.

8           (C) The system provides for the involve-  
9           ment of the families of children to whom mental  
10          health services and substance abuse treatment  
11          services are provided in the planning of treat-  
12          ment and the delivery of services.

13          (D) The system provides for the develop-  
14          ment and implementation of individualized  
15          treatment plans by multidisciplinary and multi-  
16          agency teams, which are recognized and fol-  
17          lowed by the applicable agencies and providers  
18          in the area.

19          (E) The system ensures the delivery and  
20          coordination of the range of mental health serv-  
21          ices and substance abuse treatment services re-  
22          quired by individuals under 22 years of age who  
23          have a serious emotional disturbance or a sub-  
24          stance abuse disorder.

1           (F) The system provides for the manage-  
2           ment of the individualized treatment plans de-  
3           scribed in subparagraph (D) and for a flexible  
4           response to changes in treatment needs over  
5           time.

6           (c) TREATMENT OF EXPERIMENTAL SERVICES.—In  
7           applying subsection (a), the Board shall make national  
8           coverage determinations with respect to those services that  
9           are experimental in nature. Such determinations shall be  
10          made consistent with a process that provides for input  
11          from representatives of health care professionals and pa-  
12          tients and public comment.

13          (d) APPLICATION OF PRACTICE GUIDELINES.—In  
14          the case of services for which the American Health Secu-  
15          rity Quality Council (established under section 501) has  
16          recognized a national practice guideline, the services are  
17          considered to meet the standards specified in section  
18          201(a) if they have been provided in accordance with such  
19          guideline or in accordance with such guidelines as are pro-  
20          vided by the State health security program consistent with  
21          title V. For purposes of this subsection, a service shall  
22          be considered to have been provided in accordance with  
23          a practice guideline if the health care provider providing  
24          the service exercised appropriate professional discretion to

1 deviate from the guideline in a manner authorized or an-  
2 ticipated by the guideline.

3 (e) SPECIFIC LIMITATIONS.—

4 (1) LIMITATIONS ON EYEGLASSES, CONTACT  
5 LENSES, HEARING AIDS, AND DURABLE MEDICAL  
6 EQUIPMENT.—Subject to section 201(e), the Board  
7 may impose such limits relating to the costs and fre-  
8 quency of replacement of eyeglasses, contact lenses,  
9 hearing aids, and durable medical equipment to  
10 which individuals enrolled for benefits under this Act  
11 are entitled to have payment made under a State  
12 health security program as the Board deems appro-  
13 priate.

14 (2) OVERLAP WITH PREVENTIVE SERVICES.—

15 The coverage of services described in section 201(a)  
16 (other than paragraph (3)) which also are preventive  
17 services are required to be covered only to the extent  
18 that they are required to be covered as preventive  
19 services.

20 (3) MISCELLANEOUS EXCLUSIONS FROM COV-

21 ERED SERVICES.—Covered services under this Act  
22 do not include the following:

23 (A) Surgery and other procedures (such as  
24 orthodontia) performed solely for cosmetic pur-

1 poses (as defined in regulations) and hospital or  
2 other services incident thereto, unless—

3 (i) required to correct a congenital  
4 anomaly;

5 (ii) required to restore or correct a  
6 part of the body which has been altered as  
7 a result of accidental injury, disease, or  
8 surgery; or

9 (iii) otherwise determined to be medi-  
10 cally necessary and appropriate under sec-  
11 tion 201(a).

12 (B) Personal comfort items or private  
13 rooms in inpatient facilities, unless determined  
14 to be medically necessary and appropriate  
15 under section 201(a).

16 (C) The services of a professional practi-  
17 tioner if they are furnished in a hospital or  
18 other facility which is not a participating pro-  
19 vider.

20 (f) NURSING FACILITY SERVICES AND HOME  
21 HEALTH SERVICES.—Nursing facility services and home  
22 health services (other than post-hospital services, as de-  
23 fined by the Board) furnished to an individual who is not  
24 described in section 203(a) are not covered services unless  
25 the services are determined to meet the standards speci-

1 fied in section 201(a) and, with respect to nursing facility  
2 services, to be provided in the least restrictive and most  
3 appropriate setting.

4 **SEC. 205. CERTIFICATION; QUALITY REVIEW; PLANS OF**  
5 **CARE.**

6 (a) CERTIFICATIONS.—State health security pro-  
7 grams may require, as a condition of payment for institu-  
8 tional health care services and other services of the type  
9 described in such sections 1814(a) and 1835(a) of the So-  
10 cial Security Act, periodic professional certifications of the  
11 kind described in such sections.

12 (b) QUALITY REVIEW.—For requirement that each  
13 State health security program establish a quality review  
14 program that meets the requirements for such a program  
15 under title V, see section 404(b)(1)(H).

16 (c) PLAN OF CARE REQUIREMENTS.—A State health  
17 security program may require, consistent with standards  
18 established by the Board, that payment for services ex-  
19 ceeding specified levels or duration be provided only as  
20 consistent with a plan of care or treatment formulated by  
21 one or more providers of the services or other qualified  
22 professionals. Such a plan may include, consistent with  
23 subsection (b), case management at specified intervals as  
24 a further condition of payment for services.

1                   **TITLE III—PROVIDER**  
2                   **PARTICIPATION**

3 **SEC. 301. PROVIDER PARTICIPATION AND STANDARDS.**

4           (a) IN GENERAL.—An individual or other entity fur-  
5 nishing any covered service under a State health security  
6 program under this Act is not a qualified provider unless  
7 the individual or entity—

8                   (1) is a qualified provider of the services under  
9                   section 302;

10                   (2) has filed with the State health security pro-  
11                   gram a participation agreement described in sub-  
12                   section (b); and

13                   (3) meets such other qualifications and condi-  
14                   tions as are established by the Board or the State  
15                   health security program under this Act.

16           (b) REQUIREMENTS IN PARTICIPATION AGREE-  
17 MENT.—

18                   (1) IN GENERAL.—A participation agreement  
19                   described in this subsection between a State health  
20                   security program and a provider shall provide at  
21                   least for the following:

22                           (A) Services to eligible persons will be fur-  
23                           nished by the provider without discrimination  
24                           on the ground of race, national origin, income,  
25                           religion, age, sex or sexual orientation, dis-



1 ability, handicapping condition, or (subject to  
2 the professional qualifications of the provider)  
3 illness. Nothing in this subparagraph shall be  
4 construed as requiring the provision of a type  
5 or class of services which services are outside  
6 the scope of the provider's normal practice.

7 (B) No charge will be made for any cov-  
8 ered services other than for payment authorized  
9 by this Act.

10 (C) The provider agrees to furnish such in-  
11 formation as may be reasonably required by the  
12 Board or a State health security program, in  
13 accordance with uniform reporting standards  
14 established under section 401(g)(1), for—

15 (i) quality review by designated enti-  
16 ties;

17 (ii) the making of payments under  
18 this Act (including the examination of  
19 records as may be necessary for the  
20 verification of information on which pay-  
21 ments are based);

22 (iii) statistical or other studies re-  
23 quired for the implementation of this Act;  
24 and

1 (iv) such other purposes as the Board  
2 or State may specify.

3 (D) The provider agrees not to bill the pro-  
4 gram for any services for which benefits are not  
5 available because of section 204(d).

6 (E) In the case of a provider that is not  
7 an individual, the provider agrees not to employ  
8 or use for the provision of health services any  
9 individual or other provider who or which has  
10 had a participation agreement under this sub-  
11 section terminated for cause.

12 (F) In the case of a provider paid under a  
13 fee-for-service basis under section 612, the pro-  
14 vider agrees to submit bills and any required  
15 supporting documentation relating to the provi-  
16 sion of covered services within 30 days (or such  
17 shorter period as a State health security pro-  
18 gram may require) after the date of providing  
19 such services.

20 (2) TERMINATION OF PARTICIPATION AGREE-  
21 MENTS.—

22 (A) IN GENERAL.—Participation agree-  
23 ments may be terminated, with appropriate no-  
24 tice—

1 (i) by the Board or a State health se-  
2 curity program for failure to meet the re-  
3 quirements of this title; or

4 (ii) by a provider.

5 (B) TERMINATION PROCESS.—Providers  
6 shall be provided notice and a reasonable oppor-  
7 tunity to correct deficiencies before the Board  
8 or a State health security program terminates  
9 an agreement unless a more immediate termi-  
10 nation is required for public safety or similar  
11 reasons.

12 **SEC. 302. QUALIFICATIONS FOR PROVIDERS.**

13 (a) IN GENERAL.—A health care provider is consid-  
14 ered to be qualified to provide covered services if the pro-  
15 vider is licensed or certified and meets—

16 (1) all the requirements of State law to provide  
17 such services;

18 (2) applicable requirements of Federal law to  
19 provide such services; and

20 (3) any applicable standards established under  
21 subsection (b).

22 (b) MINIMUM PROVIDER STANDARDS.—

23 (1) IN GENERAL.—The Board shall establish,  
24 evaluate, and update national minimum standards to  
25 assure the quality of services provided under this

1 Act and to monitor efforts by State health security  
2 programs to assure the quality of such services. A  
3 State health security program may also establish ad-  
4 ditional minimum standards which providers must  
5 meet.

6 (2) NATIONAL MINIMUM STANDARDS.—The na-  
7 tional minimum standards under paragraph (1) shall  
8 be established for institutional providers of services,  
9 individual health care practitioners, and comprehen-  
10 sive health service organizations. Except as the  
11 Board may specify in order to carry out this title,  
12 a hospital, nursing facility, or other institutional  
13 provider of services shall meet standards for such a  
14 facility under the medicare program under title  
15 XVIII of the Social Security Act. Such standards  
16 also may include, where appropriate, elements relat-  
17 ing to—

- 18 (A) adequacy and quality of facilities;  
19 (B) training and competence of personnel  
20 (including continuing education requirements);  
21 (C) comprehensiveness of service;  
22 (D) continuity of service;  
23 (E) patient satisfaction (including waiting  
24 time and access to services); and

1 (F) performance standards (including or-  
2 ganization, facilities, structure of services, effi-  
3 ciency of operation, and outcome in palliation,  
4 improvement of health, stabilization, cure, or  
5 rehabilitation).

6 (3) TRANSITION IN APPLICATION.—If the  
7 Board provides for additional requirements for pro-  
8 viders under this subsection, any such additional re-  
9 quirement shall be implemented in a manner that  
10 provides for a reasonable period during which a pre-  
11 viously qualified provider is permitted to meet such  
12 an additional requirement.

13 (4) EXCHANGE OF INFORMATION.—The Board  
14 shall provide for an exchange, at least annually,  
15 among State health security programs of informa-  
16 tion with respect to quality assurance and cost con-  
17 tainment.

18 **SEC. 303. QUALIFICATIONS FOR COMPREHENSIVE HEALTH**  
19 **SERVICE ORGANIZATIONS.**

20 (a) IN GENERAL.—For purposes of this Act, a com-  
21 prehensive health service organization (in this section re-  
22 ferred to as a “CHSO”) is a public or private organization  
23 which, in return for a capitated payment amount, under-  
24 takes to furnish, arrange for the provision of, or provide  
25 payment with respect to—

1           (1) a full range of health services (as identified  
2           by the Board), including at least hospital services  
3           and physicians services; and

4           (2) out-of-area coverage in the case of urgently  
5           needed services;

6           to an identified population which is living in or near a  
7           specified service area and which enrolls voluntarily in the  
8           organization.

9           (b) ENROLLMENT.—

10           (1) IN GENERAL.—All eligible persons living in  
11           or near the specified service area of a CHSO are eli-  
12           gible to enroll in the organization; except that the  
13           number of enrollees may be limited to avoid over-  
14           taxing the resources of the organization.

15           (2) MINIMUM ENROLLMENT PERIOD.—Subject  
16           to paragraph (3), the minimum period of enrollment  
17           with a CHSO shall be twelve months, unless the en-  
18           rolled individual becomes ineligible to enroll with the  
19           organization.

20           (3) WITHDRAWAL FOR CAUSE.—Each CHSO  
21           shall permit an enrolled individual to disenroll from  
22           the organization for cause at any time.

23           (c) REQUIREMENTS FOR CHSOS.—

24           (1) ACCESSIBLE SERVICES.—Each CHSO, to  
25           the maximum extent feasible, shall make all services

1 readily and promptly accessible to enrollees who live  
2 in the specified service area.

3 (2) CONTINUITY OF CARE.—Each CHSO shall  
4 furnish services in such manner as to provide con-  
5 tinuity of care and (when services are furnished by  
6 different providers) shall provide ready referral of  
7 patients to such services and at such times as may  
8 be medically appropriate.

9 (3) BOARD OF DIRECTORS.—In the case of a  
10 CHSO that is a private organization—

11 (A) CONSUMER REPRESENTATION.—At  
12 least one-third of the members of the CHSO's  
13 board of directors must be consumer members  
14 with no direct or indirect, personal or family fi-  
15 nancial relationship to the organization.

16 (B) PROVIDER REPRESENTATION.—The  
17 CHSO's board of directors must include at  
18 least one member who represents health care  
19 providers.

20 (4) PATIENT GRIEVANCE PROGRAM.—Each  
21 CHSO must have in effect a patient grievance pro-  
22 gram and must conduct regularly surveys of the sat-  
23 isfaction of members with services provided by or  
24 through the organization.

1           (5) MEDICAL STANDARDS.—Each CHSO must  
2 provide that a committee or committees of health  
3 care practitioners associated with the organization  
4 will promulgate medical standards, oversee the pro-  
5 fessional aspects of the delivery of care, perform the  
6 functions of a pharmacy and drug therapeutics com-  
7 mittee, and monitor and review the quality of all  
8 health services (including drugs, education, and pre-  
9 ventive services).

10           (6) PREMIUMS.—Premiums or other charges by  
11 a CHSO for any services not paid for under this Act  
12 must be reasonable.

13           (7) UTILIZATION AND BONUS INFORMATION.—  
14 Each CHSO must—

15           (A) comply with the requirements of sec-  
16 tion 1876(i)(8) of the Social Security Act (re-  
17 lating to prohibiting physician incentive plans  
18 that provide specific inducements to reduce or  
19 limit medically necessary services); and

20           (B) make available to its membership utili-  
21 zation information and data regarding financial  
22 performance, including bonus or incentive pay-  
23 ment arrangements to practitioners.

24           (8) PROVISION OF SERVICES TO ENROLLEES AT  
25 INSTITUTIONS OPERATING UNDER GLOBAL BUDG-



1       ETS.—The organization shall arrange to reimburse  
2       for hospital services and other facility-based services  
3       (as identified by the Board) for services provided to  
4       members of the organization in accordance with the  
5       global operating budget of the hospital or facility ap-  
6       proved under section 611.

7               (9) BROAD MARKETING.—Each CHSO must  
8       provide for the marketing of its services (including  
9       dissemination of marketing materials) to potential  
10      enrollees in a manner that is designed to enroll indi-  
11      viduals representative of the different population  
12      groups and geographic areas included within its  
13      service area and meets such requirements as the  
14      Board or a State health security program may speci-  
15      fy.

16              (10) ADDITIONAL REQUIREMENTS.—Each  
17      CHSO must meet—

18                      (A) such requirements relating to min-  
19                      imum enrollment;

20                      (B) such requirements relating to financial  
21                      solvency;

22                      (C) such requirements relating to quality  
23                      and availability of care; and

24                      (D) such other requirements,

1 as the Board or a State health security program  
2 may specify.

3 (d) PROVISION OF EMERGENCY SERVICES TO NON-  
4 ENROLLEES.—A CHSO may furnish emergency services  
5 to persons who are not enrolled in the organization. Pay-  
6 ment for such services, if they are covered services to eligi-  
7 ble persons, shall be made to the organization unless the  
8 organization requests that it be made to the individual  
9 provider who furnished the services.

10 **SEC. 304. LIMITATION ON CERTAIN PHYSICIAN REFERRALS.**

11 (a) APPLICATION TO AMERICAN HEALTH SECURITY  
12 PROGRAM.—Section 1877 of the Social Security Act, as  
13 amended by subsections (b) and (c), shall apply under this  
14 Act in the same manner as it applies under title XVIII  
15 of the Social Security Act; except that in applying such  
16 section under this Act any references in such section to  
17 the Secretary or title XVIII of the Social Security Act are  
18 deemed references to the Board and the American Health  
19 Security Program under this Act, respectively.

20 (b) EXPANSION OF PROHIBITION TO CERTAIN ADDI-  
21 TIONAL DESIGNATED SERVICES.—Section 1877(h)(6) of  
22 the Social Security Act (42 U.S.C. 1395nn(h)(6)) is  
23 amended by adding at the end the following:

24 “(M) Ambulance services.

25 “(N) Home infusion therapy services.”.

1 (c) CONFORMING AMENDMENTS.—Section 1877 of  
2 such Act is further amended—

3 (1) in subsection (a)(1)(A), by striking “for  
4 which payment otherwise may be made under this  
5 title” and inserting “for which a charge is imposed”;

6 (2) in subsection (a)(1)(B), by striking “under  
7 this title”;

8 (3) by amending paragraph (1) of subsection  
9 (g) to read as follows:

10 “(1) DENIAL OF PAYMENT.—No payment may  
11 be made under a State health security program for  
12 a designated health service for which a claim is pre-  
13 sented in violation of subsection (a)(1)(B). No indi-  
14 vidual, third party payor, or other entity is liable for  
15 payment for designated health services for which a  
16 claim is presented in violation of such subsection.”;  
17 and

18 (4) in subsection (g)(3), by striking “for which  
19 payment may not be made under paragraph (1)”  
20 and inserting “for which such a claim may not be  
21 presented under subsection (a)(1)”.

