

# Union Calendar No. 587

116<sup>TH</sup> CONGRESS  
2<sup>D</sup> SESSION

# H. R. 2328

**[Report No. 116-332, Part I]**

To reauthorize and extend funding for community health centers and the National Health Service Corps.

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## IN THE HOUSE OF REPRESENTATIVES

APRIL 15, 2019

Mr. O'HALLERAN (for himself and Ms. STEFANIK) introduced the following bill; which was referred to the Committee on Energy and Commerce

DECEMBER 9, 2019

Reported with amendments and referred to the Committee on Transportation and Infrastructure for a period ending not later than January 29, 2020, for consideration of such provisions of the bill as fall within the jurisdiction of that committee pursuant to clause 1(r) of rule X

[Strike out all after the enacting clause and insert the part printed in *italic*]

JANUARY 29, 2020

Referral to the Committee on Transportation and Infrastructure extended for a period ending not later than February 19, 2020

FEBRUARY 19, 2020

Referral to the Committee on Transportation and Infrastructure extended for a period ending not later than April 23, 2020

APRIL 23, 2020

Referral to the Committee on Transportation and Infrastructure extended for a period ending not later than July 31, 2020

JULY 31, 2020

Referral to the Committee on Transportation and Infrastructure extended for a period ending not later than September 21, 2020

SEPTEMBER 21, 2020

Referral to the Committee on Transportation and Infrastructure extended for  
a period ending not later than November 20, 2020

NOVEMBER 17, 2020

Referral to the Committee on Transportation and Infrastructure extended for  
a period ending not later than December 31, 2020

DECEMBER 31, 2020

Additional sponsors: Mr. SWALWELL of California, Mr. ESPAILLAT, Ms. GABBARD, Ms. OMAR, Ms. MCCOLLUM, Mr. SMITH of Washington, Mr. KHANNA, Mr. COHEN, Mr. GRIJALVA, Mr. COURTNEY, Mrs. HARTZLER, Ms. MUCARSEL-POWELL, Ms. JAYAPAL, Ms. KUSTER of New Hampshire, Mrs. DAVIS of California, Mr. RUSH, Mr. LIPINSKI, Mr. ENGEL, Mr. SCHIFF, Mr. CICILLINE, Mr. SERRANO, Mr. LARSEN of Washington, Mr. KRISHNAMOORTHY, Mr. PETERS, Ms. LEE of California, Mr. KILMER, Mr. SCHRADER, Mr. TURNER, Mr. KING of New York, Mr. YARMUTH, Mr. VELA, Mr. HECK, Mr. LAMALFA, Mr. YOUNG, Mr. DELGADO, Mr. TIPTON, Ms. JOHNSON of Texas, Mr. HASTINGS, Mr. SIRES, Ms. BLUNT ROCHESTER, Mr. BERGMAN, Mrs. WATSON COLEMAN, Mr. JOHNSON of Georgia, Mr. COLE, Mr. GOMEZ, Ms. KELLY of Illinois, Miss RICE of New York, Mr. ZELDIN, Mr. NEWHOUSE, Mr. RODNEY DAVIS of Illinois, Ms. CLARKE of New York, Mr. DEFazio, Mr. NADLER, Mr. MEEKS, Mr. STIVERS, Mrs. CAROLYN B. MALONEY of New York, Mr. ROSE of New York, Mr. LAMBORN, Mr. BALDERSON, Mr. FLEISCHMANN, Mr. GALLEGO, Ms. SCHAKOWSKY, Mr. WELCH, Mrs. LOWEY, Ms. OCASIO-CORTEZ, Mr. SEAN PATRICK MALONEY of New York, Ms. BASS, Mr. NORMAN, Mr. TAKANO, Mr. LUJÁN, Mr. RASKIN, Ms. JUDY CHU of California, Mr. LEVIN of Michigan, Mrs. DINGELL, Ms. PINGREE, Mr. TED LIEU of California, Ms. TORRES SMALL of New Mexico, Mr. DESAULNIER, Mr. KATKO, Mr. SABLAN, Ms. ROYBAL-ALLARD, Mr. BISHOP of Utah, Mr. GRIFFITH, Mrs. RADEWAGEN, Mr. BOST, Mr. WALDEN, Mr. STANTON, Mr. CORREA, Ms. LOFGREN, Mr. CURTIS, Mr. LOWENTHAL, Ms. SLOTKIN, Ms. FINKENAUER, Mr. FOSTER, Mr. LANGEVIN, Mrs. BUSTOS, Ms. KAPTUR, Mr. STEWART, Mr. HUFFMAN, Mr. SCHNEIDER, Mr. MCADAMS, Ms. VELÁZQUEZ, Ms. JACKSON LEE, Mr. SOTO, Mr. COOPER, Mr. AUSTIN SCOTT of Georgia, Ms. UNDERWOOD, Mr. BRINDISI, Mr. STAUBER, Mr. CLEAVER, Mr. PETERSON, Mr. MCNERNEY, Mr. KEATING, Ms. SPANBERGER, Mr. PERLMUTTER, Mr. AGUILAR, Mr. COX of California, Mr. HARDER of California, Ms. KENDRA S. HORN of Oklahoma, Mr. PRICE of North Carolina, Mrs. MILLER, Mr. VAN DREW, Mr. FITZPATRICK, Mr. CISNEROS, Mr. LARSON of Connecticut, Mrs. DEMINGS, and Mrs. HAYES

DECEMBER 31, 2020

Committee on Transportation and Infrastructure discharged; committed to the Committee of the Whole House on the State of the Union and ordered to be printed

[For text of introduced bill, see copy of bill as introduced on April 15, 2019]

# **A BILL**

To reauthorize and extend funding for community health centers and the National Health Service Corps.

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 “Re-*  
 5 *authorizing and Extending America’s Community Health*  
 6 *Act” or the “REACH Act”.*

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

*Sec. 1. Short title; table of contents.*

**TITLE I—PUBLIC HEALTH EXTENDERS**

*Sec. 101. Extension for community health centers, the National Health Service Corps, and teaching health centers that operate GME programs.*

*Sec. 102. Extension for special diabetes programs.*

*Sec. 103. Extension of Personal Responsibility Education Program.*

*Sec. 104. Extension of sexual risk avoidance education program.*

**TITLE II—MEDICARE EXTENDERS**

*Sec. 201. Extension of the work geographic index floor under the Medicare program.*

*Sec. 202. Extension of funding outreach and assistance for low-income programs.*

*Sec. 203. Extension of funding for quality measure endorsement, input, and selection under the Medicare program.*

*Sec. 204. Extension of the Independence at Home Medical Practice Demonstration Program under the Medicare program.*

*Sec. 205. Extension of appropriations and transfers to the Patient-Centered Outcomes Research Trust Fund; extension of certain health insurance fees.*

*Sec. 206. Transitional coverage and retroactive Medicare part D coverage for certain low-income beneficiaries.*

*Sec. 207. Health Equity and Access for Returning Troops and Servicemembers Act of 2019.*

*Sec. 208. Exclusion of complex rehabilitative manual wheelchairs from Medicare competitive acquisition program; Non-application of Medicare fee-schedule adjustments for certain wheelchair accessories and cushions.*

**TITLE III—MEDICAID PROVISIONS**

*Sec. 301. Modification of reductions in Medicaid DSH allotments.*

*Sec. 302. Public availability of hospital upper payment limit demonstrations.*

*Sec. 303. Report by Comptroller General.*

*Sec. 304. Sense of Congress regarding the need to develop a more permanent legislative solution to provide the territories with a reliable and consistent source of Federal funding under the Medicaid program.*

*TITLE IV—NO SURPRISES ACT*

- Sec. 401. Short title.*  
*Sec. 402. Preventing surprise medical bills.*  
*Sec. 403. Government Accountability Office study on profit- and revenue-sharing in health care.*  
*Sec. 404. State All Payer Claims Databases.*  
*Sec. 405. Air ambulance cost data reporting program.*  
*Sec. 406. Report by Secretary of Labor.*  
*Sec. 407. Billing statute of limitations.*  
*Sec. 408. GAO report on impact of surprise billing provisions.*  
*Sec. 409. Report by the Secretary of Health and Human Services.*

*TITLE V—TERRITORIES HEALTH CARE IMPROVEMENT ACT*

- Sec. 501. Short title.*  
*Sec. 502. Medicaid payments for Puerto Rico and the other territories for certain fiscal years.*  
*Sec. 503. Application of certain requirements under Medicaid program to certain territories.*  
*Sec. 504. Additional program integrity requirements.*

1                   ***TITLE I—PUBLIC HEALTH***  
2   ***EXTENDERS***

3   ***SEC. 101. EXTENSION FOR COMMUNITY HEALTH CENTERS,***  
4   ***THE NATIONAL HEALTH SERVICE CORPS, AND***  
5   ***TEACHING HEALTH CENTERS THAT OPERATE***  
6   ***GME PROGRAMS.***

7           (a) *COMMUNITY HEALTH CENTERS.*—Section  
8 *10503(b)(1)(F) of the Patient Protection and Affordable*  
9 *Care Act (42 U.S.C. 254b–2(b)(1)(F)) is amended by strik-*  
10 *ing “fiscal year 2019” and inserting “each of fiscal years*  
11 *2019 through 2023”.*

12           (b) *NATIONAL HEALTH SERVICE CORPS.*—Section  
13 *10503(b)(2)(F) of the Patient Protection and Affordable*  
14 *Care Act (42 U.S.C. 254b–2(b)(2)(F)) is amended by strik-*  
15 *ing “2018 and 2019” and inserting “2019 through 2023”.*

1           (c) *TEACHING HEALTH CENTERS THAT OPERATE*  
2 *GRADUATE MEDICAL EDUCATION PROGRAMS.*—Section  
3 *340H(g)(1) of the Public Health Service Act (42 U.S.C.*  
4 *256h(g)(1)) is amended by striking “2018 and 2019” and*  
5 *inserting “2019 through 2023”.*

6           (d) *APPLICATION.*—Amounts appropriated for a pro-  
7 gram pursuant to the amendments made by subsection (a),  
8 (b), or (c) for fiscal years 2020 through 2023 are subject  
9 to the requirements and limitations of the most recently en-  
10 acted regular or full-year continuing appropriations Act or  
11 resolution (as of the date of obligation of current funds) ap-  
12 plicable to the respective program.

13 **SEC. 102. EXTENSION FOR SPECIAL DIABETES PROGRAMS.**

14           (a) *REAUTHORIZATION OF SPECIAL DIABETES PRO-*  
15 *GRAMS FOR TYPE I DIABETES.*—Section *330B(b)(2)(D) of*  
16 *the Public Health Service Act (42 U.S.C. 254c–2(b)(2)(D))*  
17 *is amended by striking “each of fiscal years 2018 and 2019”*  
18 *and inserting “fiscal years 2019 through 2023”.*

19           (b) *REAUTHORIZATION OF SPECIAL DIABETES PRO-*  
20 *GRAMS FOR INDIANS FOR DIABETES SERVICES.*—Section  
21 *330C(c)(2)(D) of the Public Health Service Act (42 U.S.C.*  
22 *254c–3(c)(2)(D)) is amended by striking “fiscal years 2018*  
23 *and 2019” and inserting “fiscal years 2019 through 2023”.*

1 **SEC. 103. EXTENSION OF PERSONAL RESPONSIBILITY EDU-**  
2 **CATION PROGRAM.**

3 *Section 513 of the Social Security Act (42 U.S.C. 713)*  
4 *is amended—*

5 *(1) in paragraphs (1)(A) and (4)(A) of sub-*  
6 *section (a), by striking “2019” and inserting “2023”*  
7 *each place it appears;*

8 *(2) in subsection (a)(4)(B)(i), by striking “2019”*  
9 *and inserting “2023”; and*

10 *(3) in subsection (f), by striking “2019” and in-*  
11 *serting “2023”.*

12 **SEC. 104. EXTENSION OF SEXUAL RISK AVOIDANCE EDU-**  
13 **CATION PROGRAM.**

14 *Section 510 of the Social Security Act (42 U.S.C. 710)*  
15 *is amended by striking “fiscal years 2018 and 2019” each*  
16 *place it appears in subsections (a)(1), (a)(2)(A), (f)(1) and*  
17 *(f)(2) and inserting “fiscal years 2019 through 2023”.*

18 **TITLE II—MEDICARE**  
19 **EXTENDERS**

20 **SEC. 201. EXTENSION OF THE WORK GEOGRAPHIC INDEX**  
21 **FLOOR UNDER THE MEDICARE PROGRAM.**

22 *Section 1848(e)(1)(E) of the Social Security Act (42*  
23 *U.S.C. 1395w–4(e)(1)(E)) is amended by striking “2020”*  
24 *and inserting “2023”.*



1 **SEC. 202. EXTENSION OF FUNDING OUTREACH AND ASSIST-**  
2 **ANCE FOR LOW-INCOME PROGRAMS.**

3 (a) *ADDITIONAL FUNDING FOR STATE HEALTH INSUR-*  
4 *ANCE PROGRAMS.*—Subsection (a)(1)(B) of section 119 of  
5 *the Medicare Improvements for Patients and Providers Act*  
6 *of 2008 (42 U.S.C. 1395b–3 note), as amended by section*  
7 *3306 of the Patient Protection and Affordable Care Act*  
8 *(Public Law 111–148), section 610 of the American Tax-*  
9 *payer Relief Act of 2012 (Public Law 112–240), section*  
10 *1110 of the Pathway for SGR Reform Act of 2013 (Public*  
11 *Law 113–67), section 110 of the Protecting Access to Medi-*  
12 *care Act of 2014 (Public Law 113–93), section 208 of the*  
13 *Medicare Access and CHIP Reauthorization Act of 2015*  
14 *(Public Law 114–10), and section 50207 of the Bipartisan*  
15 *Budget Act of 2018 (Public Law 115–123), is amended—*

16 (1) *in clause (vii), by striking “and” at the end;*

17 (2) *in clause (viii), by striking “and” at the end;*

18 (3) *in clause (ix), by striking the period at the*  
19 *end and inserting “; and”; and*

20 (4) *by inserting after clause (ix) the following*  
21 *new clause:*

22 “(x) *for each of fiscal years 2020*  
23 *through 2022, of \$15,000,000.”.*

24 (b) *ADDITIONAL FUNDING FOR AREA AGENCIES ON*  
25 *AGING.*—Subsection (b)(1)(B) of such section 119, as so  
26 *amended, is amended—*

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

2           (2) *in clause (viii), by striking “and” at the end;*

3           (3) *in clause (ix), by striking the period at the*

4 *end and inserting “; and”; and*

5           (4) *by inserting after clause (ix) the following*

6 *new clause:*

7                           *“(x) for each of fiscal years 2020*

8                           *through 2022, of \$15,000,000.”.*

9           (c) *ADDITIONAL FUNDING FOR AGING AND DISABILITY*

10 *RESOURCE CENTERS.—Subsection (c)(1)(B) of such section*

11 *119, as so amended, is amended—*

12           (1) *in clause (vii), by striking “and” at the end;*

13           (2) *in clause (viii), by striking “and” at the end;*

14           (3) *in clause (ix), by striking the period at the*

15 *end and inserting “; and”; and*

16           (4) *by inserting after clause (ix) the following*

17 *new clause:*

18                           *“(x) for each of fiscal years 2020*

19                           *through 2022, of \$5,000,000.”.*

20           (d) *ADDITIONAL FUNDING FOR CONTRACT WITH THE*

21 *NATIONAL CENTER FOR BENEFITS AND OUTREACH EN-*

22 *ROLLMENT.—Subsection (d)(2) of such section 119, as so*

23 *amended, is amended—*

24           (1) *in clause (vii), by striking “and” at the end;*

25           (2) *in clause (viii), by striking “and” at the end;*

1           (3) in clause (ix), by striking the period at the  
2 end and inserting “; and”; and

3           (4) by inserting after clause (ix) the following  
4 new clause:

5                           “(x) for each of fiscal years 2020  
6                           through 2022, of \$15,000,000.”.

7 **SEC. 203. EXTENSION OF FUNDING FOR QUALITY MEASURE**  
8 **ENDORSEMENT, INPUT, AND SELECTION**  
9 **UNDER THE MEDICARE PROGRAM.**

10       (a) *IN GENERAL.*—Section 1890(d)(2) of the Social Se-  
11 curity Act (42 U.S.C. 1395aaa(d)(2)) is amended—

12           (1) by striking “and \$7,500,000” and inserting  
13 “\$7,500,000”; and

14           (2) by striking “and 2019.” and inserting “and  
15 2019, and \$30,000,000 for each of fiscal years 2020  
16 through 2022.”.

17       (b) *INPUT FOR REMOVAL OF MEASURES.*—Section  
18 1890(b) of the Social Security Act (42 U.S.C. 1395aaa(b))  
19 is amended by inserting after paragraph (3) the following:

20                           “(4) *REMOVAL OF MEASURES.*—The entity may,  
21 through the multistakeholder groups convened under  
22 paragraph (7)(A), provide input to the Secretary on  
23 quality and efficiency measures described in para-  
24 graph (7)(B) that could be considered for removal.”.

1           (c) *PRIORITIZATION OF MEASURE ENDORSEMENT.*—  
2 *Section 1890(b) of the Social Security Act (42 U.S.C.*  
3 *1395aaa(b)), as amended by subsection (b), is further*  
4 *amended by adding at the end the following:*

5                   “(9) *PRIORITIZATION OF MEASURE ENDORSE-*  
6 *MENT.*—*The entity—*

7                           “(A) *during the period beginning on the*  
8 *date of the enactment of this paragraph and end-*  
9 *ing on December 31, 2023, shall prioritize the*  
10 *endorsement of measures relating to maternal*  
11 *morbidity and mortality by the entity with a*  
12 *contract under subsection (a) in connection with*  
13 *endorsement of measures described in paragraph*  
14 *(2); and*

15                           “(B) *on and after January 1, 2024, may*  
16 *prioritize the endorsement of such measures by*  
17 *such entity.*”.

