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116TH CONGRESS
2D 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.

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. KRISHNAMOORTHI, 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.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Reauthorizing and Extending America's Community Health Act" or the "REACH Act".

(b) TABLE OF CONTENTS.—The table of contents for 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.

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.

(a) COMMUNITY HEALTH CENTERS.—Section 10503(b)(1)(F) of the Patient Protection and Affordable Care Act (42 U.S.C. 254b–2(b)(1)(F)) is amended by striking "fiscal year 2019" and inserting "each of fiscal years 2019 through 2023".

(b) NATIONAL HEALTH SERVICE CORPS.—Section 10503(b)(2)(F) of the Patient Protection and Affordable Care Act (42 U.S.C. 254b–2(b)(2)(F)) is amended by striking "2018 and 2019" and inserting "2019 through 2023".

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

(d) APPLICATION.—Amounts appropriated for a program pursuant to the amendments made by subsection (a), (b), or (c) for fiscal years 2020 through 2023 are subject to the requirements and limitations of the most recently enacted regular or full-year continuing appropriations Act or resolution (as of the date of obligation of current funds) applicable to the respective program.

SEC. 102. EXTENSION FOR SPECIAL DIABETES PROGRAMS.

(a) REAUTHORIZATION OF SPECIAL DIABETES PROGRAMS FOR TYPE I DIABETES.—Section 330B(b)(2)(D) of the Public Health Service Act (42 U.S.C. 254c–2(b)(2)(D)) is amended by striking "each of fiscal years 2018 and 2019" and inserting "fiscal years 2019 through 2023".

(b) REAUTHORIZATION OF SPECIAL DIABETES PROGRAMS FOR INDIANS FOR DIABETES SERVICES.—Section 330C(c)(2)(D) of the Public Health Service Act (42 U.S.C. 254c–3(c)(2)(D)) is amended by striking "fiscal years 2018 and 2019" and inserting "fiscal years 2019 through 2023".

SEC. 103. EXTENSION OF PERSONAL RESPONSIBILITY EDUCATION PROGRAM.

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

(1) in paragraphs (1)(A) and (4)(A) of subsection (a), by striking "2019" and inserting "2023" each place it appears;

(2) in subsection (a)(4)(B)(i), by striking "2019" and inserting "2023"; and

(3) in subsection (f), by striking "2019" and inserting "2023".

SEC. 104. EXTENSION OF SEXUAL RISK AVOIDANCE EDUCATION PROGRAM.

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

TITLE II—MEDICARE EXTENDERS

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

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

SEC. 202. EXTENSION OF FUNDING OUTREACH AND ASSISTANCE FOR LOW-INCOME PROGRAMS.

(a) ADDITIONAL FUNDING FOR STATE HEALTH INSURANCE PROGRAMS.—Subsection (a)(1)(B) of section 119 of the Medicare Improvements for Patients and Providers Act of 2008 (42 U.S.C. 1395b–3 note), as amended by section 3306 of the Patient Protection and Affordable Care Act (Public Law 111–148), section 610 of the American Taxpayer Relief Act of 2012 (Public Law 112–240), section 1110 of the Pathway for SGR Reform Act of 2013 (Public Law 113–67), section 110 of the Protecting Access to Medicare Act of 2014 (Public Law 113–93), section 208 of the Medicare Access and CHIP Reauthorization Act of 2015 (Public Law 114–10), and section 50207 of the Bipartisan Budget Act of 2018 (Public Law 115–123), is amended—

(1) in clause (vii), by striking "and" at the end;

(2) in clause (viii), by striking "and" at the end;

(3) in clause (ix), by striking the period at the end and inserting "; and"; and

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

"(x) for each of fiscal years 2020 through 2022, of $15,000,000.".

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

(1) in clause (vii), by striking "and" at the end;

(2) in clause (viii), by striking "and" at the end;

(3) in clause (ix), by striking the period at the end and inserting "; and"; and

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

"(x) for each of fiscal years 2020 through 2022, of $15,000,000.".

(c) ADDITIONAL FUNDING FOR AGING AND DISABILITY RESOURCE CENTERS.—Subsection (c)(1)(B) of such section 119, as so amended, is amended—

(1) in clause (vii), by striking "and" at the end;

(2) in clause (viii), by striking "and" at the end;

(3) in clause (ix), by striking the period at the end and inserting "; and"; and

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

"(x) for each of fiscal years 2020 through 2022, of $5,000,000.".

(d) ADDITIONAL FUNDING FOR CONTRACT WITH THE NATIONAL CENTER FOR BENEFITS AND OUTREACH ENROLLMENT.—Subsection (d)(2) of such section 119, as so amended, is amended—

(1) in clause (vii), by striking "and" at the end;

(2) in clause (viii), by striking "and" at the end;

(3) in clause (ix), by striking the period at the end and inserting "; and"; and

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

"(x) for each of fiscal years 2020 through 2022, of $15,000,000.".