1       **TITLE IV—ADMINISTRATION**  
2       **Subtitle A—General Administrative**  
3       **Provisions**

4       **SEC. 401. AMERICAN HEALTH SECURITY STANDARDS**  
5       **BOARD.**

6       (a) ESTABLISHMENT.—There is hereby established  
7 an American Health Security Standards Board.

8       (b) APPOINTMENT AND TERMS OF MEMBERS.—

9           (1) IN GENERAL.—The Board shall be com-  
10 posed of—

11           (A) the Secretary of Health and Human  
12 Services; and

13           (B) 6 other individuals (described in para-  
14 graph (2)) appointed by the President with the  
15 advice and consent of the Senate.

16       The President shall first nominate individuals under  
17 subparagraph (B) on a timely basis so as to provide  
18 for the operation of the Board by not later than  
19 January 1, 2010.

20       (2) SELECTION OF APPOINTED MEMBERS.—

21       With respect to the individuals appointed under  
22 paragraph (1)(B):

23           (A) They shall be chosen on the basis of  
24 backgrounds in health policy, health economics,

1 the healing professions, and the administration  
2 of health care institutions.

3 (B) They shall provide a balanced point of  
4 view with respect to the various health care in-  
5 terests and at least 2 of them shall represent  
6 the interests of individual consumers.

7 (C) Not more than 3 of them shall be from  
8 the same political party.

9 (D) To the greatest extent feasible, they  
10 shall represent the various geographic regions  
11 of the United States and shall reflect the racial,  
12 ethnic, and gender composition of the popu-  
13 lation of the United States.

14 (3) TERMS OF APPOINTED MEMBERS.—Individ-  
15 uals appointed under paragraph (1)(B) shall serve  
16 for a term of 6 years, except that the terms of 5 of  
17 the individuals initially appointed shall be, as des-  
18 ignated by the President at the time of their ap-  
19 pointment, for 1, 2, 3, 4, and 5 years. During a  
20 term of membership on the Board, no member shall  
21 engage in any other business, vocation or employ-  
22 ment.

23 (c) VACANCIES.—

24 (1) IN GENERAL.—The President shall fill any  
25 vacancy in the membership of the Board in the same

1 manner as the original appointment. The vacancy  
2 shall not affect the power of the remaining members  
3 to execute the duties of the Board.

4 (2) VACANCY APPOINTMENTS.—Any member  
5 appointed to fill a vacancy shall serve for the re-  
6 mainder of the term for which the predecessor of the  
7 member was appointed.

8 (3) REAPPOINTMENT.—The President may re-  
9 appoint an appointed member of the Board for a  
10 second term in the same manner as the original ap-  
11 pointment. A member who has served for 2 consecu-  
12 tive 6-year terms shall not be eligible for reappoint-  
13 ment until 2 years after the member has ceased to  
14 serve.

15 (4) REMOVAL FOR CAUSE.—Upon confirmation,  
16 members of the Board may not be removed except  
17 by the President for cause.

18 (d) CHAIR.—The President shall designate 1 of the  
19 members of the Board, other than the Secretary, to serve  
20 at the will of the President as Chair of the Board.

21 (e) COMPENSATION.—Members of the Board (other  
22 than the Secretary) shall be entitled to compensation at  
23 a level equivalent to level II of the Executive Schedule,  
24 in accordance with section 5313 of title 5, United States  
25 Code.

1 (f) GENERAL DUTIES OF THE BOARD.—

2 (1) IN GENERAL.—The Board shall develop  
3 policies, procedures, guidelines, and requirements to  
4 carry out this Act, including those related to—

5 (A) eligibility;

6 (B) enrollment;

7 (C) benefits;

8 (D) provider participation standards and  
9 qualifications, as defined in title III;

10 (E) national and State funding levels;

11 (F) methods for determining amounts of  
12 payments to providers of covered services, con-  
13 sistent with subtitle B of title VI;

14 (G) the determination of medical necessity  
15 and appropriateness with respect to coverage of  
16 certain services;

17 (H) assisting State health security pro-  
18 grams with planning for capital expenditures  
19 and service delivery;

20 (I) planning for health professional edu-  
21 cation funding (as specified in title VI);

22 (J) allocating funds provided under title  
23 VII; and

1           (K) encouraging States to develop regional  
2           planning mechanisms (described in section  
3           404(a)(3)).

4           (2) REGULATIONS.—Regulations authorized by  
5           this Act shall be issued by the Board in accordance  
6           with the provisions of section 553 of title 5, United  
7           States Code.

8           (g) UNIFORM REPORTING STANDARDS; ANNUAL RE-  
9           PORT; STUDIES.—

10           (1) UNIFORM REPORTING STANDARDS.—

11           (A) IN GENERAL.—The Board shall estab-  
12           lish uniform reporting requirements and stand-  
13           ards to ensure an adequate national data base  
14           regarding health services practitioners, services  
15           and finances of State health security programs,  
16           approved plans, providers, and the costs of fa-  
17           cilities and practitioners providing services.  
18           Such standards shall include, to the maximum  
19           extent feasible, health outcome measures.

20           (B) REPORTS.—The Board shall analyze  
21           regularly information reported to it, and to  
22           State health security programs pursuant to  
23           such requirements and standards.

24           (2) ANNUAL REPORT.—Beginning January 1,  
25           of the second year beginning after the date of the



1 enactment of this Act, the Board shall annually re-  
2 port to Congress on the following:

3 (A) The status of implementation of the  
4 Act.

5 (B) Enrollment under this Act.

6 (C) Benefits under this Act.

7 (D) Expenditures and financing under this  
8 Act.

9 (E) Cost-containment measures and  
10 achievements under this Act.

11 (F) Quality assurance.

12 (G) Health care utilization patterns, in-  
13 cluding any changes attributable to the pro-  
14 gram.

15 (H) Long-range plans and goals for the de-  
16 livery of health services.

17 (I) Differences in the health status of the  
18 populations of the different States, including in-  
19 come and racial characteristics.

20 (J) Necessary changes in the education of  
21 health personnel.

22 (K) Plans for improving service to medi-  
23 cally underserved populations.

24 (L) Transition problems as a result of im-  
25 plementation of this Act.

1 (M) Opportunities for improvements under  
2 this Act.

3 (3) STATISTICAL ANALYSES AND OTHER STUD-  
4 IES.—The Board may, either directly or by con-  
5 tract—

6 (A) make statistical and other studies, on  
7 a nationwide, regional, state, or local basis, of  
8 any aspect of the operation of this Act, includ-  
9 ing studies of the effect of the Act upon the  
10 health of the people of the United States and  
11 the effect of comprehensive health services upon  
12 the health of persons receiving such services;

13 (B) develop and test methods of providing  
14 through payment for services or otherwise, ad-  
15 ditional incentives for adherence by providers to  
16 standards of adequacy, access, and quality;  
17 methods of consumer and peer review and peer  
18 control of the utilization of drugs, of laboratory  
19 services, and of other services; and methods of  
20 consumer and peer review of the quality of serv-  
21 ices;

22 (C) develop and test, for use by the Board,  
23 records and information retrieval systems and  
24 budget systems for health services administra-

1           tion, and develop and test model systems for  
2           use by providers of services;

3           (D) develop and test, for use by providers  
4           of services, records and information retrieval  
5           systems useful in the furnishing of preventive  
6           or diagnostic services;

7           (E) develop, in collaboration with the phar-  
8           maceutical profession, and test, improved ad-  
9           ministrative practices or improved methods for  
10          the reimbursement of independent pharmacies  
11          for the cost of furnishing drugs as a covered  
12          service; and

13          (F) make such other studies as it may con-  
14          sider necessary or promising for the evaluation,  
15          or for the improvement, of the operation of this  
16          Act.

17          (4) REPORT ON USE OF EXISTING FEDERAL  
18          HEALTH CARE FACILITIES.—Not later than 1 year  
19          after the date of the enactment of this Act, the  
20          Board shall recommend to the Congress one or more  
21          proposals for the treatment of health care facilities  
22          of the Federal Government.

23          (h) EXECUTIVE DIRECTOR.—

24                (1) APPOINTMENT.—There is hereby estab-  
25          lished the position of Executive Director of the

1 Board. The Director shall be appointed by the  
2 Board and shall serve as secretary to the Board and  
3 perform such duties in the administration of this  
4 title as the Board may assign.

5 (2) DELEGATION.—The Board is authorized to  
6 delegate to the Director or to any other officer or  
7 employee of the Board or, with the approval of the  
8 Secretary of Health and Human Services (and sub-  
9 ject to reimbursement of identifiable costs), to any  
10 other officer or employee of the Department of  
11 Health and Human Services, any of its functions or  
12 duties under this Act other than—

13 (A) the issuance of regulations; or

14 (B) the determination of the availability of  
15 funds and their allocation to implement this  
16 Act.

17 (3) COMPENSATION.—The Executive Director  
18 of the Board shall be entitled to compensation at a  
19 level equivalent to level III of the Executive Sched-  
20 ule, in accordance with section 5314 of title 5,  
21 United States Code.

22 (i) INSPECTOR GENERAL.—The Inspector General  
23 Act of 1978 (5 U.S.C. App.) is amended—

24 (1) in section 12(1), by inserting after “Cor-  
25 poration;” the first place it appears the following:

1 “the Chair of the American Health Security Stand-  
2 ards Board;”;

3 (2) in section 12(2), by inserting after “Resolu-  
4 tion Trust Corporation,” the following: “the Amer-  
5 ican Health Security Standards Board,”; and

6 (3) by inserting before section 9 the following:

7 “SPECIAL PROVISIONS CONCERNING AMERICAN HEALTH  
8 SECURITY STANDARDS BOARD

9 “SEC. 8M. The Inspector General of the American  
10 Health Security Standards Board, in addition to the other  
11 authorities vested by this Act, shall have the same author-  
12 ity, with respect to the Board and the American Health  
13 Security Program under this Act, as the Inspector General  
14 for the Department of Health and Human Services has  
15 with respect to the Secretary of Health and Human Serv-  
16 ices and the medicare and medicaid programs, respec-  
17 tively.”.

18 (j) STAFF.—The Board shall employ such staff as the  
19 Board may deem necessary.

20 (k) ACCESS TO INFORMATION.—The Secretary of  
21 Health and Human Services shall make available to the  
22 Board all information available from sources within the  
23 Department or from other sources, pertaining to the du-  
24 ties of the Board.

1 **SEC. 402. AMERICAN HEALTH SECURITY ADVISORY COUN-**  
2 **CIL.**

3 (a) IN GENERAL.—The Board shall provide for an  
4 American Health Security Advisory Council (in this sec-  
5 tion referred to as the “Council”) to advise the Board on  
6 its activities.

7 (b) MEMBERSHIP.—The Council shall be composed  
8 of—

9 (1) the Chair of the Board, who shall serve as  
10 Chair of the Council; and

11 (2) twenty members, not otherwise in the em-  
12 ploy of the United States, appointed by the Board  
13 without regard to the provisions of title 5, United  
14 States Code, governing appointments in the competi-  
15 tive service.

16 The appointed members shall include, in accordance with  
17 subsection (e), individuals who are representative of State  
18 health security programs, public health professionals, pro-  
19 viders of health services, and of individuals (who shall con-  
20 stitute a majority of the Council) who are representative  
21 of consumers of such services, including a balanced rep-  
22 resentation of employers, unions, consumer organizations,  
23 and population groups with special health care needs. To  
24 the greatest extent feasible, the membership of the Council  
25 shall represent the various geographic regions of the

1 United States and shall reflect the racial, ethnic, and gen-  
2 der composition of the population of the United States.

3 (c) TERMS OF MEMBERS.—Each appointed member  
4 shall hold office for a term of 4 years, except that—

5 (1) any member appointed to fill a vacancy oc-  
6 ccurring during the term for which the member's  
7 predecessor was appointed shall be appointed for the  
8 remainder of that term; and

9 (2) the terms of the members first taking office  
10 shall expire, as designated by the Board at the time  
11 of appointment, 5 at the end of the first year, 5 at  
12 the end of the second year, 5 at the end of the third  
13 year, and 5 at the end of the fourth year after the  
14 date of enactment of this Act.

15 (d) VACANCIES.—

16 (1) IN GENERAL.—The Board shall fill any va-  
17 cancy in the membership of the Council in the same  
18 manner as the original appointment. The vacancy  
19 shall not affect the power of the remaining members  
20 to execute the duties of the Council.

21 (2) VACANCY APPOINTMENTS.—Any member  
22 appointed to fill a vacancy shall serve for the re-  
23 mainder of the term for which the predecessor of the  
24 member was appointed.

1           (3) REAPPOINTMENT.—The Board may re-  
2           appoint an appointed member of the Council for a  
3           second term in the same manner as the original ap-  
4           pointment.

5           (e) QUALIFICATIONS.—

6           (1) PUBLIC HEALTH REPRESENTATIVES.—  
7           Members of the Council who are representative of  
8           State health security programs and public health  
9           professionals shall be individuals who have extensive  
10          experience in the financing and delivery of care  
11          under public health programs.

12          (2) PROVIDERS.—Members of the Council who  
13          are representative of providers of health care shall  
14          be individuals who are outstanding in fields related  
15          to medical, hospital, or other health activities, or  
16          who are representative of organizations or associa-  
17          tions of professional health practitioners.

18          (3) CONSUMERS.—Members who are represent-  
19          ative of consumers of such care shall be individuals,  
20          not engaged in and having no financial interest in  
21          the furnishing of health services, who are familiar  
22          with the needs of various segments of the population  
23          for personal health services and are experienced in  
24          dealing with problems associated with the consump-  
25          tion of such services.



1 (f) DUTIES.—

2 (1) IN GENERAL.—It shall be the duty of the  
3 Council—

4 (A) to advise the Board on matters of gen-  
5 eral policy in the administration of this Act, in  
6 the formulation of regulations, and in the per-  
7 formance of the Board's duties under section  
8 401; and

9 (B) to study the operation of this Act and  
10 the utilization of health services under it, with  
11 a view to recommending any changes in the ad-  
12 ministration of the Act or in its provisions  
13 which may appear desirable.

14 (2) REPORT.—The Council shall make an an-  
15 nual report to the Board on the performance of its  
16 functions, including any recommendations it may  
17 have with respect thereto, and the Board shall  
18 promptly transmit the report to the Congress, to-  
19 gether with a report by the Board on any rec-  
20 ommendations of the Council that have not been fol-  
21 lowed.

22 (g) STAFF.—The Council, its members, and any com-  
23 mittees of the Council shall be provided with such secre-  
24 tarial, clerical, or other assistance as may be authorized  
25 by the Board for carrying out their respective functions.

1 (h) MEETINGS.—The Council shall meet as fre-  
2 quently as the Board deems necessary, but not less than  
3 4 times each year. Upon request by 7 or more members  
4 it shall be the duty of the Chair to call a meeting of the  
5 Council.

6 (i) COMPENSATION.—Members of the Council shall  
7 be reimbursed by the Board for travel and per diem in  
8 lieu of subsistence expenses during the performance of du-  
9 ties of the Board in accordance with subchapter I of chap-  
10 ter 57 of title 5, United States Code.

11 (j) FACA NOT APPLICABLE.—The provisions of the  
12 Federal Advisory Committee Act shall not apply to the  
13 Council.

14 **SEC. 403. CONSULTATION WITH PRIVATE ENTITIES.**

15 The Secretary and the Board shall consult with pri-  
16 vate entities, such as professional societies, national asso-  
17 ciations, nationally recognized associations of experts,  
18 medical schools and academic health centers, consumer  
19 groups, and labor and business organizations in the for-  
20 mulation of guidelines, regulations, policy initiatives, and  
21 information gathering to assure the broadest and most in-  
22 formed input in the administration of this Act. Nothing  
23 in this Act shall prevent the Secretary from adopting  
24 guidelines developed by such a private entity if, in the Sec-  
25 retary's and Board's judgment, such guidelines are gen-

1 erally accepted as reasonable and prudent and consistent  
2 with this Act.

3 **SEC. 404. STATE HEALTH SECURITY PROGRAMS.**

4 (a) SUBMISSION OF PLANS.—

5 (1) IN GENERAL.—Each State shall submit to  
6 the Board a plan for a State health security pro-  
7 gram for providing for health care services to the  
8 residents of the State in accordance with this Act.

9 (2) REGIONAL PROGRAMS.—A State may join  
10 with 1 or more neighboring States to submit to the  
11 Board a plan for a regional health security program  
12 instead of separate State health security programs.

13 (3) REGIONAL PLANNING MECHANISMS.—The  
14 Board shall provide incentives for States to develop  
15 regional planning mechanisms to promote the ration-  
16 al distribution of, adequate access to, and efficient  
17 use of, tertiary care facilities, equipment, and serv-  
18 ices.

19 (b) REVIEW AND APPROVAL OF PLANS.—

20 (1) IN GENERAL.—The Board shall review  
21 plans submitted under subsection (a) and determine  
22 whether such plans meet the requirements for ap-  
23 proval. The Board shall not approve such a plan un-  
24 less it finds that the plan (or State law) provides,

1 consistent with the provisions of this Act, for the fol-  
2 lowing:

3 (A) Payment for required health services  
4 for eligible individuals in the State in accord-  
5 ance with this Act.

6 (B) Adequate administration, including the  
7 designation of a single State agency responsible  
8 for the administration (or supervision of the ad-  
9 ministration) of the program.

10 (C) The establishment of a State health se-  
11 curity budget.

12 (D) Establishment of payment methodolo-  
13 gies (consistent with subtitle B of title VII).

14 (E) Assurances that individuals have the  
15 freedom to choose practitioners and other  
16 health care providers for services covered under  
17 this Act.