18 **SEC. 204. EXTENSION OF THE INDEPENDENCE AT HOME**  
19 **MEDICAL PRACTICE DEMONSTRATION PRO-**  
20 **GRAM UNDER THE MEDICARE PROGRAM.**

21           (a) *IN GENERAL.*—*Section 1866E(e)(1) of the Social*  
22 *Security Act (42 U.S.C. 1395cc–5(e)(1)) is amended by*  
23 *striking “7-year” and inserting “10-year”.*

1           (b) *EFFECTIVE DATE.*—*The amendment made by sub-*  
2 *section (a) shall take effect as if included in the enactment*  
3 *of Public Law 111–148.*

4 **SEC. 205. EXTENSION OF APPROPRIATIONS AND TRANS-**  
5 **FERS TO THE PATIENT-CENTERED OUTCOMES**  
6 **RESEARCH TRUST FUND; EXTENSION OF CER-**  
7 **TAIN HEALTH INSURANCE FEES.**

8           (a) *IN GENERAL.*—

9                 (1) *INTERNAL REVENUE CODE.*—*Section 9511 of*  
10 *the Internal Revenue Code of 1986 is amended—*

11                     (A) *in subsection (b)(1)(E), by striking*  
12 *“2014” and all that follows through “2019” and*  
13 *inserting “2014 through 2022”;*

14                     (B) *in subsection (d)(2)(A), by striking*  
15 *“2019” and inserting “2022”; and*

16                     (C) *in subsection (f), by striking “2019”*  
17 *and inserting “2022”.*

18                 (2) *TITLE XI.*—*Section 1183(a)(2) of the Social*  
19 *Security Act (42 U.S.C. 1320e–2(a)(2)) is amended*  
20 *by striking “2014” and all that follows through*  
21 *“2019” and inserting “2014 through 2022”.*

22           (b) *EXTENSION OF CERTAIN HEALTH INSURANCE*  
23 *FEES.*—

1           (1) *HEALTH INSURANCE POLICIES.*—Section  
2           4375(e) of the Internal Revenue Code of 1986 is  
3           amended by striking “2019” and inserting “2022”.

4           (2) *SELF-INSURED HEALTH PLANS.*—Section  
5           4376(e) of the Internal Revenue Code of 1986 is  
6           amended by striking “2019” and inserting “2022”.

7 **SEC. 206. TRANSITIONAL COVERAGE AND RETROACTIVE**  
8                                   **MEDICARE PART D COVERAGE FOR CERTAIN**  
9                                   **LOW-INCOME BENEFICIARIES.**

10           Section 1860D–14 of the Social Security Act (42  
11 *U.S.C. 1395w–114*) is amended—

12           (1) by redesignating subsection (e) as subsection  
13           (f); and

14           (2) by adding after subsection (d) the following  
15           new subsection:

16           “(e) *LIMITED INCOME NEWLY ELIGIBLE TRANSITION*  
17 *PROGRAM.*—

18           “(1) *IN GENERAL.*—Beginning not later than  
19           January 1, 2021, the Secretary shall carry out a pro-  
20           gram to provide transitional coverage for covered part  
21           D drugs for *LI NET* eligible individuals in accord-  
22           ance with this subsection.

23           “(2) *LI NET ELIGIBLE INDIVIDUAL DEFINED.*—  
24           For purposes of this subsection, the term ‘*LI NET* eli-

1 *gible individual’ means a part D eligible individual*  
2 *who—*

3 *“(A) meets the requirements of clauses (ii)*  
4 *and (iii) of subsection (a)(3)(A); and*

5 *“(B) has not yet enrolled in a prescription*  
6 *drug plan or an MA–PD plan, or, who has so*  
7 *enrolled, but with respect to whom coverage*  
8 *under such plan has not yet taken effect.*

9 *“(3) TRANSITIONAL COVERAGE.—For purposes of*  
10 *this subsection, the term ‘transitional coverage’*  
11 *means, with respect to an LI NET eligible indi-*  
12 *vidual—*

13 *“(A) immediate access to covered part D*  
14 *drugs at the point of sale during the period that*  
15 *begins on the first day of the month such indi-*  
16 *vidual is determined to meet the requirements of*  
17 *clauses (ii) and (iii) of subsection (a)(3)(A) and*  
18 *ends on the date that coverage under a prescrip-*  
19 *tion drug plan or MA–PD plan takes effect with*  
20 *respect to such individual; and*

21 *“(B) in the case of an LI NET eligible indi-*  
22 *vidual who is a full-benefit dual eligible indi-*  
23 *vidual (as defined in section 1935(c)(6)) or a re-*  
24 *recipient of supplemental security income benefits*  
25 *under title XVI, retroactive coverage (in the form*

1           of reimbursement of the amounts that would  
2           have been paid under this part had such indi-  
3           vidual been enrolled in a prescription drug plan  
4           or MA–PD plan) of covered part D drugs pur-  
5           chased by such individual during the period that  
6           begins on the date that is the later of—

7                   “(i) the date that such individual was  
8                   first eligible for a low-income subsidy under  
9                   this part; or

10                   “(ii) the date that is 36 months prior  
11                   to the date such individual enrolls in a pre-  
12                   scription drug plan or MA–PD plan,  
13           and ends on the date that coverage under such  
14           plan takes effect.

15           “(4) PROGRAM ADMINISTRATION.—

16                   “(A) SINGLE POINT OF CONTACT.—The Sec-  
17                   retary shall, to the extent feasible, administer the  
18                   program under this subsection through a con-  
19                   tract with a single program administrator.

20                   “(B) BENEFIT DESIGN.—The Secretary  
21                   shall ensure that the transitional coverage pro-  
22                   vided to LI NET eligible individuals under this  
23                   subsection—

24                           “(i) provides access to all covered part  
25                           D drugs under an open formulary;



1           “(ii) permits all pharmacies deter-  
2           mined by the Secretary to be in good stand-  
3           ing to process claims under the program;

4           “(iii) is consistent with such require-  
5           ments as the Secretary considers necessary  
6           to improve patient safety and ensure appro-  
7           priate dispensing of medication; and

8           “(iv) meets such other requirements as  
9           the Secretary may establish.

10           “(5) *RELATIONSHIP TO OTHER PROVISIONS OF*  
11           *THIS TITLE; WAIVER AUTHORITY.—*

12           “(A) *IN GENERAL.—The following provi-*  
13           *sions shall not apply with respect to the program*  
14           *under this subsection:*

15           “(i) *Paragraphs (1) and (3)(B) of sec-*  
16           *tion 1860D–4(a) (relating to dissemination*  
17           *of general information; availability of infor-*  
18           *mation on changes in formulary through*  
19           *the internet).*

20           “(ii) *Subparagraphs (A) and (B) of*  
21           *section 1860D–4(b)(3) (relating to require-*  
22           *ments on development and application of*  
23           *formularies; formulary development).*

1                   “(iii) Paragraphs (1)(C) and (2) of  
2                   section 1860D–4(c) (relating to medication  
3                   therapy management program).

4                   “(B) WAIVER AUTHORITY.—The Secretary  
5                   may waive such other requirements of titles XI  
6                   and this title as may be necessary to carry out  
7                   the purposes of the program established under  
8                   this subsection.”.

9   **SEC. 207. HEALTH EQUITY AND ACCESS FOR RETURNING**  
10                   **TROOPS AND SERVICEMEMBERS ACT OF 2019.**

11                   (a) *MODIFICATION OF REQUIREMENT FOR CERTAIN*  
12                   *FORMER MEMBERS OF THE ARMED FORCES TO ENROLL*  
13                   *IN MEDICARE PART B TO BE ELIGIBLE FOR TRICARE*  
14                   *FOR LIFE.*—

15                   (1) *TRICARE ELIGIBILITY.*—

16                   (A) *IN GENERAL.*—Subsection (d) of section  
17                   1086 of title 10, United States Code, is amended  
18                   by adding at the end the following new para-  
19                   graph:

20                   “(6)(A) The requirement in paragraph (2)(A) to enroll  
21                   in the supplementary medical insurance program under  
22                   part B of title XVIII of the Social Security Act (42 U.S.C.  
23                   1395j et seq.) shall not apply to a person described in sub-  
24                   paragraph (B) during any month in which such person is  
25                   not entitled to a benefit described in subparagraph (A) of

1 *section 226(b)(2) of the Social Security Act (42 U.S.C.*  
2 *426(b)(2)) if such person has received the counseling and*  
3 *information under subparagraph (C).*

4 “(B) *A person described in this subparagraph is a per-*  
5 *son—*

6 “(i) *who is under 65 years of age;*

7 “(ii) *who is entitled to hospital insurance bene-*  
8 *fits under part A of title XVIII of the Social Security*  
9 *Act pursuant to subparagraph (A) or (C) of section*  
10 *226(b)(2) of such Act (42 U.S.C. 426(b)(2));*

11 “(iii) *whose entitlement to a benefit described in*  
12 *subparagraph (A) of such section has terminated due*  
13 *to performance of substantial gainful activity; and*

14 “(iv) *who is retired under chapter 61 of this*  
15 *title.*

16 “(C) *The Secretary of Defense shall coordinate with*  
17 *the Secretary of Health and Human Services and the Com-*  
18 *missioner of Social Security to notify persons described in*  
19 *subparagraph (B) of, and provide information and coun-*  
20 *seling regarding, the effects of not enrolling in the supple-*  
21 *mentary medical insurance program under part B of title*  
22 *XVIII of the Social Security Act (42 U.S.C. 1395j et seq.),*  
23 *as described in subparagraph (A).”*

24 (B) *CONFORMING AMENDMENT.—Paragraph*  
25 *(2)(A) of such subsection is amended by striking*

1           *“is enrolled” and inserting “except as provided*  
2           *by paragraph (6), is enrolled”.*

3                   *(C) IDENTIFICATION OF PERSONS.—Section*  
4           *1110a of such title is amended by adding at the*  
5           *end the following new subsection:*

6           *“(c) CERTAIN INDIVIDUALS NOT REQUIRED TO EN-*  
7           *ROLL IN MEDICARE PART B.—In carrying out subsection*  
8           *(a), the Secretary of Defense shall coordinate with the Sec-*  
9           *retary of Health and Human Services and the Commis-*  
10           *sioner of Social Security to—*

11                   *“(1) identify persons described in subparagraph*  
12           *(B) of section 1086(d)(6) of this title; and*

13                   *“(2) provide information and counseling pursu-*  
14           *ant to subparagraph (C) of such section.”.*

15                   *(2) NON-APPLICATION OF MEDICARE PART B*  
16           *LATE ENROLLMENT PENALTY.—Section 1839(b) of the*  
17           *Social Security Act (42 U.S.C. 1395r(b)) is amended,*  
18           *in the second sentence, by inserting “or months for*  
19           *which the individual can demonstrate that the indi-*  
20           *vidual is an individual described in paragraph*  
21           *(6)(B) of section 1086(d) of title 10, United States*  
22           *Code, who is enrolled in the TRICARE program pur-*  
23           *suant to such section” after “an individual described*  
24           *in section 1837(k)(3)”.*

1           (3) *REPORT.*—Not later than October 1, 2024,  
2           the Secretary of Defense, the Secretary of Health and  
3           Human Services, and the Commissioner of Social Se-  
4           curity shall jointly submit to the Committees on  
5           Armed Services of the House of Representatives and  
6           the Senate, the Committee on Ways and Means and  
7           the Committee on Energy and Commerce of the House  
8           of Representatives, and the Committee on Finance of  
9           the Senate a report on the implementation of section  
10          1086(d)(6) of title 10, United States Code, as added  
11          by paragraph (1). Such report shall include, with re-  
12          spect to the period covered by the report—

13                 (A) the number of individuals enrolled in  
14                 *TRICARE for Life* who are not enrolled in the  
15                 supplementary medical insurance program  
16                 under part B of title XVIII of the Social Secu-  
17                 rity Act (42 U.S.C. 1395j et seq.) by reason of  
18                 such section 1086(d)(6); and

19                 (B) the number of individuals who—

20                         (i) are retired from the Armed Forces  
21                         under chapter 61 of title 10, United States  
22                         Code;

23                         (ii) are entitled to hospital insurance  
24                         benefits under part A of title XVIII of the  
25                         Social Security Act pursuant to receiving

1           *benefits for 24 months as described in sub-*  
2           *paragraph (A) or (C) of section 226(b)(2) of*  
3           *such Act (42 U.S.C. 426(b)(2)); and*

4                     *(iii) because of such entitlement, are no*  
5           *longer enrolled in TRICARE Standard,*  
6           *TRICARE Prime, TRICARE Extra, or*  
7           *TRICARE Select under chapter 55 of title*  
8           *10, United States Code.*

9           (4) *DEPOSIT OF SAVINGS INTO MEDICARE IM-*  
10          *PROVEMENT FUND.—Section 1898(b)(1) of the Social*  
11          *Security Act (42 U.S.C. 1395iii(b)(1)) is amended by*  
12          *striking “during and after fiscal year 2021, \$0” and*  
13          *inserting “during and after fiscal year 2024,*  
14          *\$5,000,000”.*

15                 (5) *APPLICATION.—The amendments made by*  
16          *paragraphs (1) and (2) shall apply with respect to a*  
17          *person who, on or after October 1, 2023, is a person*  
18          *described in section 1086(d)(6)(B) of title 10, United*  
19          *States Code, as added by paragraph (1).*

20          (b) *COVERAGE OF CERTAIN DNA SPECIMEN PROVE-*  
21          *NANCE ASSAY TESTS UNDER MEDICARE.—*

22                     (1) *BENEFIT.—*

23                             (A) *COVERAGE.—Section 1861 of the Social*  
24                     *Security Act (42 U.S.C. 1395x) is amended—*

25                                     (i) *in subsection (s)(2)—*

1 (I) in subparagraph (GG), by  
2 striking “and” at the end;

3 (II) in subparagraph (HH), by  
4 striking the period and inserting “;  
5 and”; and

6 (III) by adding at the end the fol-  
7 lowing new subparagraph:

8 “(II) a prostate cancer DNA Specimen Provenance Assay test (DSPA test) (as defined in sub-  
9 section (kkk));”; and

11 (i) by adding at the end the following  
12 new subsection:

13 “(kkk) PROSTATE CANCER DNA SPECIMEN PROVE-  
14 NANCE ASSAY TEST.—The term ‘prostate cancer DNA Spec-  
15 imen Provenance Assay Test’ (DSPA test) means a test  
16 that, after a determination of cancer in one or more pros-  
17 tate biopsy specimens obtained from an individual, assesses  
18 the identity of the DNA in such specimens by comparing  
19 such DNA with the DNA that was separately taken from  
20 such individual at the time of the biopsy.”.

21 (B) EXCLUSION FROM COVERAGE.—Section  
22 1862(a)(1) of the Social Security Act (42 U.S.C.  
23 1395y(a)(1)) is amended—

24 (i) in subparagraph (O), by striking  
25 “and” at the end;

1                   (ii) in subparagraph (P), by striking  
2                   the semicolon at the end and inserting “,  
3                   and”; and

4                   (iii) by adding at the end the following  
5                   new subparagraph:

6                   “(Q) in the case of a prostate cancer DNA Specimen  
7                   Provenance Assay test (DSPA test) (as defined  
8                   in section 1861(kkk)), unless such test is furnished on  
9                   or after January 1, 2021, and before January 1,  
10                  2026, and such test is ordered by the physician who  
11                  furnished the prostate cancer biopsy that obtained the  
12                  specimen tested;”.

13                  (2) PAYMENT AMOUNT AND RELATED REQUIRE-  
14                  MENTS.—Section 1834 of the Social Security Act (42  
15                  U.S.C. 1395m) is amended by adding at the end the  
16                  following new subsection:

17                  “(x) PROSTATE CANCER DNA SPECIMEN PROVENANCE  
18                  ASSAY TESTS.—

19                         “(1) PAYMENT FOR COVERED TESTS.—

20                                 “(A) IN GENERAL.—Subject to subpara-  
21                                 graph (B), the payment amount for a prostate  
22                                 cancer DNA Specimen Provenance Assay test  
23                                 (DSPA test) (as defined in section 1861(kkk))  
24                                 shall be \$200. Such payment shall be payment



1           *for all of the specimens obtained from the biopsy*  
2           *furnished to an individual that are tested.*

3           “(B) *LIMITATION.*—*Payment for a DSPA*  
4           *test under subparagraph (A) may only be made*  
5           *on an assignment-related basis.*

6           “(C) *PROHIBITION ON SEPARATE PAY-*  
7           *MENT.*—*No separate payment shall be made for*  
8           *obtaining DNA that was separately taken from*  
9           *an individual at the time of a biopsy described*  
10          *in subparagraph (A).*

11          “(2) *HCPCS CODE AND MODIFIER ASSIGN-*  
12          *MENT.*—

13                 “(A) *IN GENERAL.*—*The Secretary shall as-*  
14                 *sign one or more HCPCS codes to a prostate*  
15                 *cancer DNA Specimen Provenance Assay test*  
16                 *and may use a modifier to facilitate making*  
17                 *payment under this section for such test.*

18                 “(B) *IDENTIFICATION OF DNA MATCH ON*  
19                 *CLAIM.*—*The Secretary shall require an indica-*  
20                 *tion on a claim for a prostate cancer DNA Spec-*  
21                 *imen Provenance Assay test of whether the DNA*  
22                 *of the prostate biopsy specimens match the DNA*  
23                 *of the individual diagnosed with prostate cancer.*  
24                 *Such indication may be made through use of a*

1           *HCPCS code, a modifier, or other means, as de-*  
2           *termined appropriate by the Secretary.*

3           “(3) *DNA MATCH REVIEW.*—

4                   “(A) *IN GENERAL.*—*The Secretary shall re-*  
5                   *view at least three years of claims under part B*  
6                   *for prostate cancer DNA Specimen Provenance*  
7                   *Assay tests to identify whether the DNA of the*  
8                   *prostate biopsy specimens match the DNA of the*  
9                   *individuals diagnosed with prostate cancer.*

10                   “(B) *POSTING ON INTERNET WEBSITE.*—*Not*  
11                   *later than July 1, 2023, the Secretary shall post*  
12                   *on the internet website of the Centers for Medi-*  
13                   *care & Medicaid Services the findings of the re-*  
14                   *view conducted under subparagraph (A).”.*

15           (3) *COST-SHARING.*—*Section 1833(a)(1) of the*  
16           *Social Security Act (42 U.S.C. 1395l(a)(1)) is*  
17           *amended—*

18                   (A) *by striking “and (CC)” and inserting*  
19                   *“(CC)”;* *and*

20                   (B) *by inserting before the semicolon at the*  
21                   *end the following: “, and (DD) with respect to*  
22                   *a prostate cancer DNA Specimen Provenance*  
23                   *Assay test (DSPA test) (as defined in section*  
24                   *1861(kkk)), the amount paid shall be an amount*  
25                   *equal to 80 percent of the lesser of the actual*

1 charge for the test or the amount specified under  
2 section 1834(x)”.