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

(a) IN GENERAL.—Section 1890(d)(2) of the Social Security Act (42 U.S.C. 1395aaa(d)(2)) is amended—

(1) by striking "and $7,500,000" and inserting "$7,500,000"; and

(2) by striking "and 2019." and inserting "and 2019, and $30,000,000 for each of fiscal years 2020 through 2022.".

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

"(4) REMOVAL OF MEASURES.—The entity may, through the multistakeholder groups convened under paragraph (7)(A), provide input to the Secretary on quality and efficiency measures described in paragraph (7)(B) that could be considered for removal.".

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

"(9) PRIORITIZATION OF MEASURE ENDORSEMENT.—The entity—

"(A) during the period beginning on the date of the enactment of this paragraph and ending on December 31, 2023, shall prioritize the endorsement of measures relating to maternal morbidity and mortality by the entity with a contract under subsection (a) in connection with endorsement of measures described in paragraph (2); and

"(B) on and after January 1, 2024, may prioritize the endorsement of such measures by such entity.".

SEC. 204. EXTENSION OF THE INDEPENDENCE AT HOME MEDICAL PRACTICE DEMONSTRATION PROGRAM UNDER THE MEDICARE PROGRAM.

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

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as if included in the enactment of Public Law 111–148.

SEC. 205. EXTENSION OF APPROPRIATIONS AND TRANSFERS TO THE PATIENT-CENTERED OUTCOMES RESEARCH TRUST FUND; EXTENSION OF CERTAIN HEALTH INSURANCE FEES.

(a) IN GENERAL.—

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

(A) in subsection (b)(1)(E), by striking "2014" and all that follows through "2019" and inserting "2014 through 2022";

(B) in subsection (d)(2)(A), by striking "2019" and inserting "2022"; and

(C) in subsection (f), by striking "2019" and inserting "2022".

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

(b) EXTENSION OF CERTAIN HEALTH INSURANCE FEES.—

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

(2) SELF-INSURED HEALTH PLANS.—Section 4376(e) of the Internal Revenue Code of 1986 is amended by striking "2019" and inserting "2022".

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

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

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

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

"(e) LIMITED INCOME NEWLY ELIGIBLE TRANSITION PROGRAM.—

"(1) IN GENERAL.—Beginning not later than January 1, 2021, the Secretary shall carry out a program to provide transitional coverage for covered part D drugs for LI NET eligible individuals in accordance with this subsection.

"(2) LI NET ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this subsection, the term 'LI NET eli-

gible individual' means a part D eligible individual who—

"(A) meets the requirements of clauses (ii) and (iii) of subsection (a)(3)(A); and

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

"(3) TRANSITIONAL COVERAGE.—For purposes of this subsection, the term 'transitional coverage' means, with respect to an LI NET eligible individual—

"(A) immediate access to covered part D drugs at the point of sale during the period that begins on the first day of the month such individual is determined to meet the requirements of clauses (ii) and (iii) of subsection (a)(3)(A) and ends on the date that coverage under a prescription drug plan or MA–PD plan takes effect with respect to such individual; and

"(B) in the case of an LI NET eligible individual who is a full-benefit dual eligible individual (as defined in section 1935(c)(6)) or a recipient of supplemental security income benefits under title XVI, retroactive coverage (in the form

of reimbursement of the amounts that would have been paid under this part had such individual been enrolled in a prescription drug plan or MA–PD plan) of covered part D drugs purchased by such individual during the period that begins on the date that is the later of—

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

"(ii) the date that is 36 months prior to the date such individual enrolls in a prescription drug plan or MA–PD plan,

and ends on the date that coverage under such plan takes effect.

"(4) PROGRAM ADMINISTRATION.—

"(A) SINGLE POINT OF CONTACT.—The Secretary shall, to the extent feasible, administer the program under this subsection through a contract with a single program administrator.

"(B) BENEFIT DESIGN.—The Secretary shall ensure that the transitional coverage provided to LI NET eligible individuals under this subsection—

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

"(ii) permits all pharmacies determined by the Secretary to be in good standing to process claims under the program;

"(iii) is consistent with such requirements as the Secretary considers necessary to improve patient safety and ensure appropriate dispensing of medication; and

"(iv) meets such other requirements as the Secretary may establish.

"(5) RELATIONSHIP TO OTHER PROVISIONS OF THIS TITLE; WAIVER AUTHORITY.—

"(A) IN GENERAL.—The following provisions shall not apply with respect to the program under this subsection:

"(i) Paragraphs (1) and (3)(B) of section 1860D–4(a) (relating to dissemination of general information; availability of information on changes in formulary through the internet).

"(ii) Subparagraphs (A) and (B) of section 1860D–4(b)(3) (relating to requirements on development and application of formularies; formulary development).