18 (F) A procedure for carrying out long-term  
19 regional management and planning functions  
20 with respect to the delivery and distribution of  
21 health care services that—

22 (i) ensures participation of consumers  
23 of health services and providers of health  
24 services; and

1                   (ii) gives priority to the most acute  
2 shortages and maldistributions of health  
3 personnel and facilities and the most seri-  
4 ous deficiencies in the delivery of covered  
5 services and to the means for the speedy  
6 alleviation of these shortcomings.

7                   (G) The licensure and regulation of all  
8 health providers and facilities to ensure compli-  
9 ance with Federal and State laws and to pro-  
10 mote quality of care.

11                   (H) Establishment of a quality review sys-  
12 tem in accordance with section 503.

13                   (I) Establishment of an independent om-  
14 budsman for consumers to register complaints  
15 about the organization and administration of  
16 the State health security program and to help  
17 resolve complaints and disputes between con-  
18 sumers and providers.

19                   (J) Publication of an annual report on the  
20 operation of the State health security program,  
21 which report shall include information on cost,  
22 progress towards achieving full enrollment, pub-  
23 lic access to health services, quality review,  
24 health outcomes, health professional training,

1 and the needs of medically underserved popu-  
2 lations.

3 (K) Provision of a fraud and abuse preven-  
4 tion and control unit that the Inspector General  
5 determines meets the requirements of section  
6 412(a).

7 (L) Prohibit payment in cases of prohib-  
8 ited physician referrals under section 304.

9 (2) CONSEQUENCES OF FAILURE TO COMPLY.—

10 If the Board finds that a State plan submitted  
11 under paragraph (1) does not meet the requirements  
12 for approval under this section or that a State  
13 health security program or specific portion of such  
14 program, the plan for which was previously ap-  
15 proved, no longer meets such requirements, the  
16 Board shall provide notice to the State of such fail-  
17 ure and that unless corrective action is taken within  
18 a period specified by the Board, the Board shall  
19 place the State health security program (or specific  
20 portions of such program) in receivership under the  
21 jurisdiction of the Board.

22 (c) STATE HEALTH SECURITY ADVISORY COUN-  
23 CILS.—

24 (1) IN GENERAL.—For each State, the Gov-  
25 ernor shall provide for appointment of a State

1 Health Security Advisory Council to advise and  
2 make recommendations to the Governor and State  
3 with respect to the implementation of the State  
4 health security program in the State.

5 (2) MEMBERSHIP.—Each State Health Security  
6 Advisory Council shall be composed of at least 11 in-  
7 dividuals. The appointed members shall include indi-  
8 viduals who are representative of the State health  
9 security program, public health professionals, pro-  
10 viders of health services, and of individuals (who  
11 shall constitute a majority) who are representative of  
12 consumers of such services, including a balanced  
13 representation of employers, unions and consumer  
14 organizations. To the greatest extent feasible, the  
15 membership of each State Health Security Advisory  
16 Council shall represent the various geographic re-  
17 gions of the State and shall reflect the racial, ethnic,  
18 and gender composition of the population of the  
19 State.

20 (3) DUTIES.—

21 (A) IN GENERAL.—Each State Health Se-  
22 curity Advisory Council shall review, and sub-  
23 mit comments to the Governor concerning the  
24 implementation of the State health security pro-  
25 gram in the State.

1 (B) ASSISTANCE.—Each State Health Se-  
2 curity Advisory Council shall provide assistance  
3 and technical support to community organiza-  
4 tions and public and private non-profit agencies  
5 submitting applications for funding under ap-  
6 propriate State and Federal public health pro-  
7 grams, with particular emphasis placed on as-  
8 sisting those applicants with broad consumer  
9 representation.

10 (d) STATE USE OF FISCAL AGENTS.—

11 (1) IN GENERAL.—Each State health security  
12 program, using competitive bidding procedures, may  
13 enter into such contracts with qualified entities, such  
14 as voluntary associations, as the State determines to  
15 be appropriate to process claims and to perform  
16 other related functions of fiscal agents under the  
17 State health security program.

18 (2) RESTRICTION.—Except as the Board may  
19 provide for good cause shown, in no case may more  
20 than 1 contract described in paragraph (1) be en-  
21 tered into under a State health security program.

22 **SEC. 405. COMPLEMENTARY CONDUCT OF RELATED**  
23 **HEALTH PROGRAMS.**

24 In performing functions with respect to health per-  
25 sonnel education and training, health research, environ-



1 mental health, disability insurance, vocational rehabilita-  
2 tion, the regulation of food and drugs, and all other mat-  
3 ters pertaining to health, the Secretary of Health and  
4 Human Services shall direct all activities of the Depart-  
5 ment of Health and Human Services toward contributions  
6 to the health of the people complementary to this Act.

## 7 **Subtitle B—Control Over Fraud** 8 **and Abuse**

### 9 **SEC. 411. APPLICATION OF FEDERAL SANCTIONS TO ALL** 10 **FRAUD AND ABUSE UNDER AMERICAN** 11 **HEALTH SECURITY PROGRAM.**

12 The following sections of the Social Security Act shall  
13 apply to State health security programs in the same man-  
14 ner as they apply to State medical assistance plans under  
15 title XIX of such Act (except that in applying such provi-  
16 sions any reference to the Secretary is deemed a reference  
17 to the Board):

18 (1) Section 1128 (relating to exclusion of indi-  
19 viduals and entities).

20 (2) Section 1128A (civil monetary penalties).

21 (3) Section 1128B (criminal penalties).

22 (4) Section 1124 (relating to disclosure of own-  
23 ership and related information).

24 (5) Section 1126 (relating to disclosure of cer-  
25 tain owners).

1 **SEC. 412. REQUIREMENTS FOR OPERATION OF STATE**  
2 **HEALTH CARE FRAUD AND ABUSE CONTROL**  
3 **UNITS.**

4 (a) **REQUIREMENT.**—In order to meet the require-  
5 ment of section 404(b)(1)(K), each State health security  
6 program must establish and maintain a health care fraud  
7 and abuse control unit (in this section referred to as a  
8 “fraud unit”) that meets requirements of this section and  
9 other requirements of the Board. Such a unit may be a  
10 State medicaid fraud control unit (described in section  
11 1903(q) of the Social Security Act).

12 (b) **STRUCTURE OF UNIT.**—The fraud unit must—

13 (1) be a single identifiable entity of the State  
14 government;

15 (2) be separate and distinct from the State  
16 agency with principal responsibility for the adminis-  
17 tration of the State health security program; and

18 (3) meet 1 of the following requirements:

19 (A) It must be a unit of the office of the  
20 State Attorney General or of another depart-  
21 ment of State government which possesses  
22 statewide authority to prosecute individuals for  
23 criminal violations.

24 (B) If it is in a State the constitution of  
25 which does not provide for the criminal prosecu-  
26 tion of individuals by a statewide authority and

1 has formal procedures, approved by the Board,  
2 that—

3 (i) assure its referral of suspected  
4 criminal violations relating to the State  
5 health insurance plan to the appropriate  
6 authority or authorities in the States for  
7 prosecution; and

8 (ii) assure its assistance of, and co-  
9 ordination with, such authority or authori-  
10 ties in such prosecutions.

11 (C) It must have a formal working rela-  
12 tionship with the office of the State Attorney  
13 General and have formal procedures (including  
14 procedures for its referral of suspected criminal  
15 violations to such office) which are approved by  
16 the Board and which provide effective coordina-  
17 tion of activities between the fraud unit and  
18 such office with respect to the detection, inves-  
19 tigation, and prosecution of suspected criminal  
20 violations relating to the State health insurance  
21 plan.

22 (c) FUNCTIONS.—The fraud unit must—

23 (1) have the function of conducting a statewide  
24 program for the investigation and prosecution of vio-  
25 lations of all applicable State laws regarding any

1 and all aspects of fraud in connection with any as-  
2 pect of the provision of health care services and ac-  
3 tivities of providers of such services under the State  
4 health security program;

5 (2) have procedures for reviewing complaints of  
6 the abuse and neglect of patients of providers and  
7 facilities that receive payments under the State  
8 health security program, and, where appropriate, for  
9 acting upon such complaints under the criminal laws  
10 of the State or for referring them to other State  
11 agencies for action; and

12 (3) provide for the collection, or referral for col-  
13 lection to a single State agency, of overpayments  
14 that are made under the State health security pro-  
15 gram to providers and that are discovered by the  
16 fraud unit in carrying out its activities.

17 (d) RESOURCES.—The fraud unit must—

18 (1) employ such auditors, attorneys, investiga-  
19 tors, and other necessary personnel;

20 (2) be organized in such a manner; and

21 (3) provide sufficient resources (as specified by  
22 the Board),

23 as is necessary to promote the effective and efficient con-  
24 duct of the unit's activities.

1 (e) COOPERATIVE AGREEMENTS.—The fraud unit  
2 must have cooperative agreements (as specified by the  
3 Board) with—

- 4 (1) similar fraud units in other States;
- 5 (2) the Inspector General; and
- 6 (3) the Attorney General of the United States.

7 (f) REPORTS.—The fraud unit must submit to the  
8 Inspector General an application and annual reports con-  
9 taining such information as the Inspector General deter-  
10 mines to be necessary to determine whether the unit meets  
11 the previous requirements of this section.

## 12 **TITLE V—QUALITY ASSESSMENT**

### 13 **SEC. 501. AMERICAN HEALTH SECURITY QUALITY COUNCIL.**

14 (a) ESTABLISHMENT.—There is hereby established  
15 an American Health Security Quality Council (in this title  
16 referred to as the “Council”).

17 (b) DUTIES OF THE COUNCIL.—The Council shall  
18 perform the following duties:

- 19 (1) PRACTICE GUIDELINES.—The Council shall  
20 review and evaluate each practice guideline devel-  
21 oped under part B of title IX of the Public Health  
22 Service Act. The Council shall determine whether  
23 the guideline should be recognized as a national  
24 practice guideline to be used under section 204(d)

1 for purposes of determining payments under a State  
2 health security program.

3 (2) STANDARDS OF QUALITY, PERFORMANCE  
4 MEASURES, AND MEDICAL REVIEW CRITERIA.—The  
5 Council shall review and evaluate each standard of  
6 quality, performance measure, and medical review  
7 criterion developed under part B of title IX of the  
8 Public Health Service Act. The Council shall deter-  
9 mine whether the standard, measure, or criterion is  
10 appropriate for use in assessing or reviewing the  
11 quality of services provided by State health security  
12 programs, health care institutions, or health care  
13 professionals.

14 (3) CRITERIA FOR ENTITIES CONDUCTING  
15 QUALITY REVIEWS.—The Council shall develop min-  
16 imum criteria for competence for entities that can  
17 qualify to conduct ongoing and continuous external  
18 quality review for State quality review programs  
19 under section 503. Such criteria shall require such  
20 an entity to be administratively independent of the  
21 individual or board that administers the State health  
22 security program and shall ensure that such entities  
23 do not provide financial incentives to reviewers to  
24 favor one pattern of practice over another. The  
25 Council shall ensure coordination and reporting by

1 such entities to assure national consistency in qual-  
2 ity standards.

3 (4) REPORTING.—The Council shall report to  
4 the Board annually on the conduct of activities  
5 under such title and shall report to the Board annu-  
6 ally specifically on findings from outcomes research  
7 and development of practice guidelines that may af-  
8 fect the Board’s determination of coverage of serv-  
9 ices under section 401(f)(1)(G).

10 (5) OTHER FUNCTIONS.—The Council shall  
11 perform the functions of the Council described in  
12 section 502.

13 (c) APPOINTMENT AND TERMS OF MEMBERS.—

14 (1) IN GENERAL.—The Council shall be com-  
15 posed of 10 members appointed by the President.  
16 The President shall first appoint individuals on a  
17 timely basis so as to provide for the operation of the  
18 Council by not later than January 1, 2010.

19 (2) SELECTION OF MEMBERS.—Each member  
20 of the Council shall be a member of a health profes-  
21 sion. Five members of the Council shall be physi-  
22 cians. Individuals shall be appointed to the Council  
23 on the basis of national reputations for clinical and  
24 academic excellence. To the greatest extent feasible,  
25 the membership of the Council shall represent the

1 various geographic regions of the United States and  
2 shall reflect the racial, ethnic, and gender composi-  
3 tion of the population of the United States.

4 (3) TERMS OF MEMBERS.—Individuals ap-  
5 pointed to the Council shall serve for a term of 5  
6 years, except that the terms of 4 of the individuals  
7 initially appointed shall be, as designated by the  
8 President at the time of their appointment, for 1, 2,  
9 3, and 4 years.

10 (d) VACANCIES.—

11 (1) IN GENERAL.—The President shall fill any  
12 vacancy in the membership of the Council in the  
13 same manner as the original appointment. The va-  
14 cancy shall not affect the power of the remaining  
15 members to execute the duties of the Council.

16 (2) VACANCY APPOINTMENTS.—Any member  
17 appointed to fill a vacancy shall serve for the re-  
18 mainder of the term for which the predecessor of the  
19 member was appointed.

20 (3) REAPPOINTMENT.—The President may re-  
21 appoint a member of the Council for a second term  
22 in the same manner as the original appointment. A  
23 member who has served for 2 consecutive 5-year  
24 terms shall not be eligible for reappointment until 2  
25 years after the member has ceased to serve.



1 (e) CHAIR.—The President shall designate 1 of the  
2 members of the Council to serve at the will of the Presi-  
3 dent as Chair of the Council.

4 (f) COMPENSATION.—Members of the Council who  
5 are not employees of the Federal Government shall be en-  
6 titled to compensation at a level equivalent to level II of  
7 the Executive Schedule, in accordance with section 5313  
8 of title 5, United States Code.

9 **SEC. 502. DEVELOPMENT OF CERTAIN METHODOLOGIES,**  
10 **GUIDELINES, AND STANDARDS.**

11 (a) PROFILING OF PATTERNS OF PRACTICE; IDENTI-  
12 FICATION OF OUTLIERS.—The Council shall adopt meth-  
13 odologies for profiling the patterns of practice of health  
14 care professionals and for identifying outliers (as defined  
15 in subsection (e)).

16 (b) CENTERS OF EXCELLENCE.—The Council shall  
17 develop guidelines for certain medical procedures des-  
18 ignated by the Board to be performed only at tertiary care  
19 centers which can meet standards for frequency of proce-  
20 dure performance and intensity of support mechanisms  
21 that are consistent with the high probability of desired pa-  
22 tient outcome. Reimbursement under this Act for such a  
23 designated procedure may only be provided if the proce-  
24 dure was performed at a center that meets such stand-  
25 ards.

1 (c) REMEDIAL ACTIONS.—The Council shall develop  
2 standards for education and sanctions with respect to  
3 outliers so as to assure the quality of health care services  
4 provided under this Act. The Council shall develop criteria  
5 for referral of providers to the State licensing board if edu-  
6 cation proves ineffective in correcting provider practice be-  
7 havior.

8 (d) DISSEMINATION.—The Council shall disseminate  
9 to the State—

10 (1) the methodologies adopted under subsection

11 (a);

12 (2) the guidelines developed under subsection

13 (b); and

14 (3) the standards developed under subsection

15 (c);

16 for use by the States under section 503.

17 (e) OUTLIER DEFINED.—In this title, the term  
18 “outlier” means a health care provider whose pattern of  
19 practice, relative to applicable practice guidelines, suggests  
20 deficiencies in the quality of health care services being pro-  
21 vided.

22 **SEC. 503. STATE QUALITY REVIEW PROGRAMS.**

23 (a) REQUIREMENT.—In order to meet the require-  
24 ment of section 404(b)(1)(H), each State health security  
25 program shall establish 1 or more qualified entities to con-

1 duct quality reviews of persons providing covered services  
2 under the program, in accordance with standards estab-  
3 lished under subsection (b)(1) (except as provided in sub-  
4 section (b)(2)) and subsection (d).

5 (b) FEDERAL STANDARDS.—

6 (1) IN GENERAL.—The Council shall establish  
7 standards with respect to—

8 (A) the adoption of practice guidelines  
9 (whether developed by the Federal Government  
10 or other entities);

11 (B) the identification of outliers (con-  
12 sistent with methodologies adopted under sec-  
13 tion 502(a));

14 (C) the development of remedial programs  
15 and monitoring for outliers; and

16 (D) the application of sanctions (consistent  
17 with the standards developed under section  
18 502(c)).

19 (2) STATE DISCRETION.—A State may apply  
20 under subsection (a) standards other than those es-  
21 tablished under paragraph (1) so long as the State  
22 demonstrates to the satisfaction of the Council on an  
23 annual basis that the standards applied have been as  
24 efficacious in promoting and achieving improved  
25 quality of care as the application of the standards

1 established under paragraph (1). Positive improve-  
2 ments in quality shall be documented by reductions  
3 in the variations of clinical care process and im-  
4 provement in patient outcomes.

5 (c) QUALIFICATIONS.—An entity is not qualified to  
6 conduct quality reviews under subsection (a) unless the  
7 entity satisfies the criteria for competence for such entities  
8 developed by the Council under section 501(b)(3).

9 (d) INTERNAL QUALITY REVIEW.—Nothing in this  
10 section shall preclude an institutional provider from estab-  
11 lishing its own internal quality review and enhancement  
12 programs.

13 **SEC. 504. ELIMINATION OF UTILIZATION REVIEW PRO-**  
14 **GRAMS; TRANSITION.**

15 (a) INTENT.—It is the intention of this title to re-  
16 place by January 1, 2013, random utilization controls with  
17 a systematic review of patterns of practice that com-  
18 promise the quality of care.