3 **SEC. 208. EXCLUSION OF COMPLEX REHABILITATIVE MAN-**  
4 **UAL WHEELCHAIRS FROM MEDICARE COM-**  
5 **PETITIVE ACQUISITION PROGRAM; NON-AP-**  
6 **PLICATION OF MEDICARE FEE-SCHEDULE AD-**  
7 **JUSTMENTS FOR CERTAIN WHEELCHAIR AC-**  
8 **CESSORIES AND CUSHIONS.**

9 (a) *EXCLUSION OF COMPLEX REHABILITATIVE MAN-*  
10 *UAL WHEELCHAIRS FROM COMPETITIVE ACQUISITION PRO-*  
11 *GRAM.—Section 1847(a)(2)(A) of the Social Security Act*  
12 *(42 U.S.C. 1395w–3(a)(2)(A)) is amended—*

13 (1) *by inserting “, complex rehabilitative man-*  
14 *ual wheelchairs (as determined by the Secretary), and*  
15 *certain manual wheelchairs (identified, as of October*  
16 *1, 2018, by HCPCS codes E1235, E1236, E1237,*  
17 *E1238, and K0008 or any successor to such codes)”*  
18 *after “group 3 or higher”; and*

19 (2) *by striking “such wheelchairs” and inserting*  
20 *“such complex rehabilitative power wheelchairs, com-*  
21 *plex rehabilitative manual wheelchairs, and certain*  
22 *manual wheelchairs”.*

23 (b) *NON-APPLICATION OF MEDICARE FEE SCHEDULE*  
24 *ADJUSTMENTS FOR WHEELCHAIR ACCESSORIES AND SEAT*  
25 *AND BACK CUSHIONS WHEN FURNISHED IN CONNECTION*

1 *WITH COMPLEX REHABILITATIVE MANUAL WHEEL-*  
2 *CHAIRS.—*

3           (1) *IN GENERAL.—Notwithstanding any other*  
4 *provision of law, the Secretary of Health and Human*  
5 *Services shall not, during the period beginning on*  
6 *January 1, 2020, and ending on December 31, 2020,*  
7 *use information on the payment determined under the*  
8 *competitive acquisition programs under section 1847*  
9 *of the Social Security Act (42 U.S.C. 1395w–3) to ad-*  
10 *just the payment amount that would otherwise be rec-*  
11 *ognized under section 1834(a)(1)(B)(ii) of such Act*  
12 *(42 U.S.C. 1395m(a)(1)(B)(ii)) for wheelchair acces-*  
13 *sories (including seating systems) and seat and back*  
14 *cushions when furnished in connection with complex*  
15 *rehabilitative manual wheelchairs (as determined by*  
16 *the Secretary), and certain manual wheelchairs (iden-*  
17 *tified, as of October 1, 2018, by HCPCS codes E1235,*  
18 *E1236, E1237, E1238, and K0008 or any successor*  
19 *to such codes).*

20           (2) *IMPLEMENTATION.—Notwithstanding any*  
21 *other provision of law, the Secretary may implement*  
22 *this subsection by program instruction or otherwise.*

1                   **TITLE III—MEDICAID**  
2                   **PROVISIONS**

3 **SEC. 301. MODIFICATION OF REDUCTIONS IN MEDICAID**

4                   **DSH ALLOTMENTS.**

5           *Section 1923(f)(7)(A) of the Social Security Act (42*  
6 *U.S.C. 1396r-4(f)(7)(A)) is amended—*

7                   *(1) in clause (i), in the matter preceding sub-*  
8 *clause (I), by striking “2020” and inserting “2022”;*  
9 *and*

10                   *(2) in clause (ii)—*

11                           *(A) in subclause (I), by striking “2020”*  
12 *and inserting “2022”; and*

13                           *(B) in subclause (II), by striking “for each*  
14 *of fiscal years 2021 through 2025” and inserting*  
15 *“for each of fiscal years 2023 through 2025”.*

16 **SEC. 302. PUBLIC AVAILABILITY OF HOSPITAL UPPER PAY-**

17                   **MENT LIMIT DEMONSTRATIONS.**

18           *Section 1903 of the Social Security Act (42 U.S.C.*  
19 *1396b) is amended by adding at the end the following new*  
20 *subsection:*

21                   *“(bb) PUBLIC AVAILABILITY OF HOSPITAL UPPER*  
22 *PAYMENT LIMIT DEMONSTRATIONS.—The Secretary shall*  
23 *make publicly available upper payment limit demonstra-*  
24 *tions for hospital services that a State submits with respect*  
25 *to a fiscal year of the State (beginning with State fiscal*

1 year 2022) to the Administrator of the Centers for Medicare  
2 & Medicaid Services.”.

3 **SEC. 303. REPORT BY COMPTROLLER GENERAL.**

4 *Not later than the date that is 21 months after the*  
5 *date of the enactment of this Act, the Comptroller General*  
6 *of the United States shall identify and report to Congress*  
7 *policy considerations for legislative action with respect to*  
8 *establishing an equitable formula for determining dis-*  
9 *proportionate share hospital allotments for States under*  
10 *section 1923 of the Social Security Act (42 U.S.C. 1396r-*  
11 *4) that takes into account the following factors:*

12 *(1) The level of uncompensated care costs of hos-*  
13 *pitals in a State.*

14 *(2) Expenditures of a State with respect to hos-*  
15 *pitals, including payment adjustments made under*  
16 *such section 1923 to disproportionate share hospitals*  
17 *(as defined under the State plan under title XIX of*  
18 *such Act (42 U.S.C. 1396 et seq.) pursuant to sub-*  
19 *section (a)(1)(A) of such section 1923), upper pay-*  
20 *ment limit supplemental payments, and other related*  
21 *payments that hospitals may receive from the State.*

22 *(3) State policy decisions that may affect the*  
23 *level of uncompensated care costs of hospitals in a*  
24 *State.*

1 **SEC. 304. SENSE OF CONGRESS REGARDING THE NEED TO**  
2 **DEVELOP A MORE PERMANENT LEGISLATIVE**  
3 **SOLUTION TO PROVIDE THE TERRITORIES**  
4 **WITH A RELIABLE AND CONSISTENT SOURCE**  
5 **OF FEDERAL FUNDING UNDER THE MEDICAID**  
6 **PROGRAM.**

7 *It is the sense of Congress that—*

8 *(1) the territories of American Samoa, the Com-*  
9 *monwealth of the Northern Mariana Islands, Guam,*  
10 *Puerto Rico, and the United States Virgin Islands are*  
11 *currently subject to Federal funding caps for their*  
12 *Medicaid programs;*

13 *(2) as a result of these Federal funding caps,*  
14 *which have not been adjusted over time, the territories*  
15 *continue to struggle in managing their Medicaid pro-*  
16 *grams, including planning for their respective finan-*  
17 *cial obligations and managing health care services for*  
18 *low-income adults, children, pregnant women, elderly*  
19 *adults, and persons with disabilities;*

20 *(3) to address this disparate funding treatment*  
21 *and to provide the territories with some measure of*  
22 *relief, Congress has had to enact legislation six times*  
23 *in the last 15 years, including multiple temporary in-*  
24 *creases in the Federal funding caps, higher Federal*  
25 *medical assistance percentage rates, and billions of*  
26 *dollars in supplemental block grants;*

1           (4) *the supplemental funding provided to the ter-*  
 2           *ritories under title V with respect to their Medicaid*  
 3           *programs continues Congress’ commitment to ensur-*  
 4           *ing the sustainability of these critically important*  
 5           *programs and the people these programs serve; and*

6           (5) *a more permanent legislative solution must*  
 7           *be developed in order to provide the territories with*  
 8           *a reliable and consistent source of Federal funding*  
 9           *under their Medicaid programs so that the territories*  
 10          *can continue to meet the health care needs of vulner-*  
 11          *able populations.*

## 12       **TITLE IV—NO SURPRISES ACT**

### 13       **SEC. 401. SHORT TITLE.**

14           *This title may be cited as the “No Surprises Act”.*

### 15       **SEC. 402. PREVENTING SURPRISE MEDICAL BILLS.**

16           (a) *COVERAGE OF EMERGENCY SERVICES.*—*Section*  
 17       *2719A(b) of the Public Health Service Act (42 U.S.C.*  
 18       *300gg–19a(b)) is amended—*

19                   (1) *in paragraph (1)—*

20                           (A) *in the matter preceding subparagraph*

21                           (A)—

22                                   (i) *by striking “a group health plan, or*  
 23                                   *a health insurance issuer offering group or*  
 24                                   *individual health insurance issuer,” and in-*



1           serting “a health plan (as defined in sub-  
2           section (e)(2)(A))”;

3           (ii) by inserting “or, for plan year  
4           2021 or a subsequent plan year, with re-  
5           spect to emergency services in an inde-  
6           pendent freestanding emergency department  
7           (as defined in paragraph (3)(D))” after  
8           “emergency department of a hospital”;

9           (iii) by striking “the plan or issuer”  
10          and inserting “the plan”; and

11          (iv) by striking “paragraph (2)(B)”  
12          and inserting “paragraph (3)(C)”;

13          (B) in subparagraph (B), by inserting “or  
14          a participating emergency facility, as applica-  
15          ble,” after “participating provider”; and

16          (C) in subparagraph (C)—

17               (i) in the matter preceding clause (i),  
18               by inserting “by a nonparticipating pro-  
19               vider or a nonparticipating emergency fa-  
20               cility” after “enrollee”;

21               (ii) by striking clause (i);

22               (iii) by striking “(i)(I) such services”  
23               and inserting “(i) such services”;

24               (iv) by striking “where the provider of  
25               services does not have a contractual rela-

1            *tionship with the plan for the providing of*  
2            *services”;*

3            *(v) by striking “emergency department*  
4            *services received from providers who do have*  
5            *such a contractual relationship with the*  
6            *plan; and” and inserting “emergency serv-*  
7            *ices received from participating providers*  
8            *and participating emergency facilities with*  
9            *respect to such plan;”;*

10           *(vi) by striking “(II) if such services”*  
11           *and all that follows through “were provided*  
12           *in-network;” and inserting the following:*

13           *“(ii) the cost-sharing requirement (ex-*  
14           *pressed as a copayment amount or coinsur-*  
15           *ance rate) is not greater than the require-*  
16           *ment that would apply if such services were*  
17           *provided by a participating provider or a*  
18           *participating emergency facility;”;* and

19           *(vii) by adding at the end the following*  
20           *new clauses:*

21           *“(iii) such requirement is calculated as*  
22           *if the total amount that would have been*  
23           *charged for such services by such partici-*  
24           *parting provider or participating emergency*  
25           *facility were equal to—*

1           “(I) in the case of such services  
2           furnished in a State described in para-  
3           graph (3)(H)(ii), the median con-  
4           tracted rate (as defined in paragraph  
5           (3)(E)(i)) for such services; and

6           “(II) in the case of such services  
7           furnished in a State described in para-  
8           graph (3)(H)(i), the lesser of—

9                   “(aa) the amount determined  
10                   by such State for such services in  
11                   accordance with the method de-  
12                   scribed in such paragraph; and

13                   “(bb) the median contracted  
14                   rate (as so defined) for such serv-  
15                   ices;

16                   “(iv) the health plan pays to such pro-  
17                   vider or facility, respectively, the amount by  
18                   which the recognized amount (as defined in  
19                   paragraph (3)(H)) for such services exceeds  
20                   the cost-sharing amount for such services  
21                   (as determined in accordance with clauses  
22                   (ii) and (iii)); and

23                   “(v) any cost-sharing payments made  
24                   by the participant, beneficiary, or enrollee  
25                   with respect to such emergency services so

1           *furnished shall be counted toward any in-*  
2           *network deductible or out-of-pocket maxi-*  
3           *mums applied under the plan (and such in-*  
4           *network deductible shall be applied) in the*  
5           *same manner as if such cost-sharing pay-*  
6           *ments were with respect to emergency serv-*  
7           *ices furnished by a participating provider*  
8           *and a participating emergency facility;*  
9           *and”;*

10           (2) *by redesignating paragraph (2) as para-*  
11           *graph (3);*

12           (3) *by inserting after paragraph (1) the fol-*  
13           *lowing new paragraph:*

14           “(2) *AUDIT PROCESS FOR MEDIAN CONTRACTED*  
15           *RATES.—*

16           “(A) *IN GENERAL.—Not later than July 1,*  
17           *2020, the Secretary, in consultation with appro-*  
18           *priate State agencies, shall establish through*  
19           *rulemaking a process, in accordance with sub-*  
20           *paragraph (B), under which health plans are au-*  
21           *ditied by such Secretaries to ensure that—*

22           “(i) *such plans are in compliance with*  
23           *the requirement of applying a median con-*  
24           *tracted rate under this section; and*

1           “(ii) that such median contracted rate  
2           so applied satisfies the definition under  
3           paragraph (3)(E) with respect to the year  
4           involved, including with respect to a health  
5           plan described in clause (ii) of such para-  
6           graph.

7           “(B) AUDIT SAMPLES.—Under the process  
8           established pursuant to subparagraph (A), the  
9           Secretary—

10           “(i) shall conduct audits described in  
11           such subparagraph, with respect to a year  
12           (beginning with 2021), of a sample with re-  
13           spect to such year of claims data from not  
14           more than 25 health plans; and

15           “(ii) may audit any health plan if the  
16           Secretary has received any complaint about  
17           such plan that involves the compliance of  
18           the plan with either of the requirements de-  
19           scribed in clauses (i) and (ii) of such sub-  
20           paragraph.”; and

21           (4) in paragraph (3), as redesignated by para-  
22           graph (2) of this subsection—

23           (A) in the matter preceding subparagraph  
24           (A), by inserting “and subsection (e)” after “this  
25           subsection”;

1           (B) by redesignating subparagraphs (A)  
2 through (C) as subparagraphs (B) through (D),  
3 respectively;

4           (C) by inserting before subparagraph (B),  
5 as redesignated by subparagraph (B) of this  
6 paragraph, the following new subparagraph:

7           “(A) *EMERGENCY DEPARTMENT OF A HOS-*  
8 *PITAL.—The term ‘emergency department of a*  
9 *hospital’ includes a hospital outpatient depart-*  
10 *ment that provides emergency services.”;*

11           (D) by amending subparagraph (C), as re-  
12 designated by subparagraph (B) of this para-  
13 graph, to read as follows:

14           “(C) *EMERGENCY SERVICES.—*

15           “(i) *IN GENERAL.—The term ‘emer-*  
16 *gency services’, with respect to an emer-*  
17 *gency medical condition, means—*

18           “(I) *a medical screening examina-*  
19 *tion (as required under section 1867 of*  
20 *the Social Security Act, or as would be*  
21 *required under such section if such sec-*  
22 *tion applied to an independent free-*  
23 *standing emergency department) that*  
24 *is within the capability of the emer-*  
25 *gency department of a hospital or of*

1            *an independent freestanding emergency*  
2            *department, as applicable, including*  
3            *ancillary services routinely available to*  
4            *the emergency department to evaluate*  
5            *such emergency medical condition; and*

6            *“(II) within the capabilities of the*  
7            *staff and facilities available at the hos-*  
8            *pital or the independent freestanding*  
9            *emergency department, as applicable,*  
10           *such further medical examination and*  
11           *treatment as are required under section*  
12           *1867 of such Act, or as would be re-*  
13           *quired under such section if such sec-*  
14           *tion applied to an independent free-*  
15           *standing emergency department, to sta-*  
16           *bilize the patient.*

17           *“(ii)            INCLUSION            OF*  
18           *POSTSTABILIZATION SERVICES.—For pur-*  
19           *poses of this subsection and section 2799, in*  
20           *the case of an individual enrolled in a*  
21           *health plan who is furnished services de-*  
22           *scribed in clause (i) by a provider or facil-*  
23           *ity to stabilize such individual with respect*  
24           *to an emergency medical condition, the*  
25           *term ‘emergency services’ shall include such*