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

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

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

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

(1) TRICARE ELIGIBILITY.—

(A) IN GENERAL.—Subsection (d) of section 1086 of title 10, United States Code, is amended by adding at the end the following new paragraph:

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

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

"(B) A person described in this subparagraph is a person—

"(i) who is under 65 years of age;

"(ii) who is entitled to hospital insurance benefits under part A of title XVIII of the Social Security Act pursuant to subparagraph (A) or (C) of section 226(b)(2) of such Act (42 U.S.C. 426(b)(2));

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

"(iv) who is retired under chapter 61 of this title.

"(C) The Secretary of Defense shall coordinate with the Secretary of Health and Human Services and the Commissioner of Social Security to notify persons described in subparagraph (B) of, and provide information and counseling regarding, the effects of not enrolling in the supplementary medical insurance program under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.), as described in subparagraph (A).".

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

"is enrolled" and inserting "except as provided by paragraph (6), is enrolled".

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

"(c) CERTAIN INDIVIDUALS NOT REQUIRED TO ENROLL IN MEDICARE PART B.—In carrying out subsection (a), the Secretary of Defense shall coordinate with the Secretary of Health and Human Services and the Commissioner of Social Security to—

"(1) identify persons described in subparagraph (B) of section 1086(d)(6) of this title; and

"(2) provide information and counseling pursuant to subparagraph (C) of such section.".

(2) NON-APPLICATION OF MEDICARE PART B LATE ENROLLMENT PENALTY.—Section 1839(b) of the Social Security Act (42 U.S.C. 1395r(b)) is amended, in the second sentence, by inserting "or months for which the individual can demonstrate that the individual is an individual described in paragraph (6)(B) of section 1086(d) of title 10, United States Code, who is enrolled in the TRICARE program pursuant to such section" after "an individual described in section 1837(k)(3)".

(3) REPORT.—Not later than October 1, 2024, the Secretary of Defense, the Secretary of Health and Human Services, and the Commissioner of Social Security shall jointly submit to the Committees on Armed Services of the House of Representatives and the Senate, the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives, and the Committee on Finance of the Senate a report on the implementation of section 1086(d)(6) of title 10, United States Code, as added by paragraph (1). Such report shall include, with respect to the period covered by the report—

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

(B) the number of individuals who—

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

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

benefits for 24 months as described in subparagraph (A) or (C) of section 226(b)(2) of such Act (42 U.S.C. 426(b)(2)); and

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

(4) DEPOSIT OF SAVINGS INTO MEDICARE IMPROVEMENT FUND.—Section 1898(b)(1) of the Social Security Act (42 U.S.C. 1395iii(b)(1)) is amended by striking "during and after fiscal year 2021, $0" and inserting "during and after fiscal year 2024, $5,000,000".

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

(b) COVERAGE OF CERTAIN DNA SPECIMEN PROVENANCE ASSAY TESTS UNDER MEDICARE.—

(1) BENEFIT.—

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

(i) in subsection (s)(2)—

(I) in subparagraph (GG), by striking "and" at the end;

(II) in subparagraph (HH), by striking the period and inserting "; and"; and

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

"(II) a prostate cancer DNA Specimen Provenance Assay test (DSPA test) (as defined in subsection (kkk));"; and

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

"(kkk) PROSTATE CANCER DNA SPECIMEN PROVENANCE ASSAY TEST.—The term 'prostate cancer DNA Specimen Provenance Assay Test' (DSPA test) means a test that, after a determination of cancer in one or more prostate biopsy specimens obtained from an individual, assesses the identity of the DNA in such specimens by comparing such DNA with the DNA that was separately taken from such individual at the time of the biopsy.".

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

(i) in subparagraph (O), by striking "and" at the end;

(ii) in subparagraph (P), by striking the semicolon at the end and inserting ", and"; and

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

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

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

"(x) PROSTATE CANCER DNA SPECIMEN PROVENANCE ASSAY TESTS.—

"(1) PAYMENT FOR COVERED TESTS.—

"(A) IN GENERAL.—Subject to subparagraph (B), the payment amount for a prostate cancer DNA Specimen Provenance Assay test (DSPA test) (as defined in section 1861(kkk)) shall be $200. Such payment shall be payment

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

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

"(C) PROHIBITION ON SEPARATE PAYMENT.—No separate payment shall be made for obtaining DNA that was separately taken from an individual at the time of a biopsy described in subparagraph (A).

"(2) HCPCS CODE AND MODIFIER ASSIGNMENT.—

"(A) IN GENERAL.—The Secretary shall assign one or more HCPCS codes to a prostate cancer DNA Specimen Provenance Assay test and may use a modifier to facilitate making payment under this section for such test.

"(B) IDENTIFICATION OF DNA MATCH ON CLAIM.—The Secretary shall require an indication on a claim for a prostate cancer DNA Specimen Provenance Assay test of whether the DNA of the prostate biopsy specimens match the DNA of the individual diagnosed with prostate cancer. Such indication may be made through use of a

HCPCS code, a modifier, or other means, as determined appropriate by the Secretary.