19 (b) SUPERSEDING CASE REVIEWS.—

20 (1) IN GENERAL.—Subject to the succeeding  
21 provisions of this subsection, the program of quality  
22 review provided under the previous sections of this  
23 title supersede all existing Federal requirements for  
24 utilization review programs, including requirements  
25 for random case-by-case reviews and programs re-

1       quiring pre-certification of medical procedures on a  
2       case-by-case basis.

3           (2) TRANSITION.—Before January 1, 2013, the  
4       Board and the States may employ existing utiliza-  
5       tion review standards and mechanisms as may be  
6       necessary to effect the transition to pattern of prac-  
7       tice-based reviews.

8           (3) CONSTRUCTION.—Nothing in this sub-  
9       section shall be construed—

10           (A) as precluding the case-by-case review  
11       of the provision of care—

12           (i) in individual incidents where the  
13       quality of care has significantly deviated  
14       from acceptable standards of practice; and

15           (ii) with respect to a provider who has  
16       been determined to be an outlier; or

17           (B) as precluding the case management of  
18       catastrophic, mental health, or substance abuse  
19       cases or long-term care where such manage-  
20       ment is necessary to achieve appropriate, cost-  
21       effective, and beneficial comprehensive medical  
22       care, as provided for in section 204.

1 **TITLE VI—HEALTH SECURITY**  
2 **BUDGET; PAYMENTS; COST**  
3 **CONTAINMENT MEASURES**  
4 **Subtitle A—Budgeting and**  
5 **Payments to States**

6 **SEC. 601. NATIONAL HEALTH SECURITY BUDGET.**

7 (a) NATIONAL HEALTH SECURITY BUDGET.—

8 (1) IN GENERAL.—By not later than September  
9 1 before the beginning of each year (beginning with  
10 2010), the Board shall establish a national health  
11 security budget, which—

12 (A) specifies the total expenditures (includ-  
13 ing expenditures for administrative costs) to be  
14 made by the Federal Government and the  
15 States for covered health care services under  
16 this Act; and

17 (B) allocates those expenditures among the  
18 States consistent with section 604.

19 Pursuant to subsection (b), such budget for a year  
20 shall not exceed the budget for the preceding year  
21 increased by the percentage increase in gross domes-  
22 tic product.

23 (2) DIVISION OF BUDGET INTO COMPONENTS.—

24 The national health security budget shall consist of  
25 at least 4 components:

1 (A) A component for quality assessment  
2 activities (described in title V).

3 (B) A component for health professional  
4 education expenditures.

5 (C) A component for administrative costs.

6 (D) A component (in this title referred to  
7 as the “operating component”) for operating  
8 and other expenditures not described in sub-  
9 paragraphs (A) through (C), consisting of  
10 amounts not included in the other components.  
11 A State may provide for the allocation of this  
12 component between capital expenditures and  
13 other expenditures.

14 (3) ALLOCATION AMONG COMPONENTS.—Tak-  
15 ing into account the State health security budgets  
16 established and submitted under section 603, the  
17 Board shall allocate the national health security  
18 budget among the components in a manner that—

19 (A) assures a fair allocation for quality as-  
20 sessment activities (consistent with the national  
21 health security spending growth limit); and

22 (B) assures that the health professional  
23 education expenditure component is sufficient  
24 to provide for the amount of health professional  
25 education expenditures sufficient to meet the

1           need for covered health care services (consistent  
2           with the national health security spending  
3           growth limit under subsection (b)(2)).

4           (b) BASIS FOR TOTAL EXPENDITURES.—

5           (1) IN GENERAL.—The total expenditures speci-  
6           fied in such budget shall be the sum of the capita-  
7           tion amounts computed under section 602(a) and  
8           the amount of Federal administrative expenditures  
9           needed to carry out this Act.

10           (2) NATIONAL HEALTH SECURITY SPENDING  
11           GROWTH LIMIT.—For purposes of this subtitle, the  
12           national health security spending growth limit de-  
13           scribed in this paragraph for a year is (A) zero, or,  
14           if greater, (B) the average annual percentage in-  
15           crease in the gross domestic product (in current dol-  
16           lars) during the 3-year period beginning with the  
17           first quarter of the fourth previous year to the first  
18           quarter of the previous year minus the percentage  
19           increase (if any) in the number of eligible individuals  
20           residing in any State the United States from the  
21           first quarter of the second previous year to the first  
22           quarter of the previous year.

23           (c) DEFINITIONS.—In this title:

24           (1) CAPITAL EXPENDITURES.—The term “cap-  
25           ital expenditures” means expenses for the purchase,



1 lease, construction, or renovation of capital facilities  
2 and for equipment and includes return on equity  
3 capital.

4 (2) HEALTH PROFESSIONAL EDUCATION EX-  
5 PENDITURES.—The term “health professional edu-  
6 cation expenditures” means expenditures in hospitals  
7 and other health care facilities to cover costs associ-  
8 ated with teaching and related research activities.

9 **SEC. 602. COMPUTATION OF INDIVIDUAL AND STATE CAPI-**  
10 **TATION AMOUNTS.**

11 (a) CAPITATION AMOUNTS.—

12 (1) INDIVIDUAL CAPITATION AMOUNTS.—In es-  
13 tablishing the national health security budget under  
14 section 601(a) and in computing the national aver-  
15 age per capita cost under subsection (b) for each  
16 year, the Board shall establish a method for com-  
17 puting the capitation amount for each eligible indi-  
18 vidual residing in each State. The capitation amount  
19 for an eligible individual in a State classified within  
20 a risk group (established under subsection (d)(2)) is  
21 the product of—

22 (A) a national average per capita cost for  
23 all covered health care services (computed  
24 under subsection (b));

1 (B) the State adjustment factor (estab-  
2 lished under subsection (c)) for the State; and

3 (C) the risk adjustment factor (established  
4 under subsection (d)) for the risk group.

5 (2) STATE CAPITATION AMOUNT.—

6 (A) IN GENERAL.—For purposes of this  
7 title, the term “State capitation amount”  
8 means, for a State for a year, the sum of the  
9 capitation amounts computed under paragraph  
10 (1) for all the residents of the State in the year,  
11 as estimated by the Board before the beginning  
12 of the year involved.

13 (B) USE OF STATISTICAL MODEL.—The  
14 Board may provide for the computation of  
15 State capitation amounts based on statistical  
16 models that fairly reflect the elements that com-  
17 prise the State capitation amount described in  
18 subparagraph (A).

19 (C) POPULATION INFORMATION.—The Bu-  
20 reau of the Census shall assist the Board in de-  
21 termining the number, place of residence, and  
22 risk group classification of eligible individuals.

23 (b) COMPUTATION OF NATIONAL AVERAGE PER CAP-  
24 ITA COST.—

1           (1) FOR 2010.—For 2010, the national average  
2 per capita cost under this paragraph is equal to—

3           (A) the average per capita health care ex-  
4 penditures in the United States in 2008 (as es-  
5 timated by the Board);

6           (B) increased to 2009 by the Board’s esti-  
7 mate of the actual amount of such per capita  
8 expenditures during 2009; and

9           (C) updated to 2010 by the national health  
10 security spending growth limit specified in sec-  
11 tion 601(b)(2) for 2010.

12          (2) FOR SUCCEEDING YEARS.—For each suc-  
13 ceeding year, the national average per capita cost  
14 under this subsection is equal to the national aver-  
15 age per capita cost computed under this subsection  
16 for the previous year increased by the national  
17 health security spending growth limit (specified in  
18 section 601(b)(2)) for the year involved.

19          (c) STATE ADJUSTMENT FACTORS.—

20           (1) IN GENERAL.—Subject to the succeeding  
21 paragraphs of this subsection, the Board shall de-  
22 velop for each State a factor to adjust the national  
23 average per capita costs to reflect differences be-  
24 tween the State and the United States in—

1 (A) average labor and nonlabor costs that  
2 are necessary to provide covered health services;

3 (B) any social, environmental, or geo-  
4 graphic condition affecting health status or the  
5 need for health care services, to the extent such  
6 a condition is not taken into account in the es-  
7 tablishment of risk groups under subsection (d);

8 (C) the geographic distribution of the  
9 State's population, particularly the proportion  
10 of the population residing in medically under-  
11 served areas, to the extent such a condition is  
12 not taken into account in the establishment of  
13 risk groups under subsection (d); and

14 (D) any other factor relating to operating  
15 costs required to assure equitable distribution  
16 of funds among the States.

17 (2) MODIFICATION OF HEALTH PROFESSIONAL  
18 EDUCATION COMPONENT.—With respect to the por-  
19 tion of the national health security budget allocated  
20 to expenditures for health professional education, the  
21 Board shall modify the State adjustment factors so  
22 as to take into account—

23 (A) differences among States in health  
24 professional education programs in operation as  
25 of the date of the enactment of this Act; and

1 (B) differences among States in their rel-  
2 ative need for expenditures for health profes-  
3 sional education, taking into account the health  
4 professional education expenditures proposed in  
5 State health security budgets under section  
6 603(a).

7 (3) BUDGET NEUTRALITY.—The State adjust-  
8 ment factors, as modified under paragraph (2), shall  
9 be applied under this subsection in a manner that  
10 results in neither an increase nor a decrease in the  
11 total amount of the Federal contributions to all  
12 State health security programs under subsection (b)  
13 as a result of the application of such factors.

14 (4) PHASE-IN.—In applying State adjustment  
15 factors under this subsection during the 5-year pe-  
16 riod beginning with 2010, the Board shall phase-in,  
17 over such period, the use of factors described in  
18 paragraph (1) in a manner so that the adjustment  
19 factor for a State is based on a blend of such factors  
20 and a factor that reflects the relative actual average  
21 per capita costs of health services of the different  
22 States as of the time of enactment of this Act.

23 (5) PERIODIC ADJUSTMENT.—In establishing  
24 the national health security budget before the begin-  
25 ning of each year, the Board shall provide for appro-

1        appropriate adjustments in the State adjustment factors  
2        under this subsection.

3        (d) ADJUSTMENTS FOR RISK GROUP CLASSIFICA-  
4        TION.—

5            (1) IN GENERAL.—The Board shall develop an  
6        adjustment factor to the national average per capita  
7        costs computed under subsection (b) for individuals  
8        classified in each risk group (as designated under  
9        paragraph (2)) to reflect the difference between the  
10       average national average per capita costs and the  
11       national average per capita cost for individuals clas-  
12       sified in the risk group.

13           (2) RISK GROUPS.—The Board shall designate  
14        a series of risk groups, determined by age, health in-  
15        dicators, and other factors that represent distinct  
16        patterns of health care services utilization and costs.

17           (3) PERIODIC ADJUSTMENT.—In establishing  
18        the national health security budget before the begin-  
19        ning of each year, the Board shall provide for appro-  
20        priate adjustments in the risk adjustment factors  
21        under this subsection.

22        **SEC. 603. STATE HEALTH SECURITY BUDGETS.**

23           (a) ESTABLISHMENT AND SUBMISSION OF BUDG-  
24        ETS.—

1           (1) IN GENERAL.—Each State health security  
2 program shall establish and submit to the Board for  
3 each year a proposed and a final State health secu-  
4 rity budget, which specifies the following:

5           (A) The total expenditures (including ex-  
6 penditures for administrative costs) to be made  
7 under the program in the State for covered  
8 health care services under this Act, consistent  
9 with subsection (b), broken down as follows:

10           (i) By the 4 components (described in  
11 section 601(a)(2)), consistent with sub-  
12 section (b).

13           (ii) Within the operating component—

14           (I) expenditures for operating  
15 costs of hospitals and other facility-  
16 based services in the State;

17           (II) expenditures for payment to  
18 comprehensive health service organiza-  
19 tions;

20           (III) expenditures for payment of  
21 services provided by health care prac-  
22 titioners; and

23           (IV) expenditures for other cov-  
24 ered items and services.

1           Amounts included in the operating compo-  
2           nent include amounts that may be used by  
3           providers for capital expenditures.

4           (B) The total revenues required to meet  
5           the State health security expenditures.

6           (2) PROPOSED BUDGET DEADLINE.—The pro-  
7           posed budget for a year shall be submitted under  
8           paragraph (1) not later than June 1 before the year.

9           (3) FINAL BUDGET.—The final budget for a  
10          year shall—

11           (A) be established and submitted under  
12           paragraph (1) not later than October 1 before  
13           the year, and

14           (B) take into account the amounts estab-  
15           lished under the national health security budget  
16           under section 601 for the year.

17           (4) ADJUSTMENT IN ALLOCATIONS PER-  
18          MITTED.—

19           (A) IN GENERAL.—Subject to subpara-  
20           graphs (B) and (C), in the case of a final budg-  
21           et, a State may change the allocation of  
22           amounts among components.

23           (B) NOTICE.—No such change may be  
24           made unless the State has provided prior notice  
25           of the change to the Board.



1           (C) DENIAL.—Such a change may not be  
2           made if the Board, within such time period as  
3           the Board specifies, disapproves such change.

4           (b) EXPENDITURE LIMITS.—

5           (1) IN GENERAL.—The total expenditures speci-  
6           fied in each State health security budget under sub-  
7           section (a)(1) shall take into account Federal con-  
8           tributions made under section 604.

9           (2) LIMIT ON CLAIMS PROCESSING AND BILL-  
10          ING EXPENDITURES.—Each State health security  
11          budget shall provide that State administrative ex-  
12          penditures, including expenditures for claims proc-  
13          essing and billing, shall not exceed 3 percent of the  
14          total expenditures under the State health security  
15          program, unless the Board determines, on a case-by-  
16          case basis, that additional administrative expendi-  
17          tures would improve health care quality and cost ef-  
18          fectiveness.

19          (3) WORKER ASSISTANCE.—A State health se-  
20          curity program may provide that, for budgets for  
21          years before 2013, up to 1 percent of the budget  
22          may be used for purposes of programs providing as-  
23          sistance to workers who are currently performing  
24          functions in the administration of the health insur-  
25          ance system and who may experience economic dis-

1 location as a result of the implementation of the pro-  
2 gram.

3 (c) APPROVAL PROCESS FOR CAPITAL EXPENDI-  
4 TURES PERMITTED.—Nothing in this title shall be con-  
5 strued as preventing a State health security program from  
6 providing for a process for the approval of capital expendi-  
7 tures based on information derived from regional planning  
8 agencies.

9 **SEC. 604. FEDERAL PAYMENTS TO STATES.**

10 (a) IN GENERAL.—Each State with an approved  
11 State health security program is entitled to receive, from  
12 amounts in the American Health Security Trust Fund, on  
13 a monthly basis each year, of an amount equal to one-  
14 twelfth of the product of—

15 (1) the State capitation amount (computed  
16 under section 602(a)(2)) for the State for the year;  
17 and

18 (2) the Federal contribution percentage (estab-  
19 lished under subsection (b)).

20 (b) FEDERAL CONTRIBUTION PERCENTAGE.—The  
21 Board shall establish a formula for the establishment of  
22 a Federal contribution percentage for each State. Such  
23 formula shall take into consideration a State's per capita  
24 income and revenue capacity and such other relevant eco-  
25 nomic indicators as the Board determines to be appro-

1 priate. In addition, during the 5-year period beginning  
2 with 2010, the Board may provide for a transition adjust-  
3 ment to the formula in order to take into account current  
4 expenditures by the State (and local governments thereof)  
5 for health services covered under the State health security  
6 program. The weighted-average Federal contribution per-  
7 centage for all States shall equal 86 percent and in no  
8 event shall such percentage be less than 81 percent nor  
9 more than 91 percent.

10 (c) USE OF PAYMENTS.—All payments made under  
11 this section may only be used to carry out the State health  
12 security program.

13 (d) EFFECT OF SPENDING EXCESS OR SURPLUS.—

14 (1) SPENDING EXCESS.—If a State exceeds its  
15 budget in a given year, the State shall continue to  
16 fund covered health services from its own revenues.

17 (2) SURPLUS.—If a State provides all covered  
18 health services for less than the budgeted amount  
19 for a year, it may retain its Federal payment for  
20 that year for uses consistent with this Act.

21 **SEC. 605. ACCOUNT FOR HEALTH PROFESSIONAL EDU-**  
22 **CATION EXPENDITURES.**

23 (a) SEPARATE ACCOUNT.—Each State health secu-  
24 rity program shall—

1           (1) include a separate account for health pro-  
2           fessional education expenditures; and

3           (2) specify the general manner, consistent with  
4           subsection (b), in which such expenditures are to be  
5           distributed among different types of institutions and  
6           the different areas of the State.

7           (b) DISTRIBUTION RULES.—The distribution of  
8           funds to hospitals and other health care facilities from the  
9           account must conform to the following principles:

10           (1) The disbursement of funds must be con-  
11           sistent with achievement of the national and pro-  
12           gram goals (specified in section 701(b)) within the  
13           State health security program and the distribution  
14           of funds from the account must be conditioned upon  
15           the receipt of such reports as the Board may require  
16           in order to monitor compliance with such goals.

17           (2) The distribution of funds from the account  
18           must take into account the potentially higher costs  
19           of placing health professional students in clinical  
20           education programs in health professional shortage  
21           areas.