1            *items and services in addition to those de-*  
2            *scribed in clause (i) that such a provider or*  
3            *facility determines are needed to be fur-*  
4            *nished (after such stabilization but during*  
5            *such visit in which such individual is so*  
6            *stabilized) to such individual, unless each of*  
7            *the following conditions are met:*

8                    *“(I) Such a provider or facility*  
9                    *determines such individual is able to*  
10                   *travel using nonmedical transportation*  
11                   *or nonemergency medical transpor-*  
12                   *tation.*

13                   *“(II) Such provider furnishing*  
14                   *such additional items and services is*  
15                   *in compliance with section 2799A(d)*  
16                   *with respect to such items and serv-*  
17                   *ices.”;*

18                   *(E) by redesignating subparagraph (D), as*  
19                   *redesignated by subparagraph (B) of this para-*  
20                   *graph, as subparagraph (I); and*

21                   *(F) by inserting after subparagraph (C), as*  
22                   *redesignated by subparagraph (B) of this para-*  
23                   *graph, the following new subparagraphs:*

24                   *“(D) INDEPENDENT FREESTANDING EMER-*  
25                   *GENCY DEPARTMENT.—The term ‘independent*



1           *freestanding emergency department’ means a fa-*  
2           *cility that—*

3                     *“(i) is geographically separate and dis-*  
4                     *tinct and licensed separately from a hos-*  
5                     *pital under applicable State law; and*

6                     *“(ii) provides emergency services.*

7           *“(E) MEDIAN CONTRACTED RATE.—*

8                     *“(i) IN GENERAL.—The term ‘median*  
9                     *contracted rate’ means, with respect to an*  
10                    *item or service and a health plan (as de-*  
11                    *finied in subsection (e)(2)(A))—*

12                    *“(I) for 2021, the median of the*  
13                    *negotiated rates recognized by the*  
14                    *sponsor or issuer of such plan (deter-*  
15                    *mined with respect to all such plans of*  
16                    *such sponsor or such issuer that are*  
17                    *within the same line of business) as the*  
18                    *total maximum payment (including*  
19                    *the cost-sharing amount imposed for*  
20                    *such services (as determined in accord-*  
21                    *ance with clauses (ii) and (iii) of*  
22                    *paragraph (1)(C) or subparagraphs*  
23                    *(A) and (B) of subsection (e)(1), as ap-*  
24                    *plicable) and the amount to be paid by*  
25                    *the plan or issuer) under such plans in*

1                   2019 for the same or a similar item or  
2                   service that is provided by a provider  
3                   in the same or similar specialty and  
4                   provided in the geographic region in  
5                   which the item or service is furnished,  
6                   consistent with the methodology estab-  
7                   lished by the Secretary under section  
8                   402(e) of the No Surprises Act, in-  
9                   creased by the percentage increase in  
10                  the consumer price index for all urban  
11                  consumers (United States city average)  
12                  over 2019 and 2020; and

13                   “(II) for 2022 and each subse-  
14                  quent year, the median contracted rate  
15                  determined under this clause for the  
16                  previous year, increased by the per-  
17                  centage increase in the consumer price  
18                  index for all urban consumers (United  
19                  States city average) over such previous  
20                  year.

21                   “(ii) *SPECIAL RULE.*—The Secretary  
22                  shall provide pursuant to rulemaking de-  
23                  scribed in section 402(e) of the No Surprises  
24                  Act that—

1           “(I) if the sponsor or issuer of a  
2 health plan does not have sufficient in-  
3 formation to calculate a median con-  
4 tracted rate for an item or service or  
5 provider type, or amount of, claims for  
6 items or services (as determined by the  
7 Secretary) provided in a particular ge-  
8 ographic area (other than in a case de-  
9 scribed in item (bb)), such sponsor or  
10 issuer shall demonstrate that such  
11 sponsor or issuer will use any database  
12 free of conflicts of interest that has suf-  
13 ficient information reflecting allowed  
14 amounts paid to a health care provider  
15 for relevant services provided in the  
16 applicable geographic region (such as  
17 State All Payer Claims Databases (as  
18 defined in section 404(d) of such Act)),  
19 and that such sponsor or issuer will  
20 use any such database to determine a  
21 median contracted rate and cover the  
22 cost of accessing any such database;  
23 and

24           “(II) in the case of a sponsor or  
25 issuer offering a health plan in a geo-

1            *graphic region that did not offer any*  
2            *health plan in such region during*  
3            *2019, such sponsor or issuer shall use*  
4            *a methodology established by the Sec-*  
5            *retary for determining the median con-*  
6            *tracted rate for items and services cov-*  
7            *ered by such plan for the first year in*  
8            *which such plan is offered in such re-*  
9            *gion, and that, for each succeeding*  
10           *year, the median contracted rate for*  
11           *such items and services under such*  
12           *plan shall be the median contracted*  
13           *rate for such items and services under*  
14           *such plan for the previous year, in-*  
15           *creased by the percentage increase in*  
16           *the consumer price index for all urban*  
17           *consumers (United States city average)*  
18           *over such previous year.*

19            *“(F) NONPARTICIPATING EMERGENCY FA-*  
20            *CILITY; PARTICIPATING EMERGENCY FACILITY.—*

21            *“(i) NONPARTICIPATING EMERGENCY*  
22            *FACILITY.—The term ‘nonparticipating*  
23            *emergency facility’ means, with respect to*  
24            *an item or service and a health plan, an*  
25            *emergency department of a hospital, or an*

1           *independent freestanding emergency depart-*  
2           *ment, that does not have a contractual rela-*  
3           *tionship with the plan (or, if applicable,*  
4           *issuer offering the plan) for furnishing such*  
5           *item or service under the plan.*

6           “(ii) *PARTICIPATING EMERGENCY FA-*  
7           *CILITY.—The term ‘participating emergency*  
8           *facility’ means, with respect to an item or*  
9           *service and a health plan, an emergency de-*  
10           *partment of a hospital, or an independent*  
11           *freestanding emergency department, that*  
12           *has a contractual relationship with the plan*  
13           *(or, if applicable, issuer offering the plan)*  
14           *for furnishing such item or service under*  
15           *the plan.*

16           “(G) *NONPARTICIPATING PROVIDERS; PAR-*  
17           *TICIPATING PROVIDERS.—*

18           “(i) *NONPARTICIPATING PROVIDER.—*  
19           *The term ‘nonparticipating provider’*  
20           *means, with respect to an item or service*  
21           *and a health plan, a physician or other*  
22           *health care provider who is acting within*  
23           *the scope of practice of that provider’s li-*  
24           *cence or certification under applicable State*  
25           *law and who does not have a contractual re-*

1            *relationship with the plan (or, if applicable,*  
2            *issuer offering the plan) for furnishing such*  
3            *item or service under the plan.*

4            “(ii) *PARTICIPATING PROVIDER.*—*The*  
5            *term ‘participating provider’ means, with*  
6            *respect to an item or service and a health*  
7            *plan, a physician or other health care pro-*  
8            *vider who is acting within the scope of*  
9            *practice of that provider’s license or certifi-*  
10           *cation under applicable State law and who*  
11           *has a contractual relationship with the plan*  
12           *(or, if applicable, issuer offering the plan)*  
13           *for furnishing such item or service under*  
14           *the plan.*

15           “(H) *RECOGNIZED AMOUNT.*—*The term*  
16           *‘recognized amount’ means, with respect to an*  
17           *item or service—*

18           “(i) *in the case of such item or service*  
19           *furnished in a State that has in effect a*  
20           *State law that provides for a method for de-*  
21           *termining the amount of payment that is*  
22           *required to be covered by a health plan reg-*  
23           *ulated by such State in the case of a partic-*  
24           *ipant, beneficiary, or enrollee covered under*  
25           *such plan and receiving such item or service*

1           *from a nonparticipating provider or facil-*  
2           *ity, not more than the amount determined*  
3           *in accordance with such law plus the cost-*  
4           *sharing amount imposed under the plan for*  
5           *such item or service (as determined in ac-*  
6           *cordance with clauses (ii) and (iii) of para-*  
7           *graph (1)(C) or subparagraphs (A) and (B)*  
8           *of subsection (e)(1), as applicable); or*

9           *“(ii) in the case of such item or service*  
10          *furnished in a State that does not have in*  
11          *effect such a law, an amount that is at least*  
12          *the median contracted rate (as defined in*  
13          *subparagraph (E)(i) and determined in ac-*  
14          *cordance with rulemaking described in sec-*  
15          *tion 402(e) of the No Surprises Act) for*  
16          *such item or service.”.*

17          ***(b) COVERAGE OF NON-EMERGENCY SERVICES PER-***  
18          ***FORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN***  
19          ***PARTICIPATING FACILITIES; INDEPENDENT DISPUTE RESO-***  
20          ***LUTION PROCESS.—Section 2719A of the Public Health***  
21          ***Service Act (42 U.S.C. 300gg–19a) is amended by adding***  
22          ***at the end the following new subsections:***

23          ***“(e) COVERAGE OF NON-EMERGENCY SERVICES PER-***  
24          ***FORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN***  
25          ***PARTICIPATING FACILITIES.—***

1           “(1) *IN GENERAL.*—Subject to paragraph (3), in  
2           the case of items or services (other than emergency  
3           services to which subsection (b) applies) furnished to  
4           a participant, beneficiary, or enrollee of a health plan  
5           (as defined in paragraph (2)(A)) by a nonparticipating  
6           provider (as defined in subsection (b)(3)(G)(i))  
7           during a visit (as defined by the Secretary in accordance  
8           with paragraph (2)(C)) at a participating  
9           health care facility (as defined in paragraph (2)(B)),  
10          with respect to such plan, the plan—

11                 “(A) shall not impose on such participant,  
12                 beneficiary, or enrollee a cost-sharing amount  
13                 (expressed as a copayment amount or coinsurance  
14                 rate) for such items and services so furnished  
15                 that is greater than the cost-sharing  
16                 amount that would apply under such plan had  
17                 such items or services been furnished by a participating  
18                 provider (as defined in subsection  
19                 (b)(3)(G)(ii));

20                 “(B) shall calculate such cost-sharing  
21                 amount as if the amount that would have been  
22                 charged for such items and services by such participating  
23                 provider were equal to—

24                         “(i) in the case of such items and services  
25                         furnished in a State described in sub-



1            *section (b)(3)(H)(ii), the median contracted*  
2            *rate (as defined in subsection (b)(3)(E)(i))*  
3            *for such items and services; and*

4            *“(ii) in the case of such items and*  
5            *services furnished in a State described in*  
6            *subsection (b)(3)(H)(i), the lesser of—*

7            *“(I) the amount determined by*  
8            *such State for such items and services*  
9            *in accordance with the method de-*  
10           *scribed in such subsection; and*

11           *“(II) the median contracted rate*  
12           *(as so defined) for such items and serv-*  
13           *ices;*

14           *“(C) shall pay to such provider furnishing*  
15           *such items and services to such participant, ben-*  
16           *eficiary, or enrollee the amount by which the rec-*  
17           *ognized amount (as defined in subsection*  
18           *(b)(3)(H)) for such items and services exceeds the*  
19           *cost-sharing amount imposed under the plan for*  
20           *such items and services (as determined in ac-*  
21           *cordance with subparagraphs (A) and (B)); and*

22           *“(D) shall count toward any in-network de-*  
23           *ductible or out-of-pocket maximums applied*  
24           *under the plan any cost-sharing payments made*  
25           *by the participant, beneficiary, or enrollee (and*

1           *such in-network deductible shall be applied) with*  
2           *respect to such items and services so furnished in*  
3           *the same manner as if such cost-sharing pay-*  
4           *ments were with respect to items and services*  
5           *furnished by a participating provider.*

6           “(2) *DEFINITIONS.—In this subsection and sub-*  
7           *section (b):*

8                   “(A) *HEALTH PLAN.—The term ‘health*  
9                   *plan’ means a group health plan and health in-*  
10                   *surance coverage offered by a health insurance*  
11                   *issuer in the group or individual market and in-*  
12                   *cludes a grandfathered health plan (as defined in*  
13                   *section 1251(e) of the Patient Protection and Af-*  
14                   *fordable Care Act).*

15                   “(B) *PARTICIPATING HEALTH CARE FACIL-*  
16                   *ITY.—*

17                           “(i) *IN GENERAL.—The term ‘partici-*  
18                           *parting health care facility’ means, with re-*  
19                           *spect to an item or service and a health*  
20                           *plan, a health care facility described in*  
21                           *clause (ii) that has a contractual relation-*  
22                           *ship with the plan (or, if applicable, issuer*  
23                           *offering the plan) for furnishing such item*  
24                           *or service.*

1           “(i) *HEALTH CARE FACILITY DE-*  
2           *SCRIBED.—A health care facility described*  
3           *in this clause is each of the following:*

4                     “(I) *A hospital (as defined in*  
5                     *1861(e) of the Social Security Act).*

6                     “(II) *A critical access hospital (as*  
7                     *defined in section 1861(mm) of such*  
8                     *Act).*

9                     “(III) *An ambulatory surgical*  
10                    *center (as defined in section*  
11                    *1833(i)(1)(A) of such Act).*

12                    “(IV) *A laboratory.*

13                    “(V) *A radiology facility or imag-*  
14                    *ing center.*

15           “(C) *DURING A VISIT.—The term ‘during a*  
16           *visit’ shall, with respect to items and services*  
17           *furnished to an individual at a participating*  
18           *health care facility, include equipment and de-*  
19           *VICES, telemedicine services, imaging services, lab-*  
20           *ORATORY services, and such other items and serv-*  
21           *ICES as the Secretary may specify, regardless of*  
22           *whether or not the provider furnishing such*  
23           *items or services is at the facility.*

24           “(3) *EXCEPTION.—Paragraph (1) shall not*  
25           *apply to a health plan in the case of items or services*

1       *(other than emergency services to which subsection (b)*  
2       *applies) furnished to a participant, beneficiary, or*  
3       *enrollee of a health plan (as defined in paragraph*  
4       *(2)(A)) by a nonparticipating provider (as defined in*  
5       *subsection (b)(3)(G)(i)) during a visit (as defined by*  
6       *the Secretary in accordance with paragraph (2)(C))*  
7       *at a participating health care facility (as defined in*  
8       *paragraph (2)(B)) if such provider is in compliance*  
9       *with section 2799A(d) with respect to such items and*  
10       *services.*

11       “(f) *INDEPENDENT DISPUTE RESOLUTION PROC-*  
12 *ESS.—*

13               “(1) *ESTABLISHMENT.—*

14                       “(A) *IN GENERAL.—Not later than 1 year*  
15                       *after the date of the enactment of this subsection,*  
16                       *the Secretary, in consultation with the Secretary*  
17                       *of Labor, shall establish by regulation an inde-*  
18                       *pendent dispute resolution process (referred to in*  
19                       *this subsection as the ‘IDR process’) under*  
20                       *which—*

21                               “(i) *a nonparticipating provider (as*  
22                               *defined in subparagraph (G) of subsection*  
23                               *(b)(3)), nonparticipating emergency facility*  
24                               *(as defined in subparagraph (F) of such*  
25                               *subsection), or health plan (as defined in*

1            *subsection (e)(2)(A)) may submit a request*  
2            *for resolution by an entity certified under*  
3            *paragraph (2) (in this subsection referred to*  
4            *as a ‘certified IDR entity’) of a specified*  
5            *claim; and*

6            *“(ii) in the case a settlement described*  
7            *in subparagraph (B) of paragraph (4) is*  
8            *not reached with respect to such claim, such*  
9            *entity so resolves such claim in accordance*  
10           *with such paragraph.*

11           *“(B) DEFINITIONS.—In this subsection:*

12           *“(i) SPECIFIED CLAIM.—*

13           *“(I) IN GENERAL.—Subject to*  
14           *subclause (II), the term ‘specified*  
15           *claim’ means a claim by a nonpartici-*  
16           *pating provider, a nonparticipating*  
17           *emergency facility, or a health plan*  
18           *with respect to qualifying items and*  
19           *services (as defined in clause (ii)) fur-*  
20           *nished by such provider or facility in*  
21           *a State described in subparagraph*  
22           *(H)(ii) of subsection (b)(3) for which a*  
23           *health plan is required to make pay-*  
24           *ment pursuant to subsection (b)(1) or*  
25           *subsection (e)(1)—*

1           “(aa) that such payment  
2           should be increased or decreased;  
3           and

4           “(bb) that is made not later  
5           than—

6                   “(AA) in the case of  
7                   such a claim filed by such a  
8                   provider or facility, the date  
9                   on which the appeal with re-  
10                  spect to such items and serv-  
11                  ices described in clause  
12                  (ii)(I)(aa)(AA) has been re-  
13                  solved (or the date that is 30  
14                  days after such appeal is  
15                  filed, whichever is earlier); or

16                   “(BB) in the case of  
17                   such a claim filed by such  
18                   plan, the date on which the  
19                   period described in clause  
20                  (ii)(I)(bb)(BB) with respect  
21                  to such items and services  
22                  elapses.