"(3) DNA MATCH REVIEW.—

"(A) IN GENERAL.—The Secretary shall review at least three years of claims under part B for prostate cancer DNA Specimen Provenance Assay tests to identify whether the DNA of the prostate biopsy specimens match the DNA of the individuals diagnosed with prostate cancer.

"(B) POSTING ON INTERNET WEBSITE.—Not later than July 1, 2023, the Secretary shall post on the internet website of the Centers for Medicare & Medicaid Services the findings of the review conducted under subparagraph (A).".

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

(A) by striking "and (CC)" and inserting "(CC)"; and

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

charge for the test or the amount specified under section 1834(x)".

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.

(a) EXCLUSION OF COMPLEX REHABILITATIVE MANUAL WHEELCHAIRS FROM COMPETITIVE ACQUISITION PROGRAM.—Section 1847(a)(2)(A) of the Social Security Act (42 U.S.C. 1395w–3(a)(2)(A)) is amended—

(1) by inserting ", complex rehabilitative manual wheelchairs (as determined by the Secretary), and certain manual wheelchairs (identified, as of October 1, 2018, by HCPCS codes E1235, E1236, E1237, E1238, and K0008 or any successor to such codes)" after "group 3 or higher"; and

(2) by striking "such wheelchairs" and inserting "such complex rehabilitative power wheelchairs, complex rehabilitative manual wheelchairs, and certain manual wheelchairs".

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

WITH COMPLEX REHABILITATIVE MANUAL WHEELCHAIRS.—

(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary of Health and Human Services shall not, during the period beginning on January 1, 2020, and ending on December 31, 2020, use information on the payment determined under the competitive acquisition programs under section 1847 of the Social Security Act (42 U.S.C. 1395w–3) to adjust the payment amount that would otherwise be recognized under section 1834(a)(1)(B)(ii) of such Act (42 U.S.C. 1395m(a)(1)(B)(ii)) for wheelchair accessories (including seating systems) and seat and back cushions when furnished in connection with complex rehabilitative manual wheelchairs (as determined by the Secretary), and certain manual wheelchairs (identified, as of October 1, 2018, by HCPCS codes E1235, E1236, E1237, E1238, and K0008 or any successor to such codes).

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

TITLE III—MEDICAID PROVISIONS

SEC. 301. MODIFICATION OF REDUCTIONS IN MEDICAID DSH ALLOTMENTS.

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

(1) in clause (i), in the matter preceding subclause (I), by striking "2020" and inserting "2022"; and

(2) in clause (ii)—

(A) in subclause (I), by striking "2020" and inserting "2022"; and

(B) in subclause (II), by striking "for each of fiscal years 2021 through 2025" and inserting "for each of fiscal years 2023 through 2025".

SEC. 302. PUBLIC AVAILABILITY OF HOSPITAL UPPER PAYMENT LIMIT DEMONSTRATIONS.

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

"(bb) PUBLIC AVAILABILITY OF HOSPITAL UPPER PAYMENT LIMIT DEMONSTRATIONS.—The Secretary shall make publicly available upper payment limit demonstrations for hospital services that a State submits with respect to a fiscal year of the State (beginning with State fiscal

year 2022) to the Administrator of the Centers for Medicare & Medicaid Services.".

SEC. 303. REPORT BY COMPTROLLER GENERAL.

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

(1) The level of uncompensated care costs of hospitals in a State.

(2) Expenditures of a State with respect to hospitals, including payment adjustments made under such section 1923 to disproportionate share hospitals (as defined under the State plan under title XIX of such Act (42 U.S.C. 1396 et seq.) pursuant to subsection (a)(1)(A) of such section 1923), upper payment limit supplemental payments, and other related payments that hospitals may receive from the State.

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

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.

It is the sense of Congress that—

(1) the territories of American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the United States Virgin Islands are currently subject to Federal funding caps for their Medicaid programs;

(2) as a result of these Federal funding caps, which have not been adjusted over time, the territories continue to struggle in managing their Medicaid programs, including planning for their respective financial obligations and managing health care services for low-income adults, children, pregnant women, elderly adults, and persons with disabilities;

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

(4) the supplemental funding provided to the territories under title V with respect to their Medicaid programs continues Congress' commitment to ensuring the sustainability of these critically important programs and the people these programs serve; and

(5) a more permanent legislative solution must be developed in order to provide the territories with a reliable and consistent source of Federal funding under their Medicaid programs so that the territories can continue to meet the health care needs of vulnerable populations.

TITLE IV—NO SURPRISES ACT

SEC. 401. SHORT TITLE.

This title may be cited as the "No Surprises Act".

SEC. 402. PREVENTING SURPRISE MEDICAL BILLS.