1     **Subtitle B—Payments by States to**  
2                     **Providers**

3     **SEC. 611. PAYMENTS TO HOSPITALS AND OTHER FACILITY-**  
4                     **BASED SERVICES FOR OPERATING EXPENSES**  
5                     **ON THE BASIS OF APPROVED GLOBAL BUDG-**  
6                     **ETS.**

7             (a) DIRECT PAYMENT UNDER GLOBAL BUDGET.—

8     Payment for operating expenses for institutional and facil-  
9     ity-based care, including hospital services and nursing fa-  
10    cility services, under State health security programs shall  
11    be made directly to each institution or facility by each  
12    State health security program under an annual prospec-  
13    tive global budget approved under the program. Such a  
14    budget shall include payment for outpatient care and non-  
15    facility-based care that is furnished by or through the fa-  
16    cility. In the case of a hospital that is wholly owned (or  
17    controlled) by a comprehensive health service organization  
18    that is paid under section 614 on the basis of a global  
19    budget, the global budget of the organization shall include  
20    the budget for the hospital.

21             (b) ANNUAL NEGOTIATIONS; BUDGET APPROVAL.—

22                     (1) IN GENERAL.—The prospective global budg-  
23             et for an institution or facility shall—

24                             (A) be developed through annual negotia-  
25             tions between—

1 (i) a panel of individuals who are ap-  
2 pointed by the Governor of the State and  
3 who represent consumers, labor, business,  
4 and the State government; and

5 (ii) the institution or facility; and

6 (B) be based on a nationally uniform sys-  
7 tem of cost accounting established under stand-  
8 ards of the Board.

9 (2) CONSIDERATIONS.—In developing a budget  
10 through negotiations, there shall be taken into ac-  
11 count at least the following:

12 (A) With respect to inpatient hospital serv-  
13 ices, the number, and classification by diag-  
14 nosis-related group, of discharges.

15 (B) An institution's or facility's past ex-  
16 penditures.

17 (C) The extent to which debt service for  
18 capital expenditures has been included in the  
19 proposed operating budget.

20 (D) The extent to which capital expendi-  
21 tures are financed directly or indirectly through  
22 reductions in direct care to patients, including  
23 (but not limited to) reductions in registered  
24 nursing staffing patterns or changes in emer-

1 agency room or primary care services or avail-  
2 ability.

3 (E) Change in the consumer price index  
4 and other price indices.

5 (F) The cost of reasonable compensation  
6 to health care practitioners.

7 (G) The compensation level of the institu-  
8 tion's or facility's work force.

9 (H) The extent to which the institution or  
10 facility is providing health care services to meet  
11 the needs of residents in the area served by the  
12 institution or facility, including the institution's  
13 or facility's occupancy level.

14 (I) The institution's or facility's previous  
15 financial and clinical performance, based on uti-  
16 lization and outcomes data provided under this  
17 Act.

18 (J) The type of institution or facility, in-  
19 cluding whether the institution or facility is  
20 part of a clinical education program or serves  
21 a health professional education, research or  
22 other training purpose.

23 (K) Technological advances or changes.

1           (L) Costs of the institution or facility asso-  
2           ciated with meeting Federal and State regula-  
3           tions.

4           (M) The costs associated with necessary  
5           public outreach activities.

6           (N) In the case of a for-profit facility, a  
7           reasonable rate of return on equity capital,  
8           independent of those operating expenses nec-  
9           essary to fulfill the objectives of this Act.

10          (O) Incentives to facilities that maintain  
11          costs below previous reasonable budgeted levels  
12          without reducing the care provided.

13          (P) With respect to facilities that provide  
14          mental health services and substance abuse  
15          treatment services, any additional costs involved  
16          in the treatment of dually diagnosed individ-  
17          uals.

18          The portion of such a budget that relates to expendi-  
19          tures for health professional education shall be con-  
20          sistent with the State health security budget for  
21          such expenditures.

22          (3) PROVISION OF REQUIRED INFORMATION; DI-  
23          AGNOSIS-RELATED GROUP.—No budget for an insti-  
24          tution or facility for a year may be approved unless  
25          the institution or facility has submitted on a timely



1 basis to the State health security program such in-  
2 formation as the program or the Board shall specify,  
3 including in the case of hospitals information on dis-  
4 charges classified by diagnosis-related group.

5 (c) ADJUSTMENTS IN APPROVED BUDGETS.—

6 (1) ADJUSTMENTS TO GLOBAL BUDGETS THAT  
7 CONTRACT WITH COMPREHENSIVE HEALTH SERVICE  
8 ORGANIZATIONS.—Each State health security pro-  
9 gram shall develop an administrative mechanism for  
10 reducing operating funds to institutions or facilities  
11 in proportion to payments made to such institutions  
12 or facilities for services contracted for by a com-  
13 prehensive health service organization.

14 (2) AMENDMENTS.—In accordance with stand-  
15 ards established by the Board, an operating and  
16 capital budget approved under this section for a year  
17 may be amended before, during, or after the year if  
18 there is a substantial change in any of the factors  
19 relevant to budget approval.

20 (d) DONATIONS PERMISSIBLE.—The States health  
21 security programs may permit institutions and facilities  
22 to raise funds from private sources to pay for newly con-  
23 structed facilities, major renovations, and equipment. The  
24 expenditure of such funds, whether for operating or cap-  
25 ital expenditures, does not obligate the State health secu-

1 rity program to provide for continued support for such ex-  
2 penditures unless included in an approved global budget.

3 **SEC. 612. PAYMENTS TO HEALTH CARE PRACTITIONERS**

4 **BASED ON PROSPECTIVE FEE SCHEDULE.**

5 (a) FEE FOR SERVICE.—

6 (1) IN GENERAL.—Every independent health  
7 care practitioner is entitled to be paid, for the provi-  
8 sion of covered health services under the State  
9 health security program, a fee for each billable cov-  
10 ered service.

11 (2) GLOBAL FEE PAYMENT METHODOLOGIES.—

12 The Board shall establish models and encourage  
13 State health security programs to implement alter-  
14 native payment methodologies that incorporate glob-  
15 al fees for related services (such as all outpatient  
16 procedures for treatment of a condition) or for a  
17 basic group of services (such as primary care serv-  
18 ices) furnished to an individual over a period of  
19 time, in order to encourage continuity and efficiency  
20 in the provision of services. Such methodologies shall  
21 be designed to ensure a high quality of care.

22 (3) BILLING DEADLINES; ELECTRONIC BILL-  
23 ING.—A State health security program may deny  
24 payment for any service of an independent health  
25 care practitioner for which it did not receive a bill

1 and appropriate supporting documentation (which  
2 had been previously specified) within 30 days after  
3 the date the service was provided. Such a program  
4 may require that bills for services for which payment  
5 may be made under this section, or for any class of  
6 such services, be submitted electronically.

7 (b) PAYMENT RATES BASED ON NEGOTIATED PRO-  
8 SPECTIVE FEE SCHEDULES.—With respect to any pay-  
9 ment method for a class of services of practitioners, the  
10 State health security program shall establish, on a pro-  
11 spective basis, a payment schedule. The State health secu-  
12 rity program may establish such a schedule after negotia-  
13 tions with organizations representing the practitioners in-  
14 volved. Such fee schedules shall be designed to provide in-  
15 centives for practitioners to choose primary care medicine,  
16 including general internal medicine and pediatrics, over  
17 medical specialization. Nothing in this section shall be con-  
18 strued as preventing a State from adjusting the payment  
19 schedule amounts on a quarterly or other periodic basis  
20 depending on whether expenditures under the schedule will  
21 exceed the budgeted amount with respect to such expendi-  
22 tures.

23 (c) BILLABLE COVERED SERVICE DEFINED.—In this  
24 section, the term “billable covered service” means a service  
25 covered under section 201 for which a practitioner is enti-

1 tled to compensation by payment of a fee determined  
2 under this section.

3 **SEC. 613. PAYMENTS TO COMPREHENSIVE HEALTH SERV-**  
4 **ICE ORGANIZATIONS.**

5 (a) IN GENERAL.—Payment under a State health se-  
6 curity program to a comprehensive health service organi-  
7 zation to its enrollees shall be determined by the State—

8 (1) based on a global budget described in sec-  
9 tion 611; or

10 (2) based on the basic capitation amount de-  
11 scribed in subsection (b) for each of its enrollees.

12 (b) BASIC CAPITATION AMOUNT.—

13 (1) IN GENERAL.—The basic capitation amount  
14 described in this subsection for an enrollee shall be  
15 determined by the State health security program on  
16 the basis of the average amount of expenditures that  
17 is estimated would be made under the State health  
18 security program for covered health care services for  
19 an enrollee, based on actuarial characteristics (as de-  
20 fined by the State health security program).

21 (2) ADJUSTMENT FOR SPECIAL HEALTH  
22 NEEDS.—The State health security program shall  
23 adjust such average amounts to take into account  
24 the special health needs, including a disproportionate

1 number of medically underserved individuals, of pop-  
2 ulations served by the organization.

3 (3) ADJUSTMENT FOR SERVICES NOT PRO-  
4 VIDED.—The State health security program shall ad-  
5 just such average amounts to take into account the  
6 cost of covered health care services that are not pro-  
7 vided by the comprehensive health service organiza-  
8 tion under section 303(a).

9 **SEC. 614. PAYMENTS FOR COMMUNITY-BASED PRIMARY**  
10 **HEALTH SERVICES.**

11 (a) IN GENERAL.—In the case of community-based  
12 primary health services, subject to subsection (b), pay-  
13 ments under a State health security program shall—

14 (1) be based on a global budget described in  
15 section 611;

16 (2) be based on the basic primary care capita-  
17 tion amount described in subsection (c) for each in-  
18 dividual enrolled with the provider of such services;  
19 or

20 (3) be made on a fee-for-service basis under  
21 section 612.

22 (b) PAYMENT ADJUSTMENT.—Payments under sub-  
23 section (a) may include, consistent with the budgets devel-  
24 oped under this title—

1           (1) an additional amount, as set by the State  
2 health security program, to cover the costs incurred  
3 by a provider which serves persons not covered by  
4 this Act whose health care is essential to overall  
5 community health and the control of communicable  
6 disease, and for whom the cost of such care is other-  
7 wise uncompensated;

8           (2) an additional amount, as set by the State  
9 health security program, to cover the reasonable  
10 costs incurred by a provider that furnishes case  
11 management services (as defined in section  
12 1915(g)(2) of the Social Security Act), transpor-  
13 tation services, and translation services; and

14           (3) an additional amount, as set by the State  
15 health security program, to cover the costs incurred  
16 by a provider in conducting health professional edu-  
17 cation programs in connection with the provision of  
18 such services.

19           (c) BASIC PRIMARY CARE CAPITATION AMOUNT.—

20           (1) IN GENERAL.—The basic primary care capi-  
21 tation amount described in this subsection for an en-  
22 rollee with a provider of community-based primary  
23 health services shall be determined by the State  
24 health security program on the basis of the average  
25 amount of expenditures that is estimated would be

1 made under the State health security program for  
2 such an enrollee, based on actuarial characteristics  
3 (as defined by the State health security program).

4 (2) ADJUSTMENT FOR SPECIAL HEALTH  
5 NEEDS.—The State health security program shall  
6 adjust such average amounts to take into account  
7 the special health needs, including a disproportionate  
8 number of medically underserved individuals, of pop-  
9 ulations served by the provider.

10 (3) ADJUSTMENT FOR SERVICES NOT PRO-  
11 VIDED.—The State health security program shall ad-  
12 just such average amounts to take into account the  
13 cost of community-based primary health services  
14 that are not provided by the provider.

15 (d) COMMUNITY-BASED PRIMARY HEALTH SERVICES  
16 DEFINED.—In this section, the term “community-based  
17 primary health services” has the meaning given such term  
18 in section 202(a).

19 **SEC. 615. PAYMENTS FOR PRESCRIPTION DRUGS.**

20 (a) ESTABLISHMENT OF LIST.—

21 (1) IN GENERAL.—The Board shall establish a  
22 list of approved prescription drugs and biologicals  
23 that the Board determines are necessary for the  
24 maintenance or restoration of health or of employ-

1 ability or self-management and eligible for coverage  
2 under this Act.

3 (2) EXCLUSIONS.—The Board may exclude re-  
4 imbursement under this Act for ineffective, unsafe,  
5 or over-priced products where better alternatives are  
6 determined to be available.

7 (b) PRICES.—For each such listed prescription drug  
8 or biological covered under this Act, for insulin, and for  
9 medical foods, the Board shall from time to time deter-  
10 mine a product price or prices which shall constitute the  
11 maximum to be recognized under this Act as the cost of  
12 a drug to a provider thereof. The Board may conduct ne-  
13 gotiations, on behalf of State health security programs,  
14 with product manufacturers and distributors in deter-  
15 mining the applicable product price or prices.

16 (c) CHARGES BY INDEPENDENT PHARMACIES.—  
17 Each State health security program shall provide for pay-  
18 ment for a prescription drug or biological or insulin fur-  
19 nished by an independent pharmacy based on the drug's  
20 cost to the pharmacy (not in excess of the applicable prod-  
21 uct price established under subsection (b)) plus a dis-  
22 pensing fee. In accordance with standards established by  
23 the Board, each State health security program, after con-  
24 sultation with representatives of the pharmaceutical pro-  
25 fession, shall establish schedules of dispensing fees, de-



1 signed to afford reasonable compensation to independent  
2 pharmacies after taking into account variations in their  
3 cost of operation resulting from regional differences, dif-  
4 ferences in the volume of prescription drugs dispensed, dif-  
5 ferences in services provided, the need to maintain expend-  
6 itures within the budgets established under this title, and  
7 other relevant factors.

8 **SEC. 616. PAYMENTS FOR APPROVED DEVICES AND EQUIP-**  
9 **MENT.**

10 (a) **ESTABLISHMENT OF LIST.**—The Board shall es-  
11 tablish a list of approved durable medical equipment and  
12 therapeutic devices and equipment (including eyeglasses,  
13 hearing aids, and prosthetic appliances), that the Board  
14 determines are necessary for the maintenance or restora-  
15 tion of health or of employability or self-management and  
16 eligible for coverage under this Act.

17 (b) **CONSIDERATIONS AND CONDITIONS.**—In estab-  
18 lishing the list under subsection (a), the Board shall take  
19 into consideration the efficacy, safety, and cost of each  
20 item contained on such list, and shall attach to any item  
21 such conditions as the Board determines appropriate with  
22 respect to the circumstances under which, or the frequency  
23 with which, the item may be prescribed.

24 (c) **PRICES.**—For each such listed item covered under  
25 this Act, the Board shall from time to time determine a

1 product price or prices which shall constitute the max-  
2 imum to be recognized under this Act as the cost of the  
3 item to a provider thereof. The Board may conduct nego-  
4 tiations, on behalf of State health security programs, with  
5 equipment and device manufacturers and distributors in  
6 determining the applicable product price or prices.

7 (d) EXCLUSIONS.—The Board may exclude from cov-  
8 erage under this Act ineffective, unsafe, or overpriced  
9 products where better alternatives are determined to be  
10 available.

11 **SEC. 617. PAYMENTS FOR OTHER ITEMS AND SERVICES.**

12 In the case of payment for other covered health serv-  
13 ices, the amount of payment under a State health security  
14 program shall be established by the program—

15 (1) in accordance with payment methodologies  
16 which are specified by the Board, after consultation  
17 with the American Health Security Advisory Coun-  
18 cil, or methodologies established by the State under  
19 section 620; and

20 (2) consistent with the State health security  
21 budget.

22 **SEC. 618. PAYMENT INCENTIVES FOR MEDICALLY UNDER-**  
23 **SERVED AREAS.**

24 (a) MODEL PAYMENT METHODOLOGIES.—In addi-  
25 tion to the payment amounts otherwise provided in this

1 title, the Board shall establish model payment methodolo-  
2 gies and other incentives that promote the provision of  
3 covered health care services in medically underserved  
4 areas, particularly in rural and inner-city underserved  
5 areas.

6 (b) CONSTRUCTION.—Nothing in this title shall be  
7 construed as limiting the authority of State health security  
8 programs to increase payment amounts or otherwise pro-  
9 vide additional incentives, consistent with the State health  
10 security budget, to encourage the provision of medically  
11 necessary and appropriate services in underserved areas.

12 **SEC. 619. AUTHORITY FOR ALTERNATIVE PAYMENT METH-**  
13 **ODOLOGIES.**

14 A State health security program, as part of its plan  
15 under section 404(a), may use a payment methodology  
16 other than a methodology required under this subtitle so  
17 long as—

18 (1) such payment methodology does not affect  
19 the entitlement of individuals to coverage, the  
20 weighting of fee schedules to encourage an increase  
21 in the number of primary care providers, the ability  
22 of individuals to choose among qualified providers,  
23 the benefits covered under the program, or the com-  
24 pliance of the program with the State health security  
25 budget under subtitle A; and

1           (2) the program submits periodic reports to the  
2           Board showing the operation and effectiveness of the  
3           alternative methodology, in order for the Board to  
4           evaluate the appropriateness of applying the alter-  
5           native methodology to other States.

6           **Subtitle C—Mandatory Assignment**  
7           **and Administrative Provisions**

8           **SEC. 631. MANDATORY ASSIGNMENT.**

9           (a) **NO BALANCE BILLING.**—Payments for benefits  
10          under this Act shall constitute payment in full for such  
11          benefits and the entity furnishing an item or service for  
12          which payment is made under this Act shall accept such  
13          payment as payment in full for the item or service and  
14          may not accept any payment or impose any charge for  
15          any such item or service other than accepting payment  
16          from the State health security program in accordance with  
17          this Act.

18          (b) **ENFORCEMENT.**—If an entity knowingly and will-  
19          fully bills for an item or service or accepts payment in  
20          violation of subsection (a), the Board may apply sanctions  
21          against the entity in the same manner as sanctions could  
22          have been imposed under section 1842(j)(2) of the Social  
23          Security Act for a violation of section 1842(j)(1) of such  
24          Act. Such sanctions are in addition to any sanctions that

1 a State may impose under its State health security pro-  
2 gram.