23                   “(II) *LIMITATION ON PACKAGING*  
24                   *OF ITEMS AND SERVICES IN A SPECI-*  
25                   *FIED CLAIM.—The term ‘specified*

1 *claim’ shall not include, in the case*  
2 *such claim is made by such provider,*  
3 *facility, or plan with respect to mul-*  
4 *tiple items and services, any claim*  
5 *with respect to items and services fur-*  
6 *nished by such provider or facility if—*

7 *“(aa) such items and services*  
8 *were not furnished by the same*  
9 *provider or facility;*

10 *“(bb) payment for such items*  
11 *and services made pursuant to*  
12 *subsection (b)(1) or subsection*  
13 *(e)(1) was made by multiple*  
14 *health plans;*

15 *“(cc) such items and services*  
16 *are not related to the treatment of*  
17 *the same condition; or*

18 *“(dd) such items and services*  
19 *were not furnished within 30 days*  
20 *of the date of the earliest item or*  
21 *service furnished that is included*  
22 *in such claim.*

23 *“(ii) QUALIFYING ITEMS AND SERV-*  
24 *ICES.—*

1           “(I) *IN GENERAL.*—Subject to  
2           *subclause (II), the term ‘qualifying*  
3           *items and services’ means—*

4                   “(aa) *with respect to a speci-*  
5                   *fied claim made by a nonpartici-*  
6                   *ating provider or nonpartici-*  
7                   *ating emergency facility, items*  
8                   *and services furnished by such*  
9                   *provider or facility for which a*  
10                  *health plan is required to make*  
11                  *payment pursuant to subsection*  
12                  *(b)(1) or subsection (e)(1), but*  
13                  *only if—*

14                   “(AA) *such items and*  
15                   *services are included in an*  
16                   *appeal filed under such*  
17                   *plan’s internal appeals proc-*  
18                   *ess not later than 30 days*  
19                   *after such payment is re-*  
20                   *ceived; and*

21                   “(BB) *such appeal*  
22                   *under such plan’s internal*  
23                   *appeals process has been re-*  
24                   *solved, or a 30-day period*



1                   *has elapsed since such appeal*  
2                   *was so filed; and*

3                   “(bb) *with respect to a speci-*  
4                   *fied claim made by a health plan,*  
5                   *items and services furnished by*  
6                   *such a provider or facility for*  
7                   *which such health plan is required*  
8                   *to make payment pursuant to*  
9                   *subsection (b)(1) or subsection*  
10                  *(e)(1), but only if—*

11                  “(AA) *such plan sub-*  
12                  *mits a notice to such pro-*  
13                  *vider or facility not later*  
14                  *than 30 days after such pro-*  
15                  *vider or facility receives such*  
16                  *payment that such plan dis-*  
17                  *putes the amount of such*  
18                  *payment with respect to such*  
19                  *items and services; and*

20                  “(BB) *a 30-day period*  
21                  *has elapsed since the submis-*  
22                  *sion of such notice.*

23                  “(II) *LIMITATION.—The term*  
24                  *‘qualifying items and services’ shall*  
25                  *not include an item or service fur-*

1           nished in a geographic area during a  
2           year by such provider or facility for  
3           which a health plan is required to  
4           make payment pursuant to subsection  
5           (b)(1) or subsection (e)(1) if the me-  
6           dian contracted rate (as defined in  
7           subsection (b)(3)(E)) under such plan  
8           for such year with respect to such item  
9           or service furnished by such a provider  
10          or such a facility in such area does not  
11          exceed—

12                   “(aa) with respect to an item  
13                   or service furnished during 2021,  
14                   \$1,250; and

15                   “(bb) with respect to an item  
16                   or service furnished during a sub-  
17                   sequent year, the amount specified  
18                   under this subclause for the pre-  
19                   vious year, increased by the per-  
20                   centage increase in the consumer  
21                   price index for all urban con-  
22                   sumers (United States city aver-  
23                   age) over such previous year.

24                   “(2) CERTIFICATION OF ENTITIES.—

1           “(A) *PROCESS OF CERTIFICATION.*—The  
2           *process described in paragraph (1) shall include*  
3           *a certification process under which eligible enti-*  
4           *ties may be certified to carry out the IDR proc-*  
5           *ess.*

6           “(B) *ELIGIBILITY.*—

7           “(i) *IN GENERAL.*—For purposes of  
8           *subparagraph (A), an eligible entity is an*  
9           *entity that is a nongovernmental entity that*  
10           *agrees to comply with the fee limitations de-*  
11           *scribed in clause (ii).*

12           “(ii) *FEE LIMITATION.*—For purposes  
13           *of clause (i), the fee limitations described in*  
14           *this clause are limitations established by the*  
15           *Secretary on the amount a certified IDR*  
16           *entity may charge a nonparticipating pro-*  
17           *vider, nonparticipating emergency facility,*  
18           *or health plan for services furnished by such*  
19           *entity with respect to the resolution of a*  
20           *specified claim of such provider, facility, or*  
21           *plan under the process described in para-*  
22           *graph (1).*

23           “(3) *SELECTION OF CERTIFIED IDR ENTITY FOR*  
24           *A SPECIFIED CLAIM.*—With respect to the resolution of  
25           *a specified claim under the IDR process, the health*

1        *plan and the nonparticipating provider or the non-*  
2        *participating emergency facility (as applicable) in-*  
3        *volved shall agree on a certified IDR entity to resolve*  
4        *such claim. In the case that such plan and such pro-*  
5        *vider or facility (as applicable) cannot so agree, such*  
6        *an entity shall be selected by the Secretary at ran-*  
7        *dom.*

8                *“(4) PAYMENT DETERMINATION.—*

9                        *“(A) TIMING.—A certified IDR entity se-*  
10                      *lected under paragraph (3) by a health plan and*  
11                      *a nonparticipating provider or a nonpartici-*  
12                      *parting emergency facility (as applicable) with*  
13                      *respect to a specified claim shall, subject to sub-*  
14                      *paragraph (B), not later than 30 days after*  
15                      *being so selected, determine the total reimburse-*  
16                      *ment that should have been made for items and*  
17                      *services included in such claim in accordance*  
18                      *with subparagraph (C).*

19                      *“(B) SETTLEMENT.—*

20                                *“(i) IN GENERAL.—If such entity de-*  
21                                *termines that a settlement between the*  
22                                *health plan and the provider or facility is*  
23                                *likely with respect to a specified claim, the*  
24                                *entity may direct the parties to attempt, for*

1           *a period not to exceed 10 days, a good faith*  
2           *negotiation for a settlement of such claim.*

3           “(ii) *TIMING.*—*The period for a settle-*  
4           *ment described in clause (i) shall accrue to-*  
5           *wards the 30-day period described in sub-*  
6           *paragraph (A).*

7           “(C) *DETERMINATION OF AMOUNT.*—

8           “(i) *IN GENERAL.*—*The health plan*  
9           *and the nonparticipating provider or non-*  
10           *participating emergency facility (as appli-*  
11           *cable) shall, with respect to a specified*  
12           *claim, each submit to the certified IDR en-*  
13           *tity a final offer of payment or reimburse-*  
14           *ment (as applicable) with respect to items*  
15           *and services which are the subject of the*  
16           *specified claim. Such entity shall determine*  
17           *which such offer is the most reasonable in*  
18           *accordance with clause (ii).*

19           “(ii) *CONSIDERATIONS IN DETERMINA-*  
20           *TION.*—

21           “(I) *IN GENERAL.*—*In deter-*  
22           *mining which final offer is the most*  
23           *reasonable under clause (i), the cer-*  
24           *tified IDR entity shall consider—*

1                   “(aa) the median contracted  
2 rates (as defined in subsection  
3 (b)(3)(E)) for items or services  
4 that are comparable to the items  
5 and services included in the speci-  
6 fied claim and that are furnished  
7 in the same geographic area (as  
8 defined by the Secretary for pur-  
9 poses of such subsection) as such  
10 items and services (not including  
11 any facility fees with respect to  
12 such rates); and

13                   “(bb) the circumstances de-  
14 scribed in subclause (II), if any  
15 information with respect to such  
16 circumstances is submitted by ei-  
17 ther party.

18                   “(II)        ADDITIONAL        CIR-  
19 CUMSTANCES.—For purposes of sub-  
20 clause (I)(bb), the circumstances de-  
21 scribed in this subclause are, with re-  
22 spect to items and services included in  
23 the specified claim of a nonpartici-  
24 pating provider, nonparticipating

1           *emergency facility, or health plan, the*  
2           *following:*

3                     “(aa) *The level of training,*  
4                     *education, experience, and quality*  
5                     *and outcomes measurements of the*  
6                     *provider or facility that furnished*  
7                     *such items and services.*

8                     “(bb) *Any other extenuating*  
9                     *circumstances with respect to the*  
10                    *furnishing of such items and serv-*  
11                    *ices that relate to the acuity of the*  
12                    *individual receiving such items*  
13                    *and services or the complexity of*  
14                    *furnishing such items and services*  
15                    *to such individual.*

16                    “(III) *PROHIBITION ON CONSID-*  
17                    *ERATION OF BILLED CHARGES.—In de-*  
18                    *termining which final offer is the most*  
19                    *reasonable under clause (i) with re-*  
20                    *spect to items and services furnished by*  
21                    *a provider or facility and included in*  
22                    *a specified claim, the certified IDR en-*  
23                    *tity may not consider the amount that*  
24                    *would have been billed by such pro-*  
25                    *vider or facility with respect to such*

1            *items and services had the provisions*  
2            *of section 2799 or 2799A (as applica-*  
3            *ble) not applied.*

4            *“(iii) EFFECT OF DETERMINATION.—A*  
5            *determination of a certified IDR entity*  
6            *under clause (i)—*

7                    *“(I) shall be binding; and*

8                    *“(II) shall not be subject to judi-*  
9            *cial review, except in a case described*  
10           *in any of paragraphs (1) through (4)*  
11           *of section 10(a) of title 9, United*  
12           *States Code.*

13           *“(iv) COSTS OF INDEPENDENT DIS-*  
14           *PUTE RESOLUTION PROCESS.—In the case*  
15           *of a specified claim made by a nonpartici-*  
16           *pating provider, nonparticipating emer-*  
17           *gency facility, or health plan and submitted*  
18           *to a certified IDR entity—*

19                    *“(I) if such entity makes a deter-*  
20           *mination with respect to such claim*  
21           *under clause (i), the party whose offer*  
22           *is not chosen under such clause shall be*  
23           *responsible for paying all fees charged*  
24           *by such entity; and*



1           “(II) if the parties reach a settle-  
2           ment with respect to such claim prior  
3           to such a determination, such fees shall  
4           be divided equally between the parties,  
5           unless the parties otherwise agree.

6           “(v) PAYMENT.—Not later than 30  
7           days after a determination described in  
8           clause (i) is made with respect to a specified  
9           claim of a nonparticipating provider, non-  
10          participating emergency facility, or health  
11          plan—

12           “(I) in the case that such deter-  
13          mination finds that the amount paid  
14          with respect to such specified claim by  
15          the health plan should have been great-  
16          er than the amount so paid, such plan  
17          shall pay directly to the provider or fa-  
18          cility (as applicable) the difference be-  
19          tween the amount so paid and the  
20          amount so determined; and

21           “(II) in the case that such deter-  
22          mination finds that the amount paid  
23          with respect to such specified claim by  
24          the health plan should have been less  
25          than the amount so paid, the provider

1                   or facility (as applicable) shall pay di-  
2                   rectly to the plan the difference between  
3                   the amount so paid and the amount so  
4                   determined.

5                   “(5) *PUBLICATION OF INFORMATION RELATING*  
6                   *TO DISPUTES.*—

7                   “(A) *IN GENERAL.*—For 2021 and each sub-  
8                   sequent year, the Secretary and the Secretary of  
9                   Labor shall publish on the public website of the  
10                  Department of Health and Human Services and  
11                  the Department of Labor, respectively—

12                  “(i) the number of specified claims  
13                  filed during such year;

14                  “(ii) the number of such claims with  
15                  respect to which a final determination was  
16                  made under paragraph (4)(C)(i); and

17                  “(iii) the information described in sub-  
18                  paragraph (B) with respect to each specified  
19                  claim with respect to which such a decision  
20                  was so made.

21                  “(B) *INFORMATION WITH RESPECT TO*  
22                  *SPECIFIED CLAIMS.*—For purposes of subpara-  
23                  graph (A), the information described in this sub-  
24                  paragraph is, with respect to a specified claim

1           *of a nonparticipating provider, nonparticipating*  
2           *emergency facility, or health plan—*

3                   “(i) a description of each item and  
4                   service included in such claim;

5                   “(ii) the amount of the offer submitted  
6                   under paragraph (4)(C)(i) by the health  
7                   plan and by the nonparticipating provider  
8                   or nonparticipating emergency facility (as  
9                   applicable);

10                   “(iii) whether the offer selected by the  
11                   certified IDR entity under such paragraph  
12                   was the offer submitted by such plan or by  
13                   such provider or facility (as applicable) and  
14                   the amount of such offer so selected; and

15                   “(iv) the category and practice spe-  
16                   cialty of each such provider or facility in-  
17                   volved in furnishing such items and serv-  
18                   ices.

19                   “(C) *CONFIDENTIALITY OF PARTIES.*—None  
20                   of the information published under this para-  
21                   graph may specify the identity of a health plan,  
22                   provider, facility, or individual with respect to  
23                   a specified claim.”.

24           (c) *PROVIDER DIRECTORY REQUIREMENTS; DISCLO-*  
25           *SURE ON PATIENT PROTECTIONS.*—Section 2719A of the

1 *Public Health Service Act, as amended by subsection (b),*  
2 *is further amended by adding at the end the following new*  
3 *subsections:*

4       “(g) *PROVIDER DIRECTORY INFORMATION REQUIRE-*  
5 *MENTS.—*

6               “(1) *IN GENERAL.—Not later than 1 year after*  
7 *the date of the enactment of this subsection, each*  
8 *group health plan and health insurance issuer offer-*  
9 *ing group or individual health insurance coverage*  
10 *shall—*

11                       “(A) *establish the verification process de-*  
12 *scribed in paragraph (2);*

13                       “(B) *establish the response protocol de-*  
14 *scribed in paragraph (3);*

15                       “(C) *establish the database described in*  
16 *paragraph (4); and*

17                       “(D) *include in any print directory con-*  
18 *taining provider directory information with re-*  
19 *spect to such plan or such coverage the informa-*  
20 *tion described in paragraph (5).*

21               “(2) *VERIFICATION PROCESS.—The verification*  
22 *process described in this paragraph is, with respect to*  
23 *a group health plan or a health insurance issuer of-*  
24 *fering group or individual health insurance coverage,*  
25 *a process—*

1           “(A) under which not less frequently than  
2           once every 90 days, such plan or such issuer (as  
3           applicable) verifies and updates the provider di-  
4           rectory information included on the database de-  
5           scribed in paragraph (4) of such plan or issuer  
6           of each health care provider and health care fa-  
7           cility included in such database; and

8           “(B) that establishes a procedure for the re-  
9           moval of such a provider or facility with respect  
10          to which such plan or issuer has been unable to  
11          verify such information during a period speci-  
12          fied by the plan or issuer.

13          “(3) *RESPONSE PROTOCOL.*—The response pro-  
14          tocol described in this paragraph is, in the case of an  
15          individual enrolled under a group health plan or  
16          group or individual health insurance coverage offered  
17          by a health insurance issuer who requests information  
18          on whether a health care provider or health care facil-  
19          ity has a contractual relationship to furnish items  
20          and services under such plan or such coverage, a pro-  
21          tocol under which such plan or such issuer (as appli-  
22          cable), in the case such request is made through a tele-  
23          phone call—

24                 “(A) responds to such individual as soon as  
25                 practicable and in no case later than 1 business

1           *day after such call is received through a written*  
2           *electronic communication; and*

3           “(B) *retains such communication in such*  
4           *individual’s file for at least 2 years following*  
5           *such response.*

6           “(4) *DATABASE.—The database described in this*  
7           *paragraph is, with respect to a group health plan or*  
8           *health insurance issuer offering group or individual*  
9           *health insurance coverage, a database on the public*  
10          *website of such plan or issuer that contains—*

11          “(A) *a list of each health care provider and*  
12          *health care facility with which such plan or such*  
13          *issuer has a contractual relationship for fur-*  
14          *nishing items and services under such plan or*  
15          *such coverage; and*

16          “(B) *provider directory information with*  
17          *respect to each such provider and facility.*

18          “(5) *INFORMATION.—The information described*  
19          *in this paragraph is, with respect to a print directory*  
20          *containing provider directory information with re-*  
21          *spect to a group health plan or individual or group*  
22          *health insurance coverage offered by a health insur-*  
23          *ance issuer, a notification that such information con-*  
24          *tained in such directory was accurate as of the date*  
25          *of publication of such directory and that an indi-*

1        *vidual enrolled under such plan or such coverage*  
2        *should consult the database described in paragraph*  
3        *(4) with respect to such plan or such coverage or con-*  
4        *tact such plan or the issuer of such coverage to obtain*  
5        *the most current provider directory information with*  
6        *respect to such plan or such coverage.*

7            *“(6) DEFINITION.—For purposes of this sub-*  
8            *section, the term ‘provider directory information’ in-*  
9            *cludes, with respect to a group health plan and a*  
10          *health insurance issuer offering group or individual*  
11          *health insurance coverage, the name, address, spe-*  
12          *cialty, and telephone number of each health care pro-*  
13          *vider or health care facility with which such plan or*  
14          *such issuer has a contractual relationship for fur-*  
15          *nishing items and services under such plan or such*  
16          *coverage.*

17          *“(h) DISCLOSURE ON PATIENT PROTECTIONS.—Each*  
18          *group health plan and health insurance issuer offering*  
19          *group or individual health insurance coverage shall make*  
20          *publicly available, and (if applicable) post on a public*  
21          *website of such plan or issuer—*

22            *“(1) information in plain language on—*

23            *“(A) the requirements and prohibitions ap-*  
24            *plied under sections 2799 and 2799A (relating to*

1           *prohibitions on balance billing in certain cir-*  
2           *cumstances);*

3           “(B) if provided for under applicable State  
4           law, any other requirements on providers and fa-  
5           cilities regarding the amounts such providers  
6           and facilities may, with respect to an item or  
7           service, charge a participant, beneficiary, or en-  
8           rollee of such plan or coverage with respect to  
9           which such a provider or facility does not have  
10          a contractual relationship for furnishing such  
11          item or service under the plan or coverage after  
12          receiving payment from the plan or coverage for  
13          such item or service and any applicable cost-  
14          sharing payment from such participant, bene-  
15          ficiary, or enrollee; and

16          “(C) the requirements applied under sub-  
17          sections (b) and (e); and

18          “(2) information on contacting appropriate  
19          State and Federal agencies in the case that an indi-  
20          vidual believes that such a provider or facility has  
21          violated any requirement described in paragraph (1)  
22          with respect to such individual.”.