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

(1) in paragraph (1)—

(A) in the matter preceding subparagraph (A)—

(i) by striking "a group health plan, or a health insurance issuer offering group or individual health insurance issuer," and in-

serting "a health plan (as defined in subsection (e)(2)(A))";

(ii) by inserting "or, for plan year 2021 or a subsequent plan year, with respect to emergency services in an independent freestanding emergency department (as defined in paragraph (3)(D))" after "emergency department of a hospital";

(iii) by striking "the plan or issuer" and inserting "the plan"; and

(iv) by striking "paragraph (2)(B)" and inserting "paragraph (3)(C)";

(B) in subparagraph (B), by inserting "or a participating emergency facility, as applicable," after "participating provider"; and

(C) in subparagraph (C)—

(i) in the matter preceding clause (i), by inserting "by a nonparticipating provider or a nonparticipating emergency facility" after "enrollee";

(ii) by striking clause (i);

(iii) by striking "(ii)(I) such services" and inserting "(i) such services";

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

tionship with the plan for the providing of services";

(v) by striking "emergency department services received from providers who do have such a contractual relationship with the plan; and" and inserting "emergency services received from participating providers and participating emergency facilities with respect to such plan;";

(vi) by striking "(II) if such services" and all that follows through "were provided in-network;" and inserting the following:

"(ii) the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is not greater than the requirement that would apply if such services were provided by a participating provider or a participating emergency facility;"; and

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

"(iii) such requirement is calculated as if the total amount that would have been charged for such services by such participating provider or participating emergency facility were equal to—

"(I) in the case of such services furnished in a State described in paragraph (3)(H)(ii), the median contracted rate (as defined in paragraph (3)(E)(i)) for such services; and

"(II) in the case of such services furnished in a State described in paragraph (3)(H)(i), the lesser of—

"(aa) the amount determined by such State for such services in accordance with the method described in such paragraph; and

"(bb) the median contracted rate (as so defined) for such services;

"(iv) the health plan pays to such provider or facility, respectively, the amount by which the recognized amount (as defined in paragraph (3)(H)) for such services exceeds the cost-sharing amount for such services (as determined in accordance with clauses (ii) and (iii)); and

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

furnished shall be counted toward any in-network deductible or out-of-pocket maximums applied under the plan (and such in-network deductible shall be applied) in the same manner as if such cost-sharing payments were with respect to emergency services furnished by a participating provider and a participating emergency facility; and";

(2) by redesignating paragraph (2) as paragraph (3);

(3) by inserting after paragraph (1) the following new paragraph:

"(2) AUDIT PROCESS FOR MEDIAN CONTRACTED RATES.—

"(A) IN GENERAL.—Not later than July 1, 2020, the Secretary, in consultation with appropriate State agencies, shall establish through rulemaking a process, in accordance with subparagraph (B), under which health plans are audited by such Secretaries to ensure that—

"(i) such plans are in compliance with the requirement of applying a median contracted rate under this section; and

"(ii) that such median contracted rate so applied satisfies the definition under paragraph (3)(E) with respect to the year involved, including with respect to a health plan described in clause (ii) of such paragraph.

"(B) AUDIT SAMPLES.—Under the process established pursuant to subparagraph (A), the Secretary—

"(i) shall conduct audits described in such subparagraph, with respect to a year (beginning with 2021), of a sample with respect to such year of claims data from not more than 25 health plans; and

"(ii) may audit any health plan if the Secretary has received any complaint about such plan that involves the compliance of the plan with either of the requirements described in clauses (i) and (ii) of such subparagraph."; and

(4) in paragraph (3), as redesignated by paragraph (2) of this subsection—

(A) in the matter preceding subparagraph (A), by inserting "and subsection (e)" after "this subsection";

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

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

"(A) EMERGENCY DEPARTMENT OF A HOSPITAL.—The term 'emergency department of a hospital' includes a hospital outpatient department that provides emergency services.";

(D) by amending subparagraph (C), as redesignated by subparagraph (B) of this paragraph, to read as follows:

"(C) EMERGENCY SERVICES.—

"(i) IN GENERAL.—The term 'emergency services', with respect to an emergency medical condition, means—

"(I) a medical screening examination (as required under section 1867 of the Social Security Act, or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a hospital or of

an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

"(II) within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required under section 1867 of such Act, or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient.

"(ii) INCLUSION OF POSTSTABILIZATION SERVICES.—For purposes of this subsection and section 2799, in the case of an individual enrolled in a health plan who is furnished services described in clause (i) by a provider or facility to stabilize such individual with respect to an emergency medical condition, the term 'emergency services' shall include such

items and services in addition to those described in clause (i) that such a provider or facility determines are needed to be furnished (after such stabilization but during such visit in which such individual is so stabilized) to such individual, unless each of the following conditions are met:

"(I) Such a provider or facility determines such individual is able to travel using nonmedical transportation or nonemergency medical transportation.