3 **SEC. 632. PROCEDURES FOR REIMBURSEMENT; APPEALS.**

4 (a) PROCEDURES FOR REIMBURSEMENT.—In accord-  
5 ance with standards issued by the Board, a State health  
6 security program shall establish a timely and administra-  
7 tively simple procedure to assure payment within 60 days  
8 of the date of submission of clean claims by providers  
9 under this Act.

10 (b) APPEALS PROCESS.—Each State health security  
11 program shall establish an appeals process to handle all  
12 grievances pertaining to payment to providers under this  
13 title.

14 **TITLE VII—PROMOTION OF PRI-**  
15 **MARY HEALTH CARE; DEVEL-**  
16 **OPMENT OF HEALTH SERV-**  
17 **ICE CAPACITY; PROGRAMS TO**  
18 **ASSIST THE MEDICALLY UN-**  
19 **DESERVED**

20 **Subtitle A—Promotion and Expans-**  
21 **ion of Primary Care Profes-**  
22 **sional Training**

23 **SEC. 701. ROLE OF BOARD; ESTABLISHMENT OF PRIMARY**  
24 **CARE PROFESSIONAL OUTPUT GOALS.**

25 (a) IN GENERAL.—The Board is responsible for—

1           (1) coordinating health professional education  
2 policies and goals, in consultation with the Secretary  
3 of Health and Human Services (in this title referred  
4 to as the “Secretary”), to achieve the national goals  
5 specified in subsection (b);

6           (2) overseeing the health professional education  
7 expenditures of the State health security programs  
8 from the account established under section 602(c);

9           (3) developing and maintaining, in cooperation  
10 with the Secretary, a system to monitor the number  
11 and specialties of individuals through their health  
12 professional education, any postgraduate training,  
13 and professional practice; and

14           (4) developing, coordinating, and promoting  
15 other policies that expand the number of primary  
16 care practitioners.

17       (b) NATIONAL GOALS.—The national goals specified  
18 in this subsection are as follows:

19           (1) GRADUATE MEDICAL EDUCATION.—By not  
20 later than 5 years after the date of the enactment  
21 of this Act, at least 50 percent of the residents in  
22 medical residency education programs (as defined in  
23 subsection (e)(1)) are primary care residents (as de-  
24 fined in subsection (e)(3)).

1           (2) MIDDLELEVEL PRIMARY CARE PRACTI-  
2           TIONERS.—To assure an adequate supply of primary  
3           care practitioners, there shall be a number, specified  
4           by the Board, of midlevel primary care practitioners  
5           (as defined in subsection (e)(2)) employed in the  
6           health care system as of January 1, 2013.

7           (c) METHOD FOR ATTAINMENT OF NATIONAL GOAL  
8           FOR GRADUATE MEDICAL EDUCATION; PROGRAM  
9           GOALS.—

10           (1) IN GENERAL.—The Board shall establish a  
11           method of applying the national goal in subsection  
12           (b)(1) to program goals for each medical residency  
13           education program or to medical residency education  
14           consortia.

15           (2) CONSIDERATION.—The program goals  
16           under paragraph (1) shall be based on the distribu-  
17           tion of medical schools and other teaching facilities  
18           within each State health security program, and the  
19           number of positions for graduate medical education.

20           (3) MEDICAL RESIDENCY EDUCATION CONSOR-  
21           TIUM.—In this subsection, the term “medical resi-  
22           dency education consortium” means a consortium of  
23           medical residency education programs in a contig-  
24           uous geographic area (which may be an interstate  
25           area) if the consortium—

1 (A) includes at least 1 medical school with  
2 a teaching hospital and related teaching set-  
3 tings; and

4 (B) has an affiliation with qualified com-  
5 munity-based primary health service providers  
6 described in section 202(a) and with at least 1  
7 comprehensive health service organization es-  
8 tablished under section 303.

9 (4) ENFORCEMENT THROUGH STATE HEALTH  
10 SECURITY BUDGETS.—The Board shall develop a  
11 formula for reducing payments to State health secu-  
12 rity programs (that provide for payments to a med-  
13 ical residency education program) that failed to meet  
14 the goal for the program established under this sub-  
15 section.

16 (d) METHOD FOR ATTAINMENT OF NATIONAL GOAL  
17 FOR MIDDLELEVEL PRIMARY CARE PRACTITIONERS.—To as-  
18 sist in attaining the national goal identified in subsection  
19 (b)(2), the Board shall—

20 (1) advise the Public Health Service on alloca-  
21 tions of funding under titles VII and VIII of the  
22 Public Health Service Act, the National Health  
23 Service Corps, and other programs in order to in-  
24 crease the supply of midlevel primary care practi-  
25 tioners; and



1           (2) commission a study of the potential benefits  
2           and disadvantages of expanding the scope of practice  
3           authorized under State laws for any class of midlevel  
4           primary care practitioners.

5           (e) DEFINITIONS.—In this title:

6           (1) MEDICAL RESIDENCY EDUCATION PRO-  
7           GRAM.—The term “medical residency education pro-  
8           gram” means a program that provides education  
9           and training to graduates of medical schools in order  
10          to meet requirements for licensing and certification  
11          as a physician, and includes the medical school su-  
12          pervising the program and includes the hospital or  
13          other facility in which the program is operated.

14          (2) MIDDLELEVEL PRIMARY CARE PRACTI-  
15          TIONER.—The term “midlevel primary care practi-  
16          tioner” means a clinical nurse practitioner, certified  
17          nurse midwife, physician assistance, or other non-  
18          physician practitioner, specified by the Board, as au-  
19          thorized to practice under State law.

20          (3) PRIMARY CARE RESIDENT.—The term “pri-  
21          mary care resident” means (in accordance with cri-  
22          teria established by the Board) a resident being  
23          trained in a distinct program of family practice med-  
24          icine, general practice, general internal medicine, or  
25          general pediatrics.

1 **SEC. 702. ESTABLISHMENT OF ADVISORY COMMITTEE ON**  
2 **HEALTH PROFESSIONAL EDUCATION.**

3 (a) IN GENERAL.—The Board shall provide for an  
4 Advisory Committee on Health Professional Education (in  
5 this section referred to as the “Committee”) to advise the  
6 Board on its activities under section 701.

7 (b) MEMBERSHIP.—The Committee shall be com-  
8 posed of—

9 (1) the Chair of the Board, who shall serve as  
10 Chair of the Committee; and

11 (2) 12 members, not otherwise in the employ of  
12 the United States, appointed by the Board without  
13 regard to the provisions of title 5, United States  
14 Code, governing appointments in the competitive  
15 service.

16 The appointed members shall provide a balanced point of  
17 view with respect to health professional education, primary  
18 care disciplines, and health care policy and shall include  
19 individuals who are representative of medical schools,  
20 other health professional schools, residency programs, pri-  
21 mary care practitioners, teaching hospitals, professional  
22 associations, public health organizations, State health se-  
23 curity programs, and consumers.

24 (c) TERMS OF MEMBERS.—Each appointed member  
25 shall hold office for a term of 5 years, except that—

1           (1) any member appointed to fill a vacancy oc-  
2           curring during the term for which the member's  
3           predecessor was appointed shall be appointed for the  
4           remainder of that term; and

5           (2) the terms of the members first taking office  
6           shall expire, as designated by the Board at the time  
7           of appointment, 2 at the end of the second year, 2  
8           at the end of the third year, 2 at the end of the  
9           fourth year, and 3 at the end of the fifth year after  
10          the date of enactment of this Act.

11          (d) VACANCIES.—

12           (1) IN GENERAL.—The Board shall fill any va-  
13           cancy in the membership of the Committee in the  
14           same manner as the original appointment. The va-  
15           cancy shall not affect the power of the remaining  
16           members to execute the duties of the Committee.

17           (2) VACANCY APPOINTMENTS.—Any member  
18           appointed to fill a vacancy shall serve for the re-  
19           mainder of the term for which the predecessor of the  
20           member was appointed.

21           (3) REAPPOINTMENT.—The Board may re-  
22           appoint an appointed member of the Committee for  
23           a second term in the same manner as the original  
24           appointment.

1       (e) DUTIES.—It shall be the duty of the Committee  
2 to advise the Board concerning graduate medical edu-  
3 cation policies under this title.

4       (f) STAFF.—The Committee, its members, and any  
5 committees of the Committee shall be provided with such  
6 secretarial, clerical, or other assistance as may be author-  
7 ized by the Board for carrying out their respective func-  
8 tions.

9       (g) MEETINGS.—The Committee shall meet as fre-  
10 quently as the Board deems necessary, but not less than  
11 4 times each year. Upon request by 4 or more members  
12 it shall be the duty of the Chair to call a meeting of the  
13 Committee.

14       (h) COMPENSATION.—Members of the Committee  
15 shall be reimbursed by the Board for travel and per diem  
16 in lieu of subsistence expenses during the performance of  
17 duties of the Board in accordance with subchapter I of  
18 chapter 57 of title 5, United States Code.

19       (i) FACA NOT APPLICABLE.—The provisions of the  
20 Federal Advisory Committee Act shall not apply to the  
21 Committee.

1 **SEC. 703. GRANTS FOR HEALTH PROFESSIONS EDUCATION,**  
2 **NURSE EDUCATION, AND THE NATIONAL**  
3 **HEALTH SERVICE CORPS.**

4 (a) **TRANSFERS TO PUBLIC HEALTH SERVICE.**—  
5 From the amounts provided under subsection (c), the  
6 Board shall make transfers from the American Health Se-  
7 curity Trust Fund to the Public Health Service under sub-  
8 part II of part D of title III, title VII, and title VIII of  
9 the Public Health Service Act for the support of the Na-  
10 tional Health Service Corps, health professions education,  
11 and nursing education, including education of clinical  
12 nurse practitioners, certified registered nurse anesthetists,  
13 certified nurse midwives, and physician assistants. Of the  
14 amounts so transferred in each year, not less than 50 per-  
15 cent shall be expended for the support of the National  
16 Health Service Corps.

17 (b) **RANGE OF FUNDS.**—The amount of transfers  
18 under subsection (a) for any fiscal year shall be an amount  
19 (specified by the Board each year) not less than  $\frac{4}{100}$  per-  
20 cent and not to exceed  $\frac{6}{100}$  percent of the amounts the  
21 Board estimates will be expended from the Trust Fund  
22 in the fiscal year.

23 (c) **FUNDS SUPPLEMENTAL TO OTHER FUNDS.**—The  
24 funds provided under this section with respect to provision  
25 of services are in addition to, and not in replacement of,  
26 funds made available under the provisions referred to in

1 subsection (a) and shall be administered in accordance  
2 with the terms of such provisions. The Board shall make  
3 no transfer of funds under this section for any fiscal year  
4 for which the total appropriations for the programs au-  
5 thorized by such provisions are less than the total amount  
6 appropriated for such programs in fiscal year 2008.

## 7 **Subtitle B—Direct Health Care** 8 **Delivery**

### 9 **SEC. 711. SET-ASIDE FOR PUBLIC HEALTH.**

10 (a) TRANSFERS TO PUBLIC HEALTH SERVICE.—  
11 From the amounts provided under subsection (c), the  
12 Board shall make transfers from the American Health Se-  
13 curity Trust Fund to the Public Health Service for the  
14 following purposes (other than payment for services cov-  
15 ered under title II):

16 (1) For payments to States under the maternal  
17 and child health block grants under title V of the  
18 Social Security Act.

19 (2) For prevention and treatment of tuber-  
20 culosis under section 317 of the Public Health Serv-  
21 ice Act.

22 (3) For the prevention and treatment of sexu-  
23 ally transmitted diseases under section 318 of the  
24 Public Health Service Act.

1           (4) Preventive health block grants under part A  
2 of title XIX of the Public Health Service Act.

3           (5) Grants to States for community mental  
4 health services under subpart I of part B of title  
5 XIX of the Public Health Service Act.

6           (6) Grants to States for prevention and treat-  
7 ment of substance abuse under subpart II of part B  
8 of title XIX of the Public Health Service Act.

9           (7) Grants for HIV health care services under  
10 parts A, B, and C of title XXVI of the Public  
11 Health Service Act.

12           (8) Public health formula grants described in  
13 subsection (d).

14       (b) RANGE OF FUNDS.—The amount of transfers  
15 under subsection (a) for any fiscal year shall be an amount  
16 (specified by the Board each year) not less than  $\frac{1}{10}$  per-  
17 cent and not to exceed  $\frac{14}{100}$  percent of the amounts the  
18 Board estimates will be expended from the Trust Fund  
19 in the fiscal year.

20       (c) FUNDS SUPPLEMENTAL TO OTHER FUNDS.—The  
21 funds provided under this section with respect to provision  
22 of services are in addition to, and not in replacement of,  
23 funds made available under the programs referred to in  
24 subsection (a) and shall be administered in accordance  
25 with the terms of such programs.

1           (d) REQUIRED REPORTS ON HEALTH STATUS.—The  
2 Secretary shall require each State receiving funds under  
3 this section to submit annual reports to the Secretary on  
4 the health status of the population and measurable objec-  
5 tives for improving the health of the public in the State.  
6 Such reports shall include the following:

7           (1) A comparison of the measures of the State  
8 and local public health system compared to relevant  
9 objectives set forth in “Healthy People 2000” or  
10 subsequent national objectives set by the Secretary.

11           (2) A description of health status measures to  
12 be improved within the State (at the State and local  
13 levels) through expanded public health functions and  
14 health promotion and disease prevention programs.

15           (3) Measurable outcomes and process objectives  
16 for improving health status, and a report on out-  
17 comes from the previous year.

18           (4) Information regarding how Federal funding  
19 has improved population-based prevention activities  
20 and programs.

21           (5) A description of the core public health func-  
22 tions to be carried out at the local level.

23           (6) A description of the relationship between  
24 the State’s public health system, community-based



1 health promotion and disease prevention providers,  
2 and the State health security program.

3 (e) LIMITATION ON FUND TRANSFERS.—The Board  
4 shall make no transfer of funds under this section for any  
5 fiscal year for which the total appropriations for such pro-  
6 grams are less than the total amount appropriated for  
7 such programs in fiscal year 2008.

8 (f) PUBLIC HEALTH FORMULA GRANTS.—The Sec-  
9 retary shall provide stable funds to States through for-  
10 mula grants for the purpose of carrying out core public  
11 health functions to monitor and protect the health of com-  
12 munities from communicable diseases and exposure to  
13 toxic environmental pollutants, occupational hazards,  
14 harmful products, and poor health outcomes. Such func-  
15 tions include the following:

16 (1) Data collection, analysis, and assessment of  
17 public health data, vital statistics, and personal  
18 health data to assess community health status and  
19 outcomes reporting. This function includes the ac-  
20 quisition and installation of hardware and software,  
21 and personnel training and technical assistance to  
22 operate and support automated and integrated infor-  
23 mation systems.

1           (2) Activities to protect the environment and to  
2 assure the safety of housing, workplaces, food, and  
3 water.

4           (3) Investigation and control of adverse health  
5 conditions, and threats to the health status of indi-  
6 viduals and the community. This function includes  
7 the identification and control of outbreaks of infec-  
8 tious disease, patterns of chronic disease and injury,  
9 and cooperative activities to reduce the levels of vio-  
10 lence.

11          (4) Health promotion and disease prevention  
12 activities for which there is a significant need and a  
13 high priority of the Public Health Service.

14          (5) The provision of public health laboratory  
15 services to complement private clinical laboratory  
16 services, including—

17           (A) screening tests for metabolic diseases  
18           in newborns;

19           (B) toxicology assessments of blood lead  
20           levels and other environmental toxins;

21           (C) tuberculosis and other diseases requir-  
22           ing partner notification; and

23           (D) testing for infectious and food-borne  
24           diseases.

1           (6) Training and education for the public  
2 health professions.

3           (7) Research on effective and cost-effective pub-  
4 lic health practices. This function includes the devel-  
5 opment, testing, evaluation, and publication of re-  
6 sults of new prevention and public health control  
7 interventions.

8           (8) Integration and coordination of the preven-  
9 tion programs and services of community-based pro-  
10 viders, local and State health departments, and  
11 other sectors of State and local government that af-  
12 fect health.

13 **SEC. 712. SET-ASIDE FOR PRIMARY HEALTH CARE DELIV-**  
14 **ERY.**

15       (a) TRANSFERS TO PUBLIC HEALTH SERVICE.—  
16 From the amounts provided under subsection (c), the  
17 Board shall make transfers from the American Health Se-  
18 curity Trust Fund to the Public Health Service for the  
19 program of primary care service expansion grants under  
20 subpart V of part D of title III of the Public Health Serv-  
21 ice Act (as added by section 713 of this Act).

22       (b) RANGE OF FUNDS.—The amount of transfers  
23 under subsection (a) for any fiscal year shall be an amount  
24 (specified by the Board each year) not less than  $\frac{6}{100}$  per-  
25 cent and not to exceed  $\frac{1}{10}$  percent of the amounts the

1 Board estimates will be expended from the Trust Fund  
2 in the fiscal year.

3 (c) FUNDS SUPPLEMENTAL TO OTHER FUNDS.—The  
4 funds provided under this section with respect to provision  
5 of services are in addition to, and not in replacement of,  
6 funds made available under the sections 329, 330, 340,  
7 340A, 1001, and 2655 of the Public Health Service Act.  
8 The Board shall make no transfer of funds under this sec-  
9 tion for any fiscal year for which the total appropriations  
10 for such sections are less than the total amount appro-  
11 priated under such sections in fiscal year 2008.