23          (d) *PREVENTING CERTAIN CASES OF BALANCE BILL-*  
24          *ING.—Title XXVII of the Public Health Service Act is*  
25          *amended by adding at the end the following new part:*



1       **“PART D—PREVENTING CERTAIN CASES OF**  
2                                   **BALANCE BILLING**

3       **“SEC. 2799. BALANCE BILLING IN CASES OF EMERGENCY**  
4                                   **SERVICES.**

5           “(a) *IN GENERAL.*—*In the case of a participant, bene-*  
6 *ficiary, or enrollee with benefits under a health plan who*  
7 *is furnished on or after January 1, 2021, emergency serv-*  
8 *ices with respect to an emergency medical condition during*  
9 *a visit at an emergency department of a hospital or an*  
10 *independent freestanding emergency department—*

11                   “(1) *the emergency department of a hospital or*  
12 *independent freestanding emergency department shall*  
13 *not hold the participant, beneficiary, or enrollee liable*  
14 *for a payment amount for such emergency services so*  
15 *furnished that is more than the cost-sharing amount*  
16 *for such services (as determined in accordance with*  
17 *clauses (ii) and (iii) of section 2719A(b)(1)(C)); and*

18                   “(2) *a health care provider shall not hold such*  
19 *participant, beneficiary, or enrollee liable for a pay-*  
20 *ment amount for an emergency service furnished to*  
21 *such individual by such provider with respect to such*  
22 *emergency medical condition and visit for which the*  
23 *individual receives emergency services at the hospital*  
24 *or emergency department that is more than the cost-*  
25 *sharing amount for such services furnished by the*

1 provider (as determined in accordance with clauses  
2 (ii) and (iii) of section 2719A(b)(1)(C)).

3 “(b) *DEFINITIONS.*—*In this section:*

4 “(1) *The terms ‘emergency department of a hos-*  
5 *pital’, ‘emergency medical condition’, ‘emergency*  
6 *services’, and ‘independent freestanding emergency de-*  
7 *partment’ have the meanings given such terms, re-*  
8 *spectively, in section 2719A(b)(3).*

9 “(2) *The term ‘health plan’ has the meaning*  
10 *given such term in section 2719A(e).*

11 “(3) *The term ‘during a visit’ shall have such*  
12 *meaning as applied to such term for purposes of sec-*  
13 *tion 2719A(e).*

14 **“SEC. 2799A. BALANCE BILLING IN CASES OF NON-EMER-**  
15 **GENCY SERVICES PERFORMED BY NON-**  
16 **PARTICIPATING PROVIDERS AT CERTAIN**  
17 **PARTICIPATING FACILITIES.**

18 “(a) *IN GENERAL.*—*Subject to subsection (b), in the*  
19 *case of a participant, beneficiary, or enrollee with benefits*  
20 *under a health plan (as defined in section 2799(b)) who*  
21 *is furnished on or after January 1, 2021, items or services*  
22 *(other than emergency services to which section 2799 ap-*  
23 *plies) at a participating health care facility by a non-*  
24 *participating provider, such provider shall not hold such*  
25 *participant, beneficiary, or enrollee liable for a payment*

1 *amount for such an item or service furnished by such pro-*  
2 *vider during a visit at such facility that is more than the*  
3 *cost-sharing amount for such item or service (as determined*  
4 *in accordance with subparagraphs (A) and (B) of section*  
5 *2719A(e)(1)).*

6 “(b) *EXCEPTION.*—

7 “(1) *IN GENERAL.*—Subsection (a) shall not  
8 *apply to a nonparticipating provider (other than a*  
9 *specified provider at a participating health care facil-*  
10 *ity), with respect to items or services furnished by the*  
11 *provider to a participant, beneficiary, or enrollee of*  
12 *a health plan, if the provider is in compliance with*  
13 *the notice and consent requirements of subsection (d).*

14 “(2) *SPECIFIED PROVIDER DEFINED.*—For pur-  
15 *poses of paragraph (1), the term ‘specified provider’,*  
16 *with respect to a participating health care facility—*

17 “(A) *means a facility-based provider, in-*  
18 *cluding emergency medicine providers, anesথে-*  
19 *siologists, pathologists, radiologists,*  
20 *neonatologists, assistant surgeons, hospitalists,*  
21 *intensivists, or other providers as determined by*  
22 *the Secretary; and*

23 “(B) *includes, with respect to an item or*  
24 *service, a nonparticipating provider if there is*

1           *no participating provider at such facility who*  
2           *can furnish such item or service.*

3           “(c) *CLARIFICATION.—In the case of a nonparticipating*  
4           *provider (other than a specified provider at a participating*  
5           *health care facility) that complies with the notice*  
6           *and consent requirements of subsection (d) with respect to*  
7           *an item or service (referred to in this subsection as a ‘covered*  
8           *item or service’), such notice and consent requirements*  
9           *may not be construed as applying with respect to any item*  
10           *or service that is furnished as a result of unforeseen medical*  
11           *needs that arise at the time such covered item or service*  
12           *is furnished.*

13           “(d) *COMPLIANCE WITH NOTICE AND CONSENT RE-*  
14           *QUIREMENTS.—*

15           “(1) *IN GENERAL.—A nonparticipating provider*  
16           *or nonparticipating facility is in compliance with*  
17           *this subsection, with respect to items or services fur-*  
18           *nished by the provider or facility to a participant,*  
19           *beneficiary, or enrollee of a health plan, if the pro-*  
20           *vider (or, if applicable, the participating health care*  
21           *facility on behalf of such provider) or nonparticipating*  
22           *facility—*

23           “(A) *provides to the participant, bene-*  
24           *ficiary, or enrollee (or to an authorized rep-*  
25           *resentative of the participant, beneficiary, or en-*

1           rollee) on the date on which the individual is  
2           furnished such items or services and, in the case  
3           that the participant, beneficiary, or enrollee  
4           makes an appointment to be furnished such  
5           items or services, on such date the appointment  
6           is made—

7                   “(i) an oral explanation of the written  
8                   notice described in clause (ii); and

9                   “(ii) a written notice specified by the  
10                  Secretary, not later than July 1, 2020,  
11                  through guidance (which shall be updated  
12                  as determined necessary by the Secretary)  
13                  that—

14                   “(I) contains the information re-  
15                   quired under paragraph (2); and

16                   “(II) is signed and dated by the  
17                   participant, beneficiary, or enrollee (or  
18                   by an authorized representative of the  
19                   participant, beneficiary, or enrollee)  
20                   and, with respect to items or services to  
21                   be furnished by such a provider that  
22                   are not poststabilization services de-  
23                   scribed in section 2719A(b)(3)(C)(ii),  
24                   is so signed and dated not less than 72  
25                   hours prior to the participant, bene-

1                   *ficiary, or enrollee being furnished*  
2                   *such items or services by such provider;*  
3                   *and*

4                   “(B) obtains from the participant, bene-  
5                   *ficiary, or enrollee (or from such an authorized*  
6                   *representative) the consent described in para-*  
7                   *graph (3).*

8                   “(2) *INFORMATION REQUIRED UNDER WRITTEN*  
9                   *NOTICE.—For purposes of paragraph (1)(A)(ii)(I), the*  
10                  *information described in this paragraph, with respect*  
11                  *to a nonparticipating provider or nonparticipating*  
12                  *facility and a participant, beneficiary, or enrollee of*  
13                  *a health plan, is each of the following:*

14                  “(A) *Notification, as applicable, that the*  
15                  *health care provider is a nonparticipating pro-*  
16                  *vider with respect to the health plan or the*  
17                  *health care facility is a nonparticipating facility*  
18                  *with respect to the health plan.*

19                  “(B) *Notification of the estimated amount*  
20                  *that such provider or facility may charge the*  
21                  *participant, beneficiary, or enrollee for such*  
22                  *items and services involved.*

23                  “(C) *In the case of a nonparticipating facil-*  
24                  *ity, a list of any participating providers at the*  
25                  *facility who are able to furnish such items and*

1           *services involved and notification that the par-*  
2           *ticipant, beneficiary, or enrollee may be referred,*  
3           *at their option, to such a participating provider.*

4           “(3) *CONSENT DESCRIBED.*—*For purposes of*  
5           *paragraph (1)(B), the consent described in this para-*  
6           *graph, with respect to a participant, beneficiary, or*  
7           *enrollee of a health plan who is to be furnished items*  
8           *or services by a nonparticipating provider or non-*  
9           *participating facility, is a document specified by the*  
10          *Secretary through rulemaking that—*

11                   “(A) *is signed by the participant, bene-*  
12                   *ficiary, or enrollee (or by an authorized rep-*  
13                   *resentative of the participant, beneficiary, or en-*  
14                   *rollee) and, with respect to items or services to*  
15                   *be furnished by such a provider or facility that*  
16                   *are not poststabilization services described in*  
17                   *section 2719A(b)(3)(C)(i), is so signed not less*  
18                   *than 72 hours prior to the participant, bene-*  
19                   *ficiary, or enrollee being furnished such items or*  
20                   *services by such provider or facility;*

21                   “(B) *acknowledges that the participant,*  
22                   *beneficiary, or enrollee has been—*

23                           “(i) *provided with a written estimate*  
24                           *and an oral explanation of the charge that*  
25                           *the participant, beneficiary, or enrollee will*

1           *be assessed for the items or services antici-*  
2           *pated to be furnished to the participant,*  
3           *beneficiary, or enrollee by such provider or*  
4           *facility; and*

5           *“(i) informed that the payment of*  
6           *such charge by the participant, beneficiary,*  
7           *or enrollee may not accrue toward meeting*  
8           *any limitation that the health plan places*  
9           *on cost-sharing; and*

10          *“(C) documents the consent of the partici-*  
11          *pant, beneficiary, or enrollee to—*

12           *“(i) be furnished with such items or*  
13           *services by such provider or facility; and*

14           *“(ii) in the case that the individual is*  
15           *so furnished such items or services, be*  
16           *charged an amount that may be greater*  
17           *than the amount that would otherwise be*  
18           *charged the individual if furnished by a*  
19           *participating provider or participating fa-*  
20           *ility with respect to such items or services*  
21           *and plan.*

22          *“(e) RETENTION OF CERTAIN DOCUMENTS.—A non-*  
23          *participating provider (or, in the case of a nonpartici-*  
24          *pating provider at a participating health care facility, such*  
25          *facility) or nonparticipating facility that obtains from a*



1 *participant, beneficiary, or enrollee of a health plan (or an*  
2 *authorized representative of such participant, beneficiary,*  
3 *or enrollee) a written notice in accordance with subsection*  
4 *(c)(1)(ii), with respect to furnishing an item or service to*  
5 *such participant, beneficiary, or enrollee, shall retain such*  
6 *notice for at least a 2-year period after the date on which*  
7 *such item or service is so furnished.*

8 “(f) *DEFINITIONS.—In this section:*

9 “(1) *The terms ‘nonparticipating provider’ and*  
10 *‘participating provider’ have the meanings given such*  
11 *terms, respectively, in subsection (b)(3) of section*  
12 *2719A.*

13 “(2) *The terms ‘participating health care facil-*  
14 *ity’ and ‘health plan’ have the meanings given such*  
15 *terms, respectively, in subsection (e)(2) of section*  
16 *2719A.*

17 “(3) *The term ‘nonparticipating facility’*  
18 *means—*

19 “(A) *with respect to emergency services (as*  
20 *defined in section 2719A(b)(3)(C)(i)) and a*  
21 *health plan, an emergency department of a hos-*  
22 *pital, or an independent freestanding emergency*  
23 *department, that does not have a contractual re-*  
24 *lationship with the plan (or, if applicable, issuer*

1           *offering the plan) for furnishing such services*  
2           *under the plan; and*

3           “(B) *with respect to poststabilization serv-*  
4           *ices described in section 2719A(b)(3)(C)(ii) and*  
5           *a health plan, an emergency department of a*  
6           *hospital (or other department of such hospital),*  
7           *or an independent freestanding emergency de-*  
8           *partment, that does not have a contractual rela-*  
9           *ationship with the plan (or, if applicable, issuer*  
10           *offering the plan) for furnishing such services*  
11           *under the plan.*

12           “(4) *The term ‘participating facility’ means—*

13           “(A) *with respect to emergency services (as*  
14           *defined in section 2719A(b)(3)(C)(i)) and a*  
15           *health plan, an emergency department of a hos-*  
16           *pital, or an independent freestanding emergency*  
17           *department, that has a contractual relationship*  
18           *with the plan (or, if applicable, issuer offering*  
19           *the plan) for furnishing such services under the*  
20           *plan; and*

21           “(B) *with respect to poststabilization serv-*  
22           *ices described in section 2719A(b)(3)(C)(ii) and*  
23           *a health plan, an emergency department of a*  
24           *hospital (or other department of such hospital),*  
25           *or an independent freestanding emergency de-*

1            *partment, that has a contractual relationship*  
2            *with the plan (or, if applicable, issuer offering*  
3            *the plan) for furnishing such services under the*  
4            *plan.*

5    **“SEC. 2799B. PROVIDER REQUIREMENTS WITH RESPECT TO**  
6            **PROVIDER DIRECTORY INFORMATION.**

7            *“Not later than 1 year after the date of the enactment*  
8            *of this section, each health care provider and health care*  
9            *facility shall establish a process under which such provider*  
10           *or facility transmits, to each health insurance issuer offer-*  
11           *ing group or individual health insurance coverage and*  
12           *group health plan with which such provider or facility has*  
13           *in effect a contractual relationship for furnishing items and*  
14           *services under such coverage or such plan, provider direc-*  
15           *tory information (as defined in section 2719A(g)(6)) with*  
16           *respect to such provider or facility, as applicable. Such pro-*  
17           *vider or facility shall so transmit such information to such*  
18           *issuer offering such coverage or such group health plan—*

19            *“(1) when the provider or facility enters into*  
20            *such a relationship with respect to such coverage of-*  
21            *fered by such issuer or with respect to such plan;*

22            *“(2) when the provider or facility terminates*  
23            *such relationship with respect to such coverage offered*  
24            *by such issuer or with respect to such plan;*



1            *nishing such item or service under the plan after*  
2            *receiving payment from the plan for such item*  
3            *or service and any applicable cost-sharing pay-*  
4            *ment from such participant, beneficiary, or en-*  
5            *rollee; and*

6            *“(2) information on contacting appropriate*  
7            *State and Federal agencies in the case that an indi-*  
8            *vidual believes that such provider or facility has vio-*  
9            *lated any requirement described in paragraph (1)*  
10           *with respect to such individual.*

11    **“SEC. 2799D. ENFORCEMENT.**

12           *“(a) STATE ENFORCEMENT.—*

13           *“(1) STATE AUTHORITY.—Each State may re-*  
14           *quire a provider or health care facility subject to the*  
15           *requirements of sections 2719A(f), 2799, 2799A,*  
16           *2799B, or 2799C to satisfy such requirements appli-*  
17           *cable to the provider or facility.*

18           *“(2) FAILURE TO IMPLEMENT REQUIREMENTS.—*

19           *In the case of a determination by the Secretary that*  
20           *a State has failed to substantially enforce the require-*  
21           *ments specified in paragraph (1) with respect to ap-*  
22           *licable providers and facilities in the State, the Sec-*  
23           *retary shall enforce such requirements under sub-*  
24           *section (b) insofar as they relate to violations of such*  
25           *requirements occurring in such State.*

1       “(b) *SECRETARIAL ENFORCEMENT AUTHORITY.*—

2               “(1) *IN GENERAL.*—*If a provider or facility is*  
3 *found to be in violation specified in subsection (a)(1)*  
4 *by the Secretary, the Secretary may apply a civil*  
5 *monetary penalty with respect to such provider or fa-*  
6 *cility in an amount not to exceed \$10,000 per viola-*  
7 *tion. The provisions of subsections (c), (d), (e), (g),*  
8 *(h), (k), and (l) of section 1128A of the Social Secu-*  
9 *rity Act shall apply to a civil monetary penalty or*  
10 *assessment under this subsection in the same manner*  
11 *as such provisions apply to a penalty, assessment, or*  
12 *proceeding under subsection (a) of such section.*

13               “(2) *LIMITATION.*—*The provisions of paragraph*  
14 *(1) shall apply to enforcement of a provision (or pro-*  
15 *visions) specified in subsection (a)(1) only as pro-*  
16 *vided under subsection (a)(2).*

17               “(3) *COMPLAINT PROCESS.*—*The Secretary shall,*  
18 *through rulemaking, establish a process to receive con-*  
19 *sumer complaints of violations of such provisions and*  
20 *resolve such complaints within 60 days of receipt of*  
21 *such complaints.*

22               “(4) *EXCEPTION.*—*The Secretary shall waive the*  
23 *penalties described under paragraph (1) with respect*  
24 *to a facility or provider who does not knowingly vio-*  
25 *late, and should not have reasonably known it vio-*