"(II) Such provider furnishing such additional items and services is in compliance with section 2799A(d) with respect to such items and services.";

(E) by redesignating subparagraph (D), as redesignated by subparagraph (B) of this paragraph, as subparagraph (I); and

(F) by inserting after subparagraph (C), as redesignated by subparagraph (B) of this paragraph, the following new subparagraphs:

"(D) INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT.—The term 'independent

freestanding emergency department' means a facility that—

"(i) is geographically separate and distinct and licensed separately from a hospital under applicable State law; and

"(ii) provides emergency services.

"(E) MEDIAN CONTRACTED RATE.—

"(i) IN GENERAL.—The term 'median contracted rate' means, with respect to an item or service and a health plan (as defined in subsection (e)(2)(A))—

"(I) for 2021, the median of the negotiated rates recognized by the sponsor or issuer of such plan (determined with respect to all such plans of such sponsor or such issuer that are within the same line of business) as the total maximum payment (including the cost-sharing amount imposed for such services (as determined in accordance with clauses (ii) and (iii) of paragraph (1)(C) or subparagraphs (A) and (B) of subsection (e)(1), as applicable) and the amount to be paid by the plan or issuer) under such plans in

2019 for the same or a similar item or service that is provided by a provider in the same or similar specialty and provided in the geographic region in which the item or service is furnished, consistent with the methodology established by the Secretary under section 402(e) of the No Surprises Act, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over 2019 and 2020; and

"(II) for 2022 and each subsequent year, the median contracted rate determined under this clause for the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

"(ii) SPECIAL RULE.—The Secretary shall provide pursuant to rulemaking described in section 402(e) of the No Surprises Act that—

"(I) if the sponsor or issuer of a health plan does not have sufficient information to calculate a median contracted rate for an item or service or provider type, or amount of, claims for items or services (as determined by the Secretary) provided in a particular geographic area (other than in a case described in item (bb)), such sponsor or issuer shall demonstrate that such sponsor or issuer will use any database free of conflicts of interest that has sufficient information reflecting allowed amounts paid to a health care provider for relevant services provided in the applicable geographic region (such as State All Payer Claims Databases (as defined in section 404(d) of such Act)), and that such sponsor or issuer will use any such database to determine a median contracted rate and cover the cost of accessing any such database; and

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

graphic region that did not offer any health plan in such region during 2019, such sponsor or issuer shall use a methodology established by the Secretary for determining the median contracted rate for items and services covered by such plan for the first year in which such plan is offered in such region, and that, for each succeeding year, the median contracted rate for such items and services under such plan shall be the median contracted rate for such items and services under such plan for the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

"(F) NONPARTICIPATING EMERGENCY FACILITY; PARTICIPATING EMERGENCY FACILITY.—

"(i) NONPARTICIPATING EMERGENCY FACILITY.—The term 'nonparticipating emergency facility' means, with respect to an item or service and a health plan, an emergency department of a hospital, or an

independent freestanding emergency department, that does not have a contractual relationship with the plan (or, if applicable, issuer offering the plan) for furnishing such item or service under the plan.

"(ii) PARTICIPATING EMERGENCY FACILITY.—The term 'participating emergency facility' means, with respect to an item or service and a health plan, an emergency department of a hospital, or an independent freestanding emergency department, that has a contractual relationship with the plan (or, if applicable, issuer offering the plan) for furnishing such item or service under the plan.

"(G) NONPARTICIPATING PROVIDERS; PARTICIPATING PROVIDERS.—

"(i) NONPARTICIPATING PROVIDER.—The term 'nonparticipating provider' means, with respect to an item or service and a health plan, a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law and who does not have a contractual re-

lationship with the plan (or, if applicable, issuer offering the plan) for furnishing such item or service under the plan.

"(ii) PARTICIPATING PROVIDER.—The term 'participating provider' means, with respect to an item or service and a health plan, a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law and who has a contractual relationship with the plan (or, if applicable, issuer offering the plan) for furnishing such item or service under the plan.

"(H) RECOGNIZED AMOUNT.—The term 'recognized amount' means, with respect to an item or service—

"(i) in the case of such item or service furnished in a State that has in effect a State law that provides for a method for determining the amount of payment that is required to be covered by a health plan regulated by such State in the case of a participant, beneficiary, or enrollee covered under such plan and receiving such item or service

from a nonparticipating provider or facility, not more than the amount determined in accordance with such law plus the cost-sharing amount imposed under the plan for such item or service (as determined in accordance with clauses (ii) and (iii) of paragraph (1)(C) or subparagraphs (A) and (B) of subsection (e)(1), as applicable); or

"(ii) in the case of such item or service furnished in a State that does not have in effect such a law, an amount that is at least the median contracted rate (as defined in subparagraph (E)(i) and determined in accordance with rulemaking described in section 402(e) of the No Surprises Act) for such item or service.".