12 **SEC. 713. PRIMARY CARE SERVICE EXPANSION GRANTS.**

13 Part D of title III of the Public Health Service Act  
14 (42 U.S.C. 254b et seq.) is amended by adding at the end  
15 thereof the following new subpart:

16 **“Subpart XI—Primary Care Expansion**

17 **“SEC. 340H. EXPANDING PRIMARY CARE DELIVERY CAPAC-**  
18 **ITY IN URBAN AND RURAL AREAS.**

19 “(a) GRANTS FOR PRIMARY CARE CENTERS.—From  
20 the amounts described in subsection (c), the American  
21 Health Security Standards Board shall make grants to  
22 public and nonprofit private entities for projects to plan  
23 and develop primary care centers which will serve medi-  
24 cally underserved populations (as defined in section  
25 330(b)(3)) in urban and rural areas and to deliver primary

1 care services to such populations in such areas. The funds  
2 provided under such a grant may be used for the same  
3 purposes for which a grant may be made under subsection  
4 (c), (e), (f), (g), (h), or (i) of section 330.

5 “(b) PROCESS OF AWARDING GRANTS.—The provi-  
6 sions of subsection (k)(1) of section 330 shall apply to  
7 a grant under this section in the same manner as they  
8 apply to a grant under the corresponding subsection of  
9 such section. The provisions of subsection (r)(2)(A) of  
10 such section shall apply to grants for projects to plan and  
11 develop primary care centers under this section in the  
12 same manner as they apply to grants under such section.

13 “(c) FUNDING AS SET-ASIDE FROM TRUST FUND.—  
14 Funds in the American Health Security Trust Fund (es-  
15 tablished under section 801 of the act) shall be available  
16 to carry out this section.

17 “(d) PRIMARY CARE CENTER DEFINED.—In this sec-  
18 tion, the term ‘primary care center’ means—

19 “(1) a health center (as defined in section  
20 330(a)(1));

21 “(2) an entity qualified to receive a grant under  
22 section 330, 1001, or 2651; or

23 “(3) a Federally-qualified health center (as de-  
24 fined in section 1905(l)(2)(B) of the Social Security  
25 Act).”.

1           **Subtitle C—Primary Care and**  
2                           **Outcomes Research**

3   **SEC. 721. SET-ASIDE FOR OUTCOMES RESEARCH.**

4           (a) GRANTS FOR OUTCOMES RESEARCH.—The  
5 Board shall make transfers from the American Health Se-  
6 curity Trust Fund to the Agency for Health Care Policy  
7 and Research under title IX of the Public Health Service  
8 Act for the purpose of carrying out activities under such  
9 title. The Secretary shall assure that there is a special em-  
10 phasis placed on pediatric outcomes research.

11          (b) RANGE OF FUNDS.—The amount of transfers  
12 under subsection (a) for any fiscal year shall be an amount  
13 (specified by the Board each year) not less than  $\frac{1}{100}$  per-  
14 cent and not to exceed  $\frac{2}{100}$  percent of the amounts the  
15 Board estimates will be expended from the Trust Fund  
16 in the fiscal year.

17          (c) FUNDS SUPPLEMENTAL TO OTHER FUNDS.—The  
18 funds provided under this section with respect to provision  
19 of services are in addition to, and not in replacement of,  
20 funds made available to the Agency for Health Care Policy  
21 and Research under 937 of the Public Health Service Act.  
22 The Board shall make no transfer of funds under this sec-  
23 tion for any fiscal year for which the total appropriations  
24 under such section are less than the total amount appro-  
25 priated under such section and title in fiscal year 2008.

1 (d) CONFORMING AMENDMENT.—Section 937(b) of  
2 the Public Health Service Act (42 U.S.C. 299e–6(b)) is  
3 amended by inserting after “of the fiscal years 2001  
4 through 2005” the following: “and of fiscal year 2010 and  
5 each subsequent year”.

6 **SEC. 722. OFFICE OF PRIMARY CARE AND PREVENTION RE-**  
7 **SEARCH.**

8 (a) IN GENERAL.—Title IV of the Public Health  
9 Service Act is amended—

10 (1) by redesignating parts G through I as parts  
11 H through J, respectively; and

12 (2) by inserting after part F the following new  
13 part:

14 **“PART G—RESEARCH ON PRIMARY CARE AND**  
15 **PREVENTION**

16 **“SEC. 486E. OFFICE OF PRIMARY CARE AND PREVENTION**  
17 **RESEARCH.**

18 “(a) ESTABLISHMENT.—There is established within  
19 the Office of the Director of NIH an office to be known  
20 as the Office of Primary Care and Prevention Research  
21 (in this part referred to as the ‘Office’). The Office shall  
22 be headed by a director, who shall be appointed by the  
23 Director of NIH.

24 “(b) PURPOSE.—The Director of the Office shall—

1           “(1) identify projects of research on primary  
2           care and prevention, for children as well as adults,  
3           that should be conducted or supported by the na-  
4           tional research institutes, with particular emphasis  
5           on—

6                   “(A) clinical patient care, with special em-  
7                   phasis on pediatric clinical care and diagnosis;

8                   “(B) diagnostic effectiveness;

9                   “(C) primary care education;

10                  “(D) health and family planning services;

11                  “(E) medical effectiveness outcomes of pri-  
12                  mary care procedures and interventions; and

13                  “(F) the use of multidisciplinary teams of  
14                  health care practitioners;

15           “(2) identify multidisciplinary research related  
16           to primary care and prevention that should be so  
17           conducted;

18           “(3) promote coordination and collaboration  
19           among entities conducting research identified under  
20           any of paragraphs (1) and (2);

21           “(4) encourage the conduct of such research by  
22           entities receiving funds from the national research  
23           institutes;

24           “(5) recommend an agenda for conducting and  
25           supporting such research;





1 supported by the national research institutes. Information  
2 from the data system shall be available through informa-  
3 tion systems available to health care professionals and pro-  
4 viders, researchers, and members of the public.

5 “(b) CLEARINGHOUSE.—The Director of NIH, in  
6 consultation with the Director of the Office and with the  
7 National Library of Medicine, shall establish, maintain,  
8 and operate a program to provide, and encourage the use  
9 of, information on research and prevention activities of the  
10 national research institutes that relate to primary care  
11 and prevention research.

12 **“SEC. 486G. BIENNIAL REPORT.**

13 “(a) IN GENERAL.—With respect to primary care  
14 and prevention research, the Director of the Office shall,  
15 not later than 1 year after the date of the enactment of  
16 this part, and biennially thereafter, prepare a report—

17 “(1) describing and evaluating the progress  
18 made during the preceding 2 fiscal years in research  
19 and treatment conducted or supported by the Na-  
20 tional Institutes of Health;

21 “(2) summarizing and analyzing expenditures  
22 made by the agencies of such Institutes (and by  
23 such Office) during the preceding 2 fiscal years; and

1           “(3) making such recommendations for legisla-  
2           tive and administrative initiatives as the Director of  
3           the Office determines to be appropriate.

4           “(b) INCLUSION IN BIENNIAL REPORT OF DIRECTOR  
5           OF NIH.—The Director of the Office shall submit each  
6           report prepared under subsection (a) to the Director of  
7           NIH for inclusion in the report submitted to the President  
8           and the Congress under section 403.

9           **“SEC. 486H. AUTHORIZATION OF APPROPRIATIONS.**

10          “For the Office of Primary Care and Prevention Re-  
11          search, there are authorized to be appropriated  
12          \$150,000,000 for fiscal year 2010, \$180,000,000 for fis-  
13          cal year 2011, and \$216,000,000 for fiscal year 2012.”.

14          (b) REQUIREMENT OF SUFFICIENT ALLOCATION OF  
15          RESOURCES OF INSTITUTES.—Section 402(b) of the Pub-  
16          lic Health Service Act (42 U.S.C. 282(b)) is amended—

17                 (1) in paragraph (22), by striking “and” after  
18                 the semicolon at the end;

19                 (2) in paragraph (23), by striking the period at  
20                 the end and inserting “; and”; and

21                 (3) by inserting after paragraph (23) the fol-  
22                 lowing new paragraph:

23                 “(24) after consultation with the Director of  
24                 the Office of Primary Care and Prevention Re-  
25                 search, shall ensure that resources of the National

1 Institutes of Health are sufficiently allocated for  
2 projects on primary care and prevention research  
3 that are identified under section 486E(b).”.

## 4 **Subtitle D—School-Related Health** 5 **Services**

### 6 **SEC. 731. AUTHORIZATIONS OF APPROPRIATIONS.**

7 (a) FUNDING FOR SCHOOL-RELATED HEALTH SERV-  
8 ICES.—For the purpose of carrying out this subtitle, there  
9 are authorized to be appropriated \$100,000,000 for fiscal  
10 year 2012, \$275,000,000 for fiscal year 2013,  
11 \$350,000,000 for fiscal year 2014, and \$400,000,000 for  
12 each of the fiscal years 2015 and 2016.

13 (b) RELATION TO OTHER FUNDS.—The authoriza-  
14 tions of appropriations established in subsection (a) are  
15 in addition to any other authorizations of appropriations  
16 that are available for the purpose described in such sub-  
17 section.

### 18 **SEC. 732. ELIGIBILITY FOR DEVELOPMENT AND OPER-** 19 **ATION GRANTS.**

20 (a) IN GENERAL.—Entities eligible to apply for and  
21 receive grants under section 734 or 735 are the following:

22 (1) State health agencies that apply on behalf  
23 of local community partnerships and other commu-  
24 nities in need of health services for school-aged chil-  
25 dren within the State.

1           (2) Local community partnerships in States in  
2 which health agencies have not applied.

3           (b) LOCAL COMMUNITY PARTNERSHIPS.—

4           (1) IN GENERAL.—A local community partner-  
5 ship under subsection (a)(2) is an entity that, at a  
6 minimum, includes—

7                   (A) a local health care provider with expe-  
8 rience in delivering services to school-aged chil-  
9 dren;

10                   (B) 1 or more local public schools; and

11                   (C) at least 1 community based organiza-  
12 tion located in the community to be served that  
13 has a history of providing services to school-  
14 aged children in the community who are at-risk.

15           (2) PARTICIPATION.—A partnership described  
16 in paragraph (1) shall, to the maximum extent fea-  
17 sible, involve broad based community participation  
18 from parents and adolescent children to be served,  
19 health and social service providers, teachers and  
20 other public school and school board personnel, de-  
21 velopment and service organizations for adolescent  
22 children, and interested business leaders. Such par-  
23 ticipation may be evidenced through an expanded  
24 partnership, or an advisory board to such partner-  
25 ship.

1 (c) DEFINITIONS REGARDING CHILDREN.—For pur-  
2 poses of this subtitle:

3 (1) The term “adolescent children” means  
4 school-aged children who are adolescents.

5 (2) The term “school-aged children” means in-  
6 dividuals who are between the ages of 4 and 19 (in-  
7 clusive).

8 **SEC. 733. PREFERENCES.**

9 (a) IN GENERAL.—In making grants under sections  
10 734 and 735, the Secretary shall give preference to appli-  
11 cants whose communities to be served show the most sub-  
12 stantial level of need for such services among school-aged  
13 children, as measured by indicators of community health  
14 including the following:

15 (1) High levels of poverty.

16 (2) The presence of a medically underserved  
17 population.

18 (3) The presence of a health professional short-  
19 age area.

20 (4) High rates of indicators of health risk  
21 among school-aged children, including a high propor-  
22 tion of such children receiving services through the  
23 Individuals with Disabilities Education Act, adoles-  
24 cent pregnancy, sexually transmitted disease (includ-  
25 ing infection with the human immunodeficiency

1 virus), preventable disease, communicable disease,  
2 intentional and unintentional injuries, community  
3 and gang violence, unemployment among adolescent  
4 children, juvenile justice involvement, and high rates  
5 of drug and alcohol exposure.

6 (b) LINKAGE TO COMMUNITY HEALTH CENTERS.—  
7 In making grants under sections 734 and 735, the Sec-  
8 retary shall give preference to applicants that demonstrate  
9 a linkage to community health centers.

10 **SEC. 734. GRANTS FOR DEVELOPMENT OF PROJECTS.**

11 (a) IN GENERAL.—The Secretary may make grants  
12 to State health agencies or to local community partner-  
13 ships to develop school health service sites.

14 (b) USE OF FUNDS.—A project for which a grant  
15 may be made under subsection (a) may include but not  
16 be limited to the cost of the following:

17 (1) Planning for the provision of school health  
18 services.

19 (2) Recruitment, compensation, and training of  
20 health and administrative staff.

21 (3) The development of agreements, and the ac-  
22 quisition and development of equipment and infor-  
23 mation services, necessary to support information  
24 exchange between school health service sites and

1 health plans, health providers, and other entities au-  
2 thorized to collect information under this Act.

3 (4) Other activities necessary to assume oper-  
4 ational status.

5 (c) APPLICATION FOR GRANT.—

6 (1) IN GENERAL.—Applicants shall submit ap-  
7 plications in a form and manner prescribed by the  
8 Secretary.

9 (2) APPLICATIONS BY STATE HEALTH AGEN-  
10 CIES.—

11 (A) In the case of applicants that are State  
12 health agencies, the application shall contain  
13 assurances that the State health agency is ap-  
14 plying for funds—

15 (i) on behalf of at least 1 local com-  
16 munity partnership; and

17 (ii) on behalf of at least 1 other com-  
18 munity identified by the State as in need  
19 of the services funded under this subtitle  
20 but without a local community partnership.

21 (B) In the case of the communities identi-  
22 fied in applications submitted by State health  
23 agencies that do not yet have local community  
24 partnerships (including the community identi-  
25 fied under subparagraph (A)(ii)), the State



1 shall describe the steps that will be taken to aid  
2 the communities in developing a local commu-  
3 nity partnership.

4 (C) A State applying on behalf of local  
5 community partnerships and other communities  
6 may retain not more than 10 percent of grants  
7 awarded under this subtitle for administrative  
8 costs.

9 (d) CONTENTS OF APPLICATION.—In order to receive  
10 a grant under this section, an applicant must include in  
11 the application the following information:

12 (1) An assessment of the need for school health  
13 services in the communities to be served, using the  
14 latest available health data and health goals and ob-  
15 jectives established by the Secretary.

16 (2) A description of how the applicant will de-  
17 sign the proposed school health services to reach the  
18 maximum number of school-aged children who are at  
19 risk.

20 (3) An explanation of how the applicant will in-  
21 tegrate its services with those of other health and  
22 social service programs within the community.

23 (4) A description of a quality assurance pro-  
24 gram which complies with standards that the Sec-  
25 retary may prescribe.

1 (e) NUMBER OF GRANTS.—Not more than 1 planning  
2 grant may be made to a single applicant. A planning grant  
3 may not exceed 2 years in duration.

4 **SEC. 735. GRANTS FOR OPERATION OF PROJECTS.**

5 (a) IN GENERAL.—The Secretary may make grants  
6 to State health agencies or to local community partner-  
7 ships for the cost of operating school health service sites.

8 (b) USE OF GRANT.—The costs for which a grant  
9 may be made under this section include but are not limited  
10 to the following:

11 (1) The cost of furnishing health services that  
12 are not otherwise covered under this Act or by any  
13 other public or private insurer.

14 (2) The cost of furnishing services whose pur-  
15 pose is to increase the capacity of individuals to uti-  
16 lize available health services, including transpor-  
17 tation, community and patient outreach, patient  
18 education, translation services, and such other serv-  
19 ices as the Secretary determines to be appropriate in  
20 carrying out such purpose.

21 (3) Training, recruitment and compensation of  
22 health professionals and other staff.

23 (4) Outreach services to school-aged children  
24 who are at risk and to the parents of such children.

1           (5) Linkage of individuals to health plans, com-  
2           munity health services and social services.

3           (6) Other activities deemed necessary by the  
4           Secretary.

5           (c) APPLICATION FOR GRANT.—Applicants shall sub-  
6           mit applications in a form and manner prescribed by the  
7           Secretary. In order to receive a grant under this section,  
8           an applicant must include in the application the following  
9           information:

10           (1) A description of the services to be furnished  
11           by the applicant.

12           (2) The amounts and sources of funding that  
13           the applicant will expend, including estimates of the  
14           amount of payments the applicant will receive from  
15           sources other than the grant.

16           (3) Such other information as the Secretary de-  
17           termines to be appropriate.

18           (d) ADDITIONAL CONTENTS OF APPLICATION.—In  
19           order to receive a grant under this section, an applicant  
20           must meet the following conditions:

21           (1) The applicant furnishes the following serv-  
22           ices:

23                   (A) Diagnosis and treatment of simple ill-  
24           nesses and minor injuries.

1 (B) Preventive health services, including  
2 health screenings.

3 (C) Services provided for the purpose de-  
4 scribed in subsection (b)(2).

5 (D) Referrals and followups in situations  
6 involving illness or injury.

7 (E) Health and social services, counseling  
8 services, and necessary referrals, including re-  
9 ferrals regarding mental health and substance  
10 abuse.

11 (F) Such other services as the Secretary  
12 determines to be appropriate.

13 (2) The applicant is a participating provider in  
14 the State's program for medical assistance under  
15 title XIX of the Social Security Act.

16 (3) The applicant does not impose charges on  
17 students or their families for services (including col-  
18 lection of any cost-sharing for services under the  
19 comprehensive benefit package that otherwise would  
20 be required).

21 (4) The applicant has reviewed and will periodi-  
22 cally review the needs of the population served by  
23 the applicant in order to ensure that its services are  
24 accessible to the maximum number of school-aged  
25 children in the area, and that, to the maximum ex-

1       tent possible, barriers to access to services of the ap-  
2       plicant are removed (including barriers resulting  
3       from the area's physical characteristics, its eco-  
4       nomic, social and cultural grouping, the health care  
5       utilization patterns of such children, and available  
6       transportation).