1 *lated, section 2799 or 2799A with respect to a partici-*  
2 *part, beneficiary, or enrollee, if such facility or prac-*  
3 *titioner, within 30 days of the violation, withdraws*  
4 *the bill that was in violation of such provision and*  
5 *reimburses the health plan or enrollee, as applicable,*  
6 *in an amount equal to the difference between the*  
7 *amount billed and the amount allowed to be billed*  
8 *under the provision, plus interest, at an interest rate*  
9 *determined by the Secretary.*

10 *“(5) HARDSHIP EXEMPTION.—The Secretary*  
11 *may establish a hardship exemption to the penalties*  
12 *under this subsection.*

13 *“(c) CONTINUED APPLICABILITY OF STATE LAW.—The*  
14 *sections specified in subsection (a)(1) shall not be construed*  
15 *to supersede any provision of State law which establishes,*  
16 *implements, or continues in effect any requirement or pro-*  
17 *hibition except to the extent that such requirement or prohi-*  
18 *bition prevents the application of a requirement or prohibi-*  
19 *tion of such a section.”.*

20 *(e) RULEMAKING FOR MEDIAN CONTRACTED RATES.—*  
21 *Not later than July 1, 2020, the Secretary of Health and*  
22 *Human Services, jointly with the Secretary of Labor, shall*  
23 *establish through rulemaking—*

24 *(1) the methodology the sponsor or issuer of a*  
25 *health plan (as defined in subsection (e) of section*

1        *2719A of the Public Health Service Act (42 U.S.C.*  
2        *300gg–19a), as added by subsection (b) of this sec-*  
3        *tion) shall use to determine the median contracted*  
4        *rate (as defined in section 2719A(b) of such Act, as*  
5        *amended by subsection (a) of this section), differen-*  
6        *tiating by business line;*

7            *(2) the information such sponsor or issuer shall*  
8        *share with the nonparticipating provider (as defined*  
9        *in such section) involved when making such a deter-*  
10       *mination; and*

11           *(3) the geographic regions applied for purposes*  
12       *of subparagraph (E) of section 2719A(b)(3), as*  
13       *amended by subsection (a) of this section, taking into*  
14       *account the needs of rural and underserved areas, in-*  
15       *cluding health professional shortage areas.*

16 *Such rulemaking shall take into account payments that are*  
17 *made by such sponsor or issuer that are not on a fee-for-*  
18 *service basis. Such methodology may account for relevant*  
19 *payment adjustments that take into account facility type*  
20 *(including higher acuity settings and the case-mix of var-*  
21 *ious facility types) that are otherwise taken into account*  
22 *for purposes of determining payment amounts with respect*  
23 *to participating facilities.*



1           (f) *EFFECTIVE DATE.*—*The amendments made by sub-*  
2 *sections (a) and (b) shall apply with respect to plan years*  
3 *beginning on or after January 1, 2021.*

4 **SEC. 403. GOVERNMENT ACCOUNTABILITY OFFICE STUDY**  
5                           **ON PROFIT- AND REVENUE-SHARING IN**  
6                           **HEALTH CARE.**

7           (a) *STUDY.*—*The Comptroller General of the United*  
8 *States shall conduct a study to—*

9                       (1) *describe what is known about profit- and*  
10 *revenue-sharing relationships in the commercial*  
11 *health care markets, including those relationships*  
12 *that—*

13                               (A) *involve one or more—*

14                                       (i) *physician groups that practice*  
15 *within a hospital included in the profit- or*  
16 *revenue-sharing relationship, or refer pa-*  
17 *tients to such hospital;*

18                                       (ii) *laboratory, radiology, or pharmacy*  
19 *services that are delivered to privately in-*  
20 *sured patients of such hospital;*

21                                       (iii) *surgical services;*

22                                       (iv) *hospitals or group purchasing or-*  
23 *ganizations; or*

24                                       (v) *rehabilitation or physical therapy*  
25 *facilities or services; and*

1           (B) include revenue- or profit-sharing  
2           whether through a joint venture, management or  
3           professional services agreement, or other form of  
4           gain-sharing contract;

5           (2) describe Federal oversight of such relation-  
6           ships, including authorities of the Department of  
7           Health and Human Services and the Federal Trade  
8           Commission to review such relationships and their  
9           potential to increase costs for patients, and identify  
10          limitations in such oversight; and

11          (3) as appropriate, make recommendations to  
12          improve Federal oversight of such relationships.

13          (b) *REPORT.*—Not later than 2 years after the date  
14          of the enactment of this Act, the Comptroller General of the  
15          United States shall prepare and submit a report on the  
16          study conducted under subsection (a) to the Committee on  
17          Health, Education, Labor, and Pensions of the Senate and  
18          the Committee on Education and Labor and Committee on  
19          Energy and Commerce of the House of Representatives.

20          **SEC. 404. STATE ALL PAYER CLAIMS DATABASES.**

21          (a) *IN GENERAL.*—The Secretary of Health and  
22          Human Services shall make one-time grants to eligible  
23          States for the purposes described in subsection (b).

24          (b) *USES.*—A State may use a grant received under  
25          subsection (a) for one of the following purposes:

1           (1) *To establish an All Payer Claims Database*  
2           *for the State.*

3           (2) *To maintain an existing All Payer Claims*  
4           *Databases for the State.*

5           (c) *ELIGIBILITY.—To be eligible to receive a grant*  
6           *under subsection (a), a State shall submit to the Secretary*  
7           *an application at such time, in such manner, and con-*  
8           *taining such information as the Secretary specifies. Such*  
9           *information shall include, with respect to an All Payer*  
10           *Claims Database for the State, at least specifics on how the*  
11           *State will ensure uniform data collection through the data-*  
12           *base and the security of such data submitted to and main-*  
13           *tained in the database.*

14           (d) *ALL PAYER CLAIMS DATABASE.—For purposes of*  
15           *this section, the term “All Payer Claims Database” means,*  
16           *with respect to a State, a State database that may include*  
17           *medical claims, pharmacy claims, dental claims, and eligi-*  
18           *bility and provider files, which are collected from private*  
19           *and public payers.*

20           (e) *AUTHORIZATION OF APPROPRIATIONS.—To carry*  
21           *out this section, there are authorized to be appropriated*  
22           *\$50,000,000, to remain available until expended.*

23           **SEC. 405. AIR AMBULANCE COST DATA REPORTING PRO-**  
24           **GRAM.**

25           (a) *COST DATA REPORTING PROGRAM.—*

1           (1) *IN GENERAL.*—Not later than 6 months after  
2           the date of the promulgation of the rule under sub-  
3           section (c), and annually thereafter, a provider of  
4           emergency air medical services shall submit to the  
5           Secretary of Health and Human Services the infor-  
6           mation specified in subsection (b) with respect to the  
7           preceding 180-day period (in the case of the initial  
8           period) and the preceding 1-year period (in each sub-  
9           sequent period).

10           (2) *PUBLICATION.*—Not later than 180 days  
11           after the date the Secretary of Health and Human  
12           Services receives from a provider described in para-  
13           graph (1) the information specified in subsection (b),  
14           the Secretary shall make publicly available such in-  
15           formation.

16           (b) *SPECIFIED INFORMATION.*—Information described  
17           in subsection (a) is—

18           (1) *information, with respect to a claim for an*  
19           *item or service—*

20           (A) *identified as paid by health insurance*  
21           *coverage offered in the group or individual mar-*  
22           *ket or a group health plan (including a self-in-*  
23           *sured plan);*

1           (B) identified as paid for non-emergent  
2 transport requiring prior authorization and  
3 emergent transport;

4           (C) identified as paid for hospital-affiliated  
5 providers and independent providers;

6           (D) identified as paid for rural transport  
7 and urban transport;

8           (E) identified as provided using rotor  
9 transport and fixed wing transport; and

10           (F) identified as furnished by a provider of  
11 emergency air medical services that has a con-  
12 tractual relationship with the plan or coverage of  
13 an individual for which such item or service is  
14 provided and such a provider that does not have  
15 a contractual relationship with the plan or cov-  
16 erage or such an individual; and

17           (2) cost data for an air ambulance service fur-  
18 nished by such a provider of emergency air medical  
19 services that the Secretary of Health and Human  
20 Services, in consultation with suppliers and providers  
21 of such services, determines appropriate, separated by  
22 the cost of air travel and the cost of emergency med-  
23 ical services and supplies.

24           (c) RULEMAKING.—Not later than 1 year after the date  
25 of the enactment of this Act, the Secretary of Health and

1 *Human Services shall determine the form and manner for*  
2 *submitting the information described in subsection (b)*  
3 *through notice and comment rulemaking.*

4 *(d) CIVIL MONETARY PENALTIES.—*

5 *(1) IN GENERAL.—A provider of emergency air*  
6 *medical services who violates the requirements of sub-*  
7 *section (a)(1) shall be subject to a civil monetary pen-*  
8 *alty of not more than \$10,000 for each act consti-*  
9 *tuting such violation.*

10 *(2) PROCEDURE.—The provisions of section*  
11 *1128A of the Social Security Act (42 U.S.C. 1320a-*  
12 *7a), other than subsections (a) and (b) and the first*  
13 *sentence of subsection (c)(1) of such subsection, shall*  
14 *apply to civil monetary penalties under this sub-*  
15 *section in the same manner as such provisions apply*  
16 *to a penalty or proceeding under such section.*

17 *(e) REPORTING.—*

18 *(1) SECRETARY OF HEALTH AND HUMAN SERV-*  
19 *ICES.—Not later than July 1, 2023, the Secretary of*  
20 *Health and Human Services shall submit to Congress*  
21 *a report summarizing the information and data spec-*  
22 *ified in subsection (b).*

23 *(2) COMPTROLLER GENERAL.—Not later than*  
24 *July 1, 2023, the Comptroller General of the United*

1       *States shall submit to Congress a report that in-*  
2       *cludes—*

3               *(A) an analysis of the cost variation of pro-*  
4               *viders of emergency air ambulance services by*  
5               *geography and status; and*

6               *(B) any other recommendations the Comp-*  
7               *troller General determines appropriate, which*  
8               *may include a recommendation of an adequate*  
9               *amount of reimbursement for such services that*  
10              *reflects operational costs of such providers in*  
11              *order to preserve access to emergency air ambu-*  
12              *lance services.*

13       *(f) LIMITATION.—The information publicly disclosed*  
14       *under subsection (a) and the reports under subsection (f)*  
15       *may not contain any proprietary information.*

16       **SEC. 406. REPORT BY SECRETARY OF LABOR.**

17       *Not later than one year after the date of the enactment*  
18       *of this Act, and annually thereafter for each of the following*  
19       *5 years, the Secretary of Labor shall—*

20               *(1) conduct a study of—*

21                       *(A) the effects of the provisions of, including*  
22                       *amendments made by, this Act on premiums and*  
23                       *out-of-pocket costs in group health plans, includ-*  
24                       *ing out-of-pocket costs that are permitted by rea-*  
25                       *son of compliance with section 2799A(d) of the*

1           *Public Health Service Act, as added by section*  
2           *2(d);*

3                   *(B) the adequacy of provider networks in*  
4           *group health plans; and*

5                   *(C) such other effects of such provisions, and*  
6           *amendments, as the Secretary deems relevant;*  
7           *and*

8           *(2) submit a report on such study to the Com-*  
9           *mittee on Health, Education, Labor, and Pensions of*  
10          *the Senate and the Committee on Education and*  
11          *Labor and the Committee on Energy and Commerce*  
12          *of the House of Representatives.*

13   **SEC. 407. BILLING STATUTE OF LIMITATIONS.**

14          *Notwithstanding any other provision of law, a health*  
15          *care provider or health care facility (or health insurance*  
16          *issuer offering health insurance coverage or group health*  
17          *plan) may not initiate a process to seek reimbursement*  
18          *from an individual for a service furnished by such provider*  
19          *or facility to such individual more than a year after such*  
20          *date of service. Any provider, facility, issuer, or plan that*  
21          *bills an individual in violation of the previous sentence*  
22          *shall be subject to a civil monetary penalty in such amount*  
23          *as specified by the Secretary of Health and Human Serv-*  
24          *ices.*



1 **SEC. 408. GAO REPORT ON IMPACT OF SURPRISE BILLING**  
2 **PROVISIONS.**

3 *Not later than 3 years after the date of the enactment*  
4 *of this Act, the Comptroller General of the United States*  
5 *shall submit to Congress a report containing the following:*

6 (1) *What is known about the impacts of the pro-*  
7 *visions of this Act, including the amendments made*  
8 *by this Act, on the incidence and prevalence of the*  
9 *furnishing of items and services to individuals en-*  
10 *rolled under a group health plan or health insurance*  
11 *coverage by health care providers and health care fa-*  
12 *cilities that do not have a contractual relationship*  
13 *with such plan or such coverage (as applicable) for*  
14 *furnishing such items and services to such an indi-*  
15 *vidual.*

16 (2) *What is known about such impacts on pro-*  
17 *vider shortages and accessibility to such providers, fo-*  
18 *cusing on rural and medically underserved commu-*  
19 *nities.*

20 (3) *The number of grants that have been award-*  
21 *ed under section 404 (relating to State All Payer*  
22 *Claims Databases) and for what purposes States have*  
23 *used funds made available under such grants.*

24 (4) *An analysis of how data made available*  
25 *through State All Payer Claims Databases receiving*  
26 *funding under such grants has been used.*

1 **SEC. 409. REPORT BY THE SECRETARY OF HEALTH AND**  
2 **HUMAN SERVICES.**

3 *Not later than one year after the date of the enactment*  
4 *of this Act, and annually thereafter for each of the following*  
5 *5 years, the Secretary of Health and Human Services*  
6 *shall—*

7 *(1) conduct a study of—*

8 *(A) the effects of the provisions of, including*  
9 *amendments made by, this Act on premiums and*  
10 *out-of-pocket costs with respect to individual*  
11 *health insurance coverage and small group*  
12 *health plans;*

13 *(B) the adequacy of provider networks with*  
14 *respect to individual health insurance coverage*  
15 *and small group health plans, taking into con-*  
16 *sideration maximum travel time and distance;*  
17 *and*

18 *(C) such other effects of such provisions, and*  
19 *amendments, as the Secretary deems relevant;*  
20 *and*

21 *(2) submit a report on such study to the Com-*  
22 *mittee on Health, Education, Labor, and Pensions of*  
23 *the Senate and the Committee on Education and*  
24 *Labor and the Committee on Energy and Commerce*  
25 *of the House of Representatives.*

1 **TITLE V—TERRITORIES HEALTH**  
2 **CARE IMPROVEMENT ACT**

3 **SEC. 501. SHORT TITLE.**

4 *This title may be cited as the “Territories Health Care*  
5 *Improvement Act”.*

6 **SEC. 502. MEDICAID PAYMENTS FOR PUERTO RICO AND THE**  
7 **OTHER TERRITORIES FOR CERTAIN FISCAL**  
8 **YEARS.**

9 *(a) TREATMENT OF CAP.—Section 1108(g) of the So-*  
10 *cial Security Act (42 U.S.C. 1308(g)) is amended—*

11 *(1) in paragraph (2)—*

12 *(A) in the matter preceding subparagraph*  
13 *(A), by striking “subject to and section*  
14 *1323(a)(2) of the Patient Protection and Afford-*  
15 *able Care Act paragraphs (3) and (5)” and in-*  
16 *serting “subject to section 1323(a)(2) of the Pa-*  
17 *tient Protection and Affordable Care Act and*  
18 *paragraphs (3) and (5)”;*

19 *(B) in subparagraph (A)—*

20 *(i) by striking “Puerto Rico shall not*  
21 *exceed the sum of” and inserting “Puerto*  
22 *Rico shall not exceed—*

23 *“(i) except as provided in clause (ii),*  
24 *the sum of”;*

1           (ii) by striking “\$100,000;” and in-  
2           serting “\$100,000; and”; and

3           (iii) by adding at the end the following  
4           new clause:

5           “(ii) for each of fiscal years 2020  
6           through 2023, the amount specified in para-  
7           graph (6) for each such fiscal year;”;

8           (C) in subparagraph (B)—

9           (i) by striking “the Virgin Islands  
10           shall not exceed the sum of” and inserting  
11           “the Virgin Islands shall not exceed—

12           “(i) except as provided in clause (ii),  
13           the sum of”;

14           (ii) by striking “\$10,000;” and insert-  
15           ing “\$10,000; and”; and

16           (iii) by adding at the end the following  
17           new clause:

18           “(ii) for each of fiscal years 2020  
19           through 2025, \$126,000,000;”;

20           (D) in subparagraph (C)—

21           (i) by striking “Guam shall not exceed  
22           the sum of” and inserting “Guam shall not  
23           exceed—

24           “(i) except as provided in clause (ii),  
25           the sum of”;

1           (ii) by striking “\$10,000;” and insert-  
2           ing “\$10,000; and”; and

3           (iii) by adding at the end the following  
4           new clause:

5           “(ii) for each of fiscal years 2020  
6           through 2025, \$127,000,000;”;

7           (E) in subparagraph (D)—

8           (i) by striking “the Northern Mariana  
9           Islands shall not exceed the sum of” and in-  
10          serting “the Northern Mariana Islands shall  
11          not exceed—

12          “(i) except as provided in clause (ii),  
13          the sum of”; and

14          (ii) by adding at the end the following  
15          new clause:

16          “(ii) for each of fiscal years 2020  
17          through 2025, \$60,000,000; and”; and

18          (F) in subparagraph (E)—

19          (i) by striking “American Samoa shall  
20          not exceed the sum of” and inserting  
21          “American Samoa shall not exceed—

22          “(i) except as provided in clause (ii),  
23          the sum of”; and

24          (ii) by striking “\$10,000.” and insert-  
25          ing “\$10,000; and”; and

1                   (iii) by adding at the end the following  
2                   new clause:

3                   “(ii) for each of fiscal years 2020  
4                   through 2025, \$84,000,000.”; and

5                   (2) by adding at the end the following new para-  
6                   graph:

7                   “(6) *APPLICATION TO PUERTO RICO FOR FISCAL*  
8                   *YEARS 2020 THROUGH 2023.*—For purposes of para-  
9                   graph (2)(A)(ii), the amount specified in this para-  
10                  graph is—

11                  “(A) for fiscal year 2020, \$2,823,188,000;

12                  “(B) for fiscal year 2021, \$2,919,072,000;

13                  “(C) for fiscal year 2022, \$3,012,610,000;

14                  and

15                  “(D) for fiscal year 2023, \$3,114,331,000.”.