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

"(e) COVERAGE OF NON-EMERGENCY SERVICES PERFORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN PARTICIPATING FACILITIES.—

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

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

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

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

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

"(ii) in the case of such items and services furnished in a State described in subsection (b)(3)(H)(i), the lesser of—

"(I) the amount determined by such State for such items and services in accordance with the method described in such subsection; and

"(II) the median contracted rate (as so defined) for such items and services;

"(C) shall pay to such provider furnishing such items and services to such participant, beneficiary, or enrollee the amount by which the recognized amount (as defined in subsection (b)(3)(H)) for such items and services exceeds the cost-sharing amount imposed under the plan for such items and services (as determined in accordance with subparagraphs (A) and (B)); and

"(D) shall count toward any in-network deductible or out-of-pocket maximums applied under the plan any cost-sharing payments made by the participant, beneficiary, or enrollee (and

such in-network deductible shall be applied) with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider.

"(2) DEFINITIONS.—In this subsection and subsection (b):

"(A) HEALTH PLAN.—The term 'health plan' means a group health plan and health insurance coverage offered by a heath insurance issuer in the group or individual market and includes a grandfathered health plan (as defined in section 1251(e) of the Patient Protection and Affordable Care Act).

"(B) PARTICIPATING HEALTH CARE FACILITY.—

"(i) IN GENERAL.—The term 'participating health care facility' means, with respect to an item or service and a health plan, a health care facility described in clause (ii) that has a contractual relationship with the plan (or, if applicable, issuer offering the plan) for furnishing such item or service.

"(ii) HEALTH CARE FACILITY DESCRIBED.—A health care facility described in this clause is each of the following:

"(I) A hospital (as defined in 1861(e) of the Social Security Act).

"(II) A critical access hospital (as defined in section 1861(mm) of such Act).

"(III) An ambulatory surgical center (as defined in section 1833(i)(1)(A) of such Act).

"(IV) A laboratory.

"(V) A radiology facility or imaging center.

"(C) DURING A VISIT.—The term 'during a visit' shall, with respect to items and services furnished to an individual at a participating health care facility, include equipment and devices, telemedicine services, imaging services, laboratory services, and such other items and services as the Secretary may specify, regardless of whether or not the provider furnishing such items or services is at the facility.

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

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

"(f) INDEPENDENT DISPUTE RESOLUTION PROCESS.—

"(1) ESTABLISHMENT.—

"(A) IN GENERAL.—Not later than 1 year after the date of the enactment of this subsection, the Secretary, in consultation with the Secretary of Labor, shall establish by regulation an independent dispute resolution process (referred to in this subsection as the 'IDR process') under which—

"(i) a nonparticipating provider (as defined in subparagraph (G) of subsection (b)(3)), nonparticipating emergency facility (as defined in subparagraph (F) of such subsection), or health plan (as defined in

subsection (e)(2)(A)) may submit a request for resolution by an entity certified under paragraph (2) (in this subsection referred to as a 'certified IDR entity') of a specified claim; and

"(ii) in the case a settlement described in subparagraph (B) of paragraph (4) is not reached with respect to such claim, such entity so resolves such claim in accordance with such paragraph.

"(B) DEFINITIONS.—In this subsection:

"(i) SPECIFIED CLAIM.—

"(I) IN GENERAL.—Subject to subclause (II), the term 'specified claim' means a claim by a nonparticipating provider, a nonparticipating emergency facility, or a health plan with respect to qualifying items and services (as defined in clause (ii)) furnished by such provider or facility in a State described in subparagraph (H)(ii) of subsection (b)(3) for which a health plan is required to make payment pursuant to subsection (b)(1) or subsection (e)(1)—

"(aa) that such payment should be increased or decreased; and

"(bb) that is made not later than—

"(AA) in the case of such a claim filed by such a provider or facility, the date on which the appeal with respect to such items and services described in clause (ii)(I)(aa)(AA) has been resolved (or the date that is 30 days after such appeal is filed, whichever is earlier); or

"(BB) in the case of such a claim filed by such plan, the date on which the period described in clause (ii)(I)(bb)(BB) with respect to such items and services elapses.

"(II) LIMITATION ON PACKAGING OF ITEMS AND SERVICES IN A SPECIFIED CLAIM.—The term 'specified

claim' shall not include, in the case such claim is made by such provider, facility, or plan with respect to multiple items and services, any claim with respect to items and services furnished by such provider or facility if—

"(aa) such items and services were not furnished by the same provider or facility;

"(bb) payment for such items and services made pursuant to subsection (b)(1) or subsection (e)(1) was made by multiple health plans;

"(cc) such items and services are not related to the treatment of the same condition; or

"(dd) such items and services were not furnished within 30 days of the date of the earliest item or service furnished that is included in such claim.