7           (5) In the case of an applicant which serves a  
8       population that includes a substantial proportion of  
9       individuals of limited English speaking ability, the  
10      applicant has developed a plan to meet the needs of  
11      such population to the extent practicable in the lan-  
12      guage and cultural context most appropriate to such  
13      individuals.

14           (6) The applicant will provide non-Federal con-  
15      tributions toward the cost of the project in an  
16      amount determined by the Secretary.

17           (7) The applicant will operate a quality assur-  
18      ance program consistent with section 734(d).

19           (e) DURATION OF GRANT.—A grant under this sec-  
20      tion shall be for a period determined by the Secretary.

21           (f) REPORTS.—A recipient of funding under this sec-  
22      tion shall provide such reports and information as are re-  
23      quired in regulations of the Secretary.

1 **SEC. 736. FEDERAL ADMINISTRATIVE COSTS.**

2       Of the amounts made available under section 731, the  
3 Secretary may reserve not more than 5 percent for admin-  
4 istrative expenses regarding this subtitle.

5 **SEC. 737. DEFINITIONS.**

6       For purposes of this subtitle:

7           (1) The term “adolescent children” has the  
8 meaning given such term in section 732(c).

9           (2) The term “at risk” means at-risk with re-  
10 spect to health.

11           (3) The term “community health center” has  
12 the meaning given such term in section 330 of the  
13 Public Health Service Act.

14           (4) The term “health professional shortage  
15 area” means a health professional shortage area des-  
16 igned under section 332 of the Public Health Serv-  
17 ice Act.

18           (5) The term “medically underserved popu-  
19 lation” has the meaning given such term in section  
20 330 of the Public Health Service Act.

21           (6) The term “school-aged children” has the  
22 meaning given such term in section 732(c).

1 **TITLE VIII—FINANCING PROVI-**  
2 **SIONS; AMERICAN HEALTH**  
3 **SECURITY TRUST FUND**

4 **SEC. 800. AMENDMENT OF 1986 CODE; SECTION 15 NOT TO**  
5 **APPLY.**

6 (a) AMENDMENT OF 1986 CODE.—Except as other-  
7 wise expressly provided, whenever in this title an amend-  
8 ment or repeal is expressed in terms of an amendment  
9 to, or repeal of, a section or other provision, the reference  
10 shall be considered to be made to a section or other provi-  
11 sion of the Internal Revenue Code of 1986.

12 (b) SECTION 15 NOT TO APPLY.—The amendments  
13 made by subtitle B shall not be treated as a change in  
14 a rate of tax for purposes of section 15 of the Internal  
15 Revenue Code of 1986.

16 **Subtitle A—American Health**  
17 **Security Trust Fund**

18 **SEC. 801. AMERICAN HEALTH SECURITY TRUST FUND.**

19 (a) IN GENERAL.—There is hereby created on the  
20 books of the Treasury of the United States a trust fund  
21 to be known as the American Health Security Trust Fund  
22 (in this section referred to as the “Trust Fund”). The  
23 Trust Fund shall consist of such gifts and bequests as  
24 may be made and such amounts as may be deposited in,

1 or appropriated to, such Trust Fund as provided in this  
2 Act.

3 (b) APPROPRIATIONS INTO TRUST FUND.—

4 (1) TAXES.—There are hereby appropriated to  
5 the Trust Fund for each fiscal year (beginning with  
6 fiscal year 2011), out of any moneys in the Treasury  
7 not otherwise appropriated, amounts equivalent to  
8 100 percent of the aggregate increase in tax liabil-  
9 ities under the Internal Revenue Code of 1986 which  
10 is attributable to the application of the amendments  
11 made by this title. The amounts appropriated by the  
12 preceding sentence shall be transferred from time to  
13 time (but not less frequently than monthly) from the  
14 general fund in the Treasury to the Trust Fund,  
15 such amounts to be determined on the basis of esti-  
16 mates by the Secretary of the Treasury of the taxes  
17 paid to or deposited into the Treasury; and proper  
18 adjustments shall be made in amounts subsequently  
19 transferred to the extent prior estimates were in ex-  
20 cess of or were less than the amounts that should  
21 have been so transferred.

22 (2) CURRENT PROGRAM RECEIPTS.—Notwith-  
23 standing any other provision of law, there are hereby  
24 appropriated to the Trust Fund for each fiscal year  
25 (beginning with fiscal year 2011) the amounts that



1 would otherwise have been appropriated to carry out  
2 the following programs:

3 (A) The medicare program, under parts A,  
4 B, and D of title XVIII of the Social Security  
5 Act (other than amounts attributable to any  
6 premiums under such parts).

7 (B) The medicaid program, under State  
8 plans approved under title XIX of such Act.

9 (C) The Federal employees health benefit  
10 program, under chapter 89 of title 5, United  
11 States Code.

12 (D) The TRICARE program (formerly  
13 known as the CHAMPUS program), under  
14 chapter 55 of title 10, United States Code.

15 (E) The maternal and child health pro-  
16 gram (under title V of the Social Security Act),  
17 vocational rehabilitation programs, programs  
18 for drug abuse and mental health services  
19 under the Public Health Service Act, programs  
20 providing general hospital or medical assistance,  
21 and any other Federal program identified by  
22 the Board, in consultation with the Secretary of  
23 the Treasury, to the extent the programs pro-  
24 vide for payment for health services the pay-  
25 ment of which may be made under this Act.

1 (c) INCORPORATION OF PROVISIONS.—The provisions  
2 of subsections (b) through (i) of section 1817 of the Social  
3 Security Act shall apply to the Trust Fund under this Act  
4 in the same manner as they applied to the Federal Hos-  
5 pital Insurance Trust Fund under part A of title XVIII  
6 of such Act, except that the American Health Security  
7 Standards Board shall constitute the Board of Trustees  
8 of the Trust Fund.

9 (d) TRANSFER OF FUNDS.—Any amounts remaining  
10 in the Federal Hospital Insurance Trust Fund or the Fed-  
11 eral Supplementary Medical Insurance Trust Fund after  
12 the settlement of claims for payments under title XVIII  
13 have been completed, shall be transferred into the Amer-  
14 ican Health Security Trust Fund.

## 15 **Subtitle B—Taxes Based on Income** 16 **and Wages**

### 17 **SEC. 811. PAYROLL TAX ON EMPLOYERS.**

18 (a) IN GENERAL.—Section 3111 (relating to tax on  
19 employers) is amended by redesignating subsection (c) as  
20 subsection (d) and inserting after subsection (b) the fol-  
21 lowing new subsection:

22 “(c) HEALTH CARE.—In addition to other taxes,  
23 there is hereby imposed on every employer an excise tax,  
24 with respect to having individuals in his employ, equal to  
25 8.7 percent of the wages (as defined in section 3121(a))

1 paid by him with respect to employment (as defined in  
2 section 3121(b)).”.

3 (b) SELF-EMPLOYMENT INCOME.—Section 1401 (re-  
4 lating to rate of tax on self-employment income) is amend-  
5 ed by redesignating subsection (c) as subsection (d) and  
6 inserting after subsection (b) the following new subsection:

7 “(c) HEALTH CARE.—In addition to other taxes,  
8 there shall be imposed for each taxable year, on the self-  
9 employment income of every individual, a tax equal to 8.7  
10 percent of the amount of the self-employment income for  
11 such taxable year.”.

12 (c) COMPARABLE TAXES FOR RAILROAD SERV-  
13 ICES.—

14 (1) TAX ON EMPLOYERS.—Section 3221 is  
15 amended by redesignating subsection (c) as sub-  
16 sections (d) and inserting after subsection (b) the  
17 following new subsection:

18 “(c) HEALTH CARE.—In addition to other taxes,  
19 there is hereby imposed on every employer an excise tax,  
20 with respect to having individuals in his employ, equal to  
21 8.7 percent of the compensation paid by such employer  
22 for services rendered to such employer.”.

23 (2) TAX ON EMPLOYEE REPRESENTATIVES.—

24 Section 3211 (relating to tax on employee represent-  
25 atives) is amended by redesignating subsection (c) as

1 subsection (d) and inserting after subsection (b) the  
2 following new paragraph:

3 “(c) HEALTH CARE.—In addition to other taxes,  
4 there is hereby imposed on the income of each employee  
5 representative a tax equal to 8.7 percent of the compensa-  
6 tion received during the calendar year by such employee  
7 representative for services rendered by such employee rep-  
8 resentative.”.

9 (3) NO APPLICABLE BASE.—Subparagraph (A)  
10 of section 3231(e)(2) is amended by adding at the  
11 end thereof the following new clause:

12 “(iv) HEALTH CARE TAXES.—Clause  
13 (i) shall not apply to the taxes imposed by  
14 sections 3221(c) and 3211(c).”.

15 (4) TECHNICAL AMENDMENT.—

16 (A) Subsection (d) of section 3211, as re-  
17 designated by paragraph (2), is amended by  
18 striking “and (b)” and inserting “, (b), and  
19 (c)”.

20 (B) Subsection (d) of section 3221, as re-  
21 designated by paragraph (1), is amended by  
22 striking “and (b)” and inserting “, (b), and  
23 (c)”.

1 (d) EFFECTIVE DATE.—The amendments made by  
 2 this section shall apply to remuneration paid after Decem-  
 3 ber 31, 2010.

4 **SEC. 812. HEALTH CARE INCOME TAX.**

5 (a) GENERAL RULE.—Subchapter A of chapter 1 (re-  
 6 lating to determination of tax liability) is amended by add-  
 7 ing at the end thereof the following new part:

8 **“PART VIII—HEALTH CARE INCOME TAX ON**  
 9 **INDIVIDUALS**

“Sec. 59B. Health care income tax.

10 **“SEC. 59B. HEALTH CARE INCOME TAX.**

11 “(a) IMPOSITION OF TAX.—In the case of an indi-  
 12 vidual, there is hereby imposed a tax (in addition to any  
 13 other tax imposed by this subtitle) equal to 2.2 percent  
 14 of the taxable income of the taxpayer for the taxable year.

15 “(b) NO CREDITS AGAINST TAX; NO EFFECT ON  
 16 MINIMUM TAX.—The tax imposed by this section shall not  
 17 be treated as a tax imposed by this chapter for purposes  
 18 of determining—

19 “(1) the amount of any credit allowable under  
 20 this chapter, or

21 “(2) the amount of the minimum tax imposed  
 22 by section 55.

23 “(c) SPECIAL RULES.—

1           “(1) TAX TO BE WITHHELD, ETC.—For pur-  
2           poses of this title, the tax imposed by this section  
3           shall be treated as imposed by section 1.

4           “(2) REIMBURSEMENT OF TAX BY EMPLOYER  
5           NOT INCLUDIBLE IN GROSS INCOME.—The gross in-  
6           come of an employee shall not include any payment  
7           by his employer to reimburse the employee for the  
8           tax paid by the employee under this section.

9           “(3) OTHER RULES.—The rules of section  
10          59A(d) shall apply to the tax imposed by this sec-  
11          tion.”.

12          (b) CLERICAL AMENDMENT.—The table of parts for  
13          subchapter A of chapter 1 is amended by adding at the  
14          end the following new item:

            “PART VIII. HEALTH CARE INCOME TAX ON INDIVIDUALS”.

15          (c) EFFECTIVE DATE.—The amendments made by  
16          this section shall apply to taxable years beginning after  
17          December 31, 2010.

1 **TITLE IX—CONFORMING AMEND-**  
2 **MENTS TO THE EMPLOYEE**  
3 **RETIREMENT INCOME SECUR-**  
4 **RITY ACT OF 1974**

5 **SEC. 901. ERISA INAPPLICABLE TO HEALTH COVERAGE AR-**  
6 **RANGEMENTS UNDER STATE HEALTH SECUR-**  
7 **RITY PROGRAMS.**

8 Section 4 of the Employee Retirement Income Secu-  
9 rity Act of 1974 (29 U.S.C. 1003) is amended—

10 (1) in subsection (a), by striking “(b) or (c)”  
11 and inserting “(b), (c), or (d)”; and

12 (2) by adding at the end the following new sub-  
13 section:

14 “(d) The provisions of this title shall not apply to  
15 any arrangement forming a part of a State health security  
16 program established pursuant to section 101(b) of the  
17 American Health Security Act of 2009.”.

18 **SEC. 902. EXEMPTION OF STATE HEALTH SECURITY PRO-**  
19 **GRAMS FROM ERISA PREEMPTION.**

20 Section 514(b) of the Employee Retirement Income  
21 Security Act of 1974 (29 U.S.C. 1144(b)) (as amended  
22 by sections 904(b)(3)(B) and 1002(b) of this Act) is  
23 amended by adding at the end the following new para-  
24 graph:

1 “(8) Subsection (a) of this section shall not apply to  
2 State health security programs established pursuant to  
3 section 101(b) of the American Health Security Act of  
4 2009.”.

5 **SEC. 903. PROHIBITION OF EMPLOYEE BENEFITS DUPLICA-**  
6 **TIVE OF BENEFITS UNDER STATE HEALTH**  
7 **SECURITY PROGRAMS; COORDINATION IN**  
8 **CASE OF WORKERS’ COMPENSATION.**

9 (a) IN GENERAL.—Part 5 of subtitle B of title I of  
10 the Employee Retirement Income Security Act of 1974 is  
11 amended by adding at the end the following new section:

12 “PROHIBITION OF EMPLOYEE BENEFITS DUPLICATIVE OF  
13 STATE HEALTH SECURITY PROGRAM BENEFITS; CO-  
14 ORDINATION IN CASE OF WORKERS’ COMPENSATION

15 “SEC. 519. (a) Subject to subsection (b), no employee  
16 benefit plan may provide benefits which duplicate payment  
17 for any items or services for which payment may be made  
18 under a State health security program established pursu-  
19 ant to section 101(b) of the American Health Security Act  
20 of 2009.

21 “(b)(1) Each workers compensation carrier that is  
22 liable for payment for workers compensation services fur-  
23 nished in a State shall reimburse the State health security  
24 plan for the State in which the services are furnished for  
25 the cost of such services.

26 “(2) In this subsection:



1           “(A) The term ‘workers compensation carrier’  
2 means an insurance company that underwrites work-  
3 ers compensation medical benefits with respect to 1  
4 or more employers and includes an employer or fund  
5 that is financially at risk for the provision of work-  
6 ers compensation medical benefits.

7           “(B) The term ‘workers compensation medical  
8 benefits’ means, with respect to an enrollee who is  
9 an employee subject to the workers compensation  
10 laws of a State, the comprehensive medical benefits  
11 for work-related injuries and illnesses provided for  
12 under such laws with respect to such an employee.

13           “(C) The term ‘workers compensation services’  
14 means items and services included in workers com-  
15 pensation medical benefits and includes items and  
16 services (including rehabilitation services and long-  
17 term-care services) commonly used for treatment of  
18 work-related injuries and illnesses.”.

19           (b) CONFORMING AMENDMENT.—Section 4(b) of  
20 such Act (29 U.S.C. 1003(b)) is amended by adding at  
21 the end the following: “Paragraph (3) shall apply subject  
22 to section 519(b) (relating to reimbursement of State  
23 health security plans by workers compensation carriers).”.

1           (c) CLERICAL AMENDMENT.—The table of contents  
2 in section 1 of such Act is amended by inserting after the  
3 item relating to section 518 the following new items:

“Sec. 519. Prohibition of employee benefits duplicative of state health security  
program benefits; coordination in case of workers’ compensa-  
tion.”.

4 **SEC. 904. REPEAL OF CONTINUATION COVERAGE REQUIRE-**  
5 **MENTS UNDER ERISA AND CERTAIN OTHER**  
6 **REQUIREMENTS RELATING TO GROUP**  
7 **HEALTH PLANS.**

8           (a) IN GENERAL.—Part 6 of subtitle B of title I of  
9 the Employee Retirement Income Security Act of 1974  
10 (29 U.S.C. 1161 et seq.) is repealed.

11           (b) CONFORMING AMENDMENTS.—

12                 (1) Section 502(a) of such Act (29 U.S.C.  
13 1132(a)) is amended—

14                         (A) by striking paragraph (7); and

15                         (B) by redesignating paragraphs (8), (9),  
16 and (10) as paragraphs (7), (8), and (9), re-  
17 spectively.

18                 (2) Section 502(c)(1) of such Act (29 U.S.C.  
19 1132(c)(1)) is amended by striking “paragraph (1)  
20 or (4) of section 606,”.

21                 (3) Section 514(b) of such Act (29 U.S.C.  
22 1144(b)) is amended—

1 (A) in paragraph (7), by striking “section  
2 206(d)(3)(B)(i),” and all that follows and in-  
3 serting “section 206(d)(3)(B)(i).”; and

4 (B) by striking paragraph (8).

5 (4) The table of contents in section 1 of the  
6 Employee Retirement Income Security Act of 1974  
7 is amended by striking the items relating to part 6  
8 of subtitle B of title I of such Act.

9 **SEC. 905. EFFECTIVE DATE OF TITLE.**

10 The amendments made by this title shall take effect  
11 January 1, 2012.

12 **TITLE X—ADDITIONAL**  
13 **CONFORMING AMENDMENTS**

14 **SEC. 1001. REPEAL OF CERTAIN PROVISIONS IN INTERNAL**  
15 **REVENUE CODE OF 1986.**

16 The provisions of titles III and IV of the Health In-  
17 surance Portability and Accountability Act of 1996, other  
18 than subtitles D and H of title III and section 342, are  
19 repealed and the provisions of law that were amended or  
20 repealed by such provisions are hereby restored as if such  
21 provisions had not been enacted.