16                  (b) *TREATMENT OF FUNDING UNDER ENHANCED AL-*  
17                  *LOTMENT PROGRAM.*—Section 1935(e) of the Social Secu-  
18                  rity Act (42 U.S.C. 1396u–5(e)) is amended—

19                  (1) in paragraph (1)(B), by striking “if the  
20                  State” and inserting “subject to paragraph (4), if the  
21                  State”;

22                  (2) by redesignating paragraph (4) as para-  
23                  graph (5); and

24                  (3) by inserting after paragraph (3) the fol-  
25                  lowing new paragraph:

1           “(4) *TREATMENT OF FUNDING FOR CERTAIN FIS-*  
2           *CAL YEARS.*—

3           “(A) *PUERTO RICO.*—*Notwithstanding*  
4           *paragraph (1)(B), in the case that Puerto Rico*  
5           *establishes and submits to the Secretary a plan*  
6           *described in paragraph (2) with respect to any*  
7           *of fiscal years 2020 through 2023, the amount*  
8           *specified in paragraph (3) for Puerto Rico for*  
9           *such a year shall be taken into account in apply-*  
10           *ing subparagraph (A)(ii) of section 1108(g)(2)*  
11           *for such year.*

12           “(B) *OTHER TERRITORIES.*—*Notwith-*  
13           *standing paragraph (1)(B), in the case that the*  
14           *Virgin Islands, Guam, the Northern Mariana Is-*  
15           *lands, or American Samoa establishes and sub-*  
16           *mits to the Secretary a plan described in para-*  
17           *graph (2) with respect to any of fiscal years*  
18           *2020 through 2025, the amount specified in*  
19           *paragraph (3) for the Virgin Islands, Guam, the*  
20           *Northern Mariana Islands, or American Samoa,*  
21           *as the case may be, shall be taken into account*  
22           *in applying, as applicable, subparagraph*  
23           *(B)(ii), (C)(ii), (D)(ii), or (E)(ii) of section*  
24           *1108(g)(2) for such year.”.*

1           (c) *INCREASED FMAP.*—*Section 1905 of the Social Se-*  
2 *curity Act (42 U.S.C. 1396d(b)) is amended—*

3                 (1) *in subsection (b), by striking “and (aa)” and*  
4 *inserting “(aa), and (ff)”;* and

5                 (2) *by adding at the end the following new sub-*  
6 *section:*

7           “*(ff) TEMPORARY INCREASE IN FMAP FOR TERRI-*  
8 *TORIES FOR CERTAIN FISCAL YEARS.—*

9                 “(1) *PUERTO RICO.*—*Notwithstanding subsection*  
10 *(b) and subject to subsection (z)(2), the Federal med-*  
11 *ical assistance percentage for Puerto Rico shall be*  
12 *equal to—*

13                         “(A) *83 percent for fiscal years 2020 and*  
14 *2021; and*

15                         “(B) *76 percent for fiscal years 2022 and*  
16 *2023.*

17                 “(2) *VIRGIN ISLANDS.*—*Notwithstanding sub-*  
18 *section (b) and subject to subsection (z)(2), the Fed-*  
19 *eral medical assistance percentage for the Virgin Is-*  
20 *lands shall be equal to—*

21                         “(A) *100 percent for fiscal year 2020;*

22                         “(B) *83 percent for fiscal years 2021*  
23 *through 2024; and*

24                         “(C) *76 percent for fiscal year 2025.*



1           “(3) *OTHER TERRITORIES.*—*Notwithstanding*  
2           *subsection (b) and subject to subsection (z)(2), the*  
3           *Federal medical assistance percentage for Guam, the*  
4           *Northern Mariana Islands, and American Samoa*  
5           *shall be equal to—*

6                     “(A) *100 percent for fiscal years 2020 and*  
7                     *2021;*

8                     “(B) *83 percent for fiscal years 2022*  
9                     *through 2024; and*

10                    “(C) *76 percent for fiscal year 2025.*”.

11           (d) *ANNUAL REPORT.*—*Section 1108(g) of the Social*  
12           *Security Act (42 U.S.C. 1308(g)), as amended by subsection*  
13           *(a), is further amended by adding at the end the following*  
14           *new paragraph:*

15                    “(7) *ANNUAL REPORT.*—

16                    “(A) *IN GENERAL.*—*Not later than the date*  
17                    *that is 180 days after the end of each fiscal year*  
18                    *(beginning with fiscal year 2020 and ending*  
19                    *with fiscal year 2025), in the case that a speci-*  
20                    *fied territory receives a Medicaid cap increase,*  
21                    *or an increase in the Federal medical assistance*  
22                    *percentage for such territory under section*  
23                    *1905(ff), for such fiscal year, such territory shall*  
24                    *submit to the Chair and Ranking Member of the*  
25                    *Committee on Energy and Commerce of the*

1 *House of Representatives and the Chair and*  
2 *Ranking Member of the Committee on Finance of*  
3 *the Senate a report that describes how such terri-*  
4 *tory has used such Medicaid cap increase, or*  
5 *such increase in the Federal medical assistance*  
6 *percentage, as applicable, to increase access to*  
7 *health care under the State Medicaid plan of*  
8 *such territory under title XIX (or a waiver of*  
9 *such plan). Such report may include—*

10 *“(i) the extent to which such territory*  
11 *has, with respect to such plan (or waiver)—*

12 *“(I) increased payments to health*  
13 *care providers;*

14 *“(II) increased covered benefits;*

15 *“(III) expanded health care pro-*  
16 *vider networks; or*

17 *“(IV) improved in any other*  
18 *manner the carrying out of such plan*  
19 *(or waiver); and*

20 *“(ii) any other information as deter-*  
21 *mined necessary by such territory.*

22 *“(B) DEFINITIONS.—In this paragraph:*

23 *“(i) MEDICAID CAP INCREASE.—The*  
24 *term ‘Medicaid cap increase’ means, with*  
25 *respect to a specified territory and fiscal*

1           year, any increase in the amounts otherwise  
2           determined under this subsection for such  
3           territory for such fiscal year by reason of  
4           the amendments made by section 502(a) of  
5           the Territories Health Care Improvement  
6           Act.

7           “(i) *SPECIFIED TERRITORY.*—The  
8           term ‘specified territory’ means Puerto  
9           Rico, the Virgin Islands, Guam, the North-  
10          ern Mariana Islands, and American  
11          Samoa.”.

12 **SEC. 503. APPLICATION OF CERTAIN REQUIREMENTS**  
13 **UNDER MEDICAID PROGRAM TO CERTAIN**  
14 **TERRITORIES.**

15       (a) *APPLICATION OF PAYMENT ERROR RATE MEAS-*  
16 *UREMENT REQUIREMENTS TO PUERTO RICO.*—Section  
17 *1903(u)(4) of the Social Security Act (42 U.S.C.*  
18 *1396b(u)(4)) is amended—*

19           (1) by striking “to Puerto Rico, Guam” and in-  
20           serting “to Guam”; and

21           (2) by striking “or American Samoa.” and in-  
22           serting “or American Samoa, or, for fiscal years be-  
23           fore fiscal year 2023, to Puerto Rico.”.

24       (b) *APPLICATION OF ASSET VERIFICATION PROGRAM*  
25 *REQUIREMENTS TO PUERTO RICO AND VIRGIN ISLANDS.*—

1 *Section 1940(a) of the Social Security Act (42 U.S.C.*  
2 *1396w(a)) is amended—*

3 *(1) in paragraph (3)(A), by adding at the end*  
4 *the following new clause:*

5 *“(iii) IMPLEMENTATION IN PUERTO*  
6 *RICO AND VIRGIN ISLANDS.—The Secretary*  
7 *shall require Puerto Rico to implement an*  
8 *asset verification program under this sub-*  
9 *section by the end of fiscal year 2022 and*  
10 *the Virgin Islands to implement such a pro-*  
11 *gram by the end of fiscal year 2023.”; and*

12 *(2) in paragraph (4)—*

13 *(A) in the paragraph heading, by striking*  
14 *“EXEMPTION OF TERRITORIES” and inserting*  
15 *“EXEMPTION OF CERTAIN TERRITORIES”; and*

16 *(B) by striking “and the District of Colum-*  
17 *bia” and inserting “, the District of Columbia,*  
18 *Puerto Rico, and the Virgin Islands”.*

19 *(c) APPLICATION OF CERTAIN DATA REPORTING AND*  
20 *PROGRAM INTEGRITY REQUIREMENTS TO NORTHERN MAR-*  
21 *IANA ISLANDS, AMERICAN SAMOA, AND GUAM.—*

22 *(1) IN GENERAL.—Section 1902 of the Social Se-*  
23 *curity Act (42 U.S.C. 1396a) is amended by adding*  
24 *at the end the following new subsection:*

1       “(qq) *APPLICATION OF CERTAIN DATA REPORTING*  
 2 *AND PROGRAM INTEGRITY REQUIREMENTS TO NORTHERN*  
 3 *MARIANA ISLANDS, AMERICAN SAMOA, AND GUAM.*—Not  
 4 *later than October 1, 2023, the Northern Mariana Islands,*  
 5 *American Samoa, and Guam shall—*

6               “(1) *implement methods, satisfactory to the Sec-*  
 7 *retary, for the collection and reporting of reliable*  
 8 *data to the Transformed Medicaid Statistical Infor-*  
 9 *mation System (T-MSIS) (or a successor system);*  
 10 *and*

11               “(2) *demonstrate progress in establishing a State*  
 12 *medicaid fraud control unit described in section*  
 13 *1903(q).”.*

14               (2) *CONFORMING AMENDMENT.*—Section 1902(j)  
 15 *of the Social Security Act (42 U.S.C. 1396a(j)) is*  
 16 *amended—*

17                       (A) *by striking “or the requirement” and*  
 18 *inserting “, the requirement”; and*

19                       (B) *by inserting before the period at the end*  
 20 *the following: “, or the requirement under sub-*  
 21 *section (qq)(1) (relating to data reporting)”.*

22 **SEC. 504. ADDITIONAL PROGRAM INTEGRITY REQUIRE-**  
 23 **MENTS.**

24               (a) *AUDIT RELATING TO FRAUD, WASTE, AND*  
 25 *ABUSE.*—Not sooner than the date that is one year after

1 *the date of the enactment of this Act, the Inspector General*  
2 *of the Department of Health and Human Services (referred*  
3 *to in this section as the “Inspector General”)* shall conduct  
4 *an audit of Puerto Rico with respect to any part of the*  
5 *administration of Puerto Rico’s State plan under title XIX*  
6 *of the Social Security Act (42 U.S.C. 1396 et seq.) (or a*  
7 *waiver of such plan), such as contracting protocols, denials*  
8 *of care, and financial management, that the Inspector Gen-*  
9 *eral determines to be at high risk for waste, fraud, or abuse.*

10       **(b) PLAN FOR AUDITS AND INVESTIGATIONS OF CON-**  
11 *TRACTING PRACTICES.—Not later than the date that is one*  
12 *year after the date of the enactment of this Act, the Inspec-*  
13 *tor General shall develop and submit to Congress a plan*  
14 *for auditing and investigating contracting practices relat-*  
15 *ing to Puerto Rico’s State plan under title XIX of the Social*  
16 *Security Act (42 U.S.C. 1396 et seq.) (or a waiver of such*  
17 *plan).*

18       **(c) REPORT ON CONTRACTING OVERSIGHT AND AP-**  
19 *PROVAL.—Not later than the date that is two years after*  
20 *the date of the enactment of this Act, the Comptroller Gen-*  
21 *eral of the United States shall issue, and submit to the*  
22 *Chair and Ranking Member of the Committee on Energy*  
23 *and Commerce of the House of Representatives and the*  
24 *Chair and Ranking Member of the Committee on Finance*  
25 *of the Senate, a report on contracting oversight and ap-*

1 *proval with respect to Puerto Rico's State plan under title*  
2 *XIX of the Social Security Act (42 U.S.C. 1396 et seq.)*  
3 *(or a waiver of such plan). Such report shall—*

4 *(1) examine—*

5 *(A) the process used by Puerto Rico to*  
6 *evaluate bids and award contracts under such*  
7 *plan (or waiver);*

8 *(B) which contracts are not subject to com-*  
9 *petitive bidding or requests for proposals under*  
10 *such plan (or waiver); and*

11 *(C) oversight by the Centers for Medicare &*  
12 *Medicaid Services of contracts awarded under*  
13 *such plan (or waiver); and*

14 *(2) include any recommendations for Congress,*  
15 *the Secretary of Health and Human Services, or*  
16 *Puerto Rico relating to changes that the Inspector*  
17 *General determines necessary to improve the program*  
18 *integrity of such plan (or waiver).*

19 *(d) REEVALUATION OF WAIVERS OF MEDICAID FRAUD*  
20 *CONTROL UNIT REQUIREMENT.—Not later than the date*  
21 *that is one year after the date of the enactment of this Act,*  
22 *the Secretary of Health and Human Services shall—*

23 *(1) reevaluate any waiver approved (and in ef-*  
24 *fect as of the date of the enactment of this Act) for*  
25 *Guam, the Northern Mariana Islands, or American*

1 *Samoa under subsection (a)(61) or subsection (j) of*  
2 *section 1902 of the Social Security Act (42 U.S.C.*  
3 *1396a) with respect to the requirement to establish a*  
4 *State medicaid fraud control unit (as described in*  
5 *section 1903(q) of such Act (42 U.S.C. 1396b(q)); and*

6 *(2) determine whether any such waiver should*  
7 *continue to be approved with respect to Guam, the*  
8 *Northern Mariana Islands, or American Samoa, re-*  
9 *spectively, after October 1, 2023.*

10 *(e) SYSTEM FOR TRACKING FEDERAL FUNDING PRO-*  
11 *VIDED TO PUERTO RICO.—Section 1902 of the Social Secu-*  
12 *rity Act (42 U.S.C. 1396a), as amended by section 503(c),*  
13 *is further amended by adding at the end the following new*  
14 *subsection:*

15 *“(rr) PROGRAM INTEGRITY REQUIREMENTS FOR*  
16 *PUERTO RICO.—*

17 *“(1) SYSTEM FOR TRACKING FEDERAL FUNDING*  
18 *PROVIDED TO PUERTO RICO.—*

19 *“(A) IN GENERAL.—Puerto Rico shall estab-*  
20 *lish and maintain a system for tracking any*  
21 *amounts paid by the Federal Government to*  
22 *Puerto Rico with respect to the State plan of*  
23 *Puerto Rico (or a waiver of such plan). Under*  
24 *such system, Puerto Rico shall ensure that infor-*  
25 *mation is available, with respect to each quarter*



1           *in a fiscal year (beginning with the first quarter*  
2           *beginning on or after the date that is one year*  
3           *after the date of the enactment of this sub-*  
4           *section), on the following:*

5                     *“(i) In the case of a quarter other than*  
6                     *the first quarter of such fiscal year—*

7                             *“(I) the total amount expended by*  
8                             *Puerto Rico during any previous quar-*  
9                             *ter of such fiscal year under the State*  
10                            *plan of Puerto Rico (or a waiver of*  
11                            *such plan); and*

12                            *“(II) a description of how such*  
13                            *amount was so expended.*

14                     *“(ii) The total amount that Puerto*  
15                     *Rico expects to expend during the quarter*  
16                     *under the State plan of Puerto Rico (or a*  
17                     *waiver of such plan), and a description of*  
18                     *how Puerto Rico expects to expend such*  
19                     *amount.*

20                     *“(B) REPORT TO CMS.—For each quarter*  
21                     *with respect to which Puerto Rico is required*  
22                     *under subparagraph (A) to ensure that informa-*  
23                     *tion described in such subparagraph is available,*  
24                     *Puerto Rico shall submit to the Administrator of*

1           *the Centers for Medicare & Medicaid Services a*  
2           *report on such information for such quarter.*

3           “(2) *SUBMISSION OF DOCUMENTATION ON CON-*  
4           *TRACTS UPON REQUEST.—Puerto Rico shall, upon re-*  
5           *quest, submit to the Administrator of the Centers for*  
6           *Medicare & Medicaid Services all documentation re-*  
7           *quested with respect to contracts awarded under the*  
8           *State plan of Puerto Rico (or a waiver of such*  
9           *plan).”.*

Amend the title so as to read: “A bill to reauthorize and extend funding for critical public health programs that improve access to health care and strengthen the health care workforce, to extend provisions of the Medicare program, to strengthen the Medicaid program in the territories, to protect health care consumers from surprise billing practices, and for other purposes.”.



Union Calendar No. 587

116<sup>TH</sup> CONGRESS  
2<sup>D</sup> SESSION

**H. R. 2328**

[Report No. 116-332, Part I]

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## **A BILL**

To reauthorize and extend funding for community health centers and the National Health Service Corps.

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DECEMBER 31, 2020

Committee on Transportation and Infrastructure discharged; committed to the Committee of the Whole House on the State of the Union and ordered to be printed