"(ii) QUALIFYING ITEMS AND SERVICES.—

"(I) IN GENERAL.—Subject to subclause (II), the term 'qualifying items and services' means—

"(aa) with respect to a specified claim made by a nonparticipating provider or nonparticipating emergency facility, items and services furnished by such provider or facility for which a health plan is required to make payment pursuant to subsection (b)(1) or subsection (e)(1), but only if—

"(AA) such items and services are included in an appeal filed under such plan's internal appeals process not later than 30 days after such payment is received; and

"(BB) such appeal under such plan's internal appeals process has been resolved, or a 30-day period

has elapsed since such appeal was so filed; and

"(bb) with respect to a specified claim made by a health plan, items and services furnished by such a provider or facility for which such health plan is required to make payment pursuant to subsection (b)(1) or subsection (e)(1), but only if—

"(AA) such plan submits a notice to such provider or facility not later than 30 days after such provider or facility receives such payment that such plan disputes the amount of such payment with respect to such items and services; and

"(BB) a 30-day period has elapsed since the submission of such notice.

"(II) LIMITATION.—The term 'qualifying items and services' shall not include an item or service fur-

nished in a geographic area during a year by such provider or facility for which a health plan is required to make payment pursuant to subsection (b)(1) or subsection (e)(1) if the median contracted rate (as defined in subsection (b)(3)(E)) under such plan for such year with respect to such item or service furnished by such a provider or such a facility in such area does not exceed—

"(aa) with respect to an item or service furnished during 2021, $1,250; and

"(bb) with respect to an item or service furnished during a subsequent year, the amount specified under this subclause for the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

"(2) CERTIFICATION OF ENTITIES.—

"(A) PROCESS OF CERTIFICATION.—The process described in paragraph (1) shall include a certification process under which eligible entities may be certified to carry out the IDR process.

"(B) ELIGIBILITY.—

"(i) IN GENERAL.—For purposes of subparagraph (A), an eligible entity is an entity that is a nongovernmental entity that agrees to comply with the fee limitations described in clause (ii).

"(ii) FEE LIMITATION.—For purposes of clause (i), the fee limitations described in this clause are limitations established by the Secretary on the amount a certified IDR entity may charge a nonparticipating provider, nonparticipating emergency facility, or health plan for services furnished by such entity with respect to the resolution of a specified claim of such provider, facility, or plan under the process described in paragraph (1).

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

plan and the nonparticipating provider or the nonparticipating emergency facility (as applicable) involved shall agree on a certified IDR entity to resolve such claim. In the case that such plan and such provider or facility (as applicable) cannot so agree, such an entity shall be selected by the Secretary at random.

"(4) PAYMENT DETERMINATION.—

"(A) TIMING.—A certified IDR entity selected under paragraph (3) by a health plan and a nonparticipating provider or a nonparticipating emergency facility (as applicable) with respect to a specified claim shall, subject to subparagraph (B), not later than 30 days after being so selected, determine the total reimbursement that should have been made for items and services included in such claim in accordance with subparagraph (C).

"(B) SETTLEMENT.—

"(i) IN GENERAL.—If such entity determines that a settlement between the health plan and the provider or facility is likely with respect to a specified claim, the entity may direct the parties to attempt, for

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

"(ii) TIMING.—The period for a settlement described in clause (i) shall accrue towards the 30-day period described in subparagraph (A).

"(C) DETERMINATION OF AMOUNT.—

"(i) IN GENERAL.—The health plan and the nonparticipating provider or nonparticipating emergency facility (as applicable) shall, with respect to a specified claim, each submit to the certified IDR entity a final offer of payment or reimbursement (as applicable) with respect to items and services which are the subject of the specified claim. Such entity shall determine which such offer is the most reasonable in accordance with clause (ii).

"(ii) CONSIDERATIONS IN DETERMINATION.—

"(I) IN GENERAL.—In determining which final offer is the most reasonable under clause (i), the certified IDR entity shall consider—

"(aa) the median contracted rates (as defined in subsection (b)(3)(E)) for items or services that are comparable to the items and services included in the specified claim and that are furnished in the same geographic area (as defined by the Secretary for purposes of such subsection) as such items and services (not including any facility fees with respect to such rates); and

"(bb) the circumstances described in subclause (II), if any information with respect to such circumstances is submitted by either party.

"(II) ADDITIONAL CIRCUMSTANCES.—For purposes of subclause (I)(bb), the circumstances described in this subclause are, with respect to items and services included in the specified claim of a nonparticipating provider, nonparticipating

emergency facility, or health plan, the following:

"(aa) The level of training, education, experience, and quality and outcomes measurements of the provider or facility that furnished such items and services.

"(bb) Any other extenuating circumstances with respect to the furnishing of such items and services that relate to the acuity of the individual receiving such items and services or the complexity of furnishing such items and services to such individual.

"(III) PROHIBITION ON CONSIDERATION OF BILLED CHARGES.—In determining which final offer is the most reasonable under clause (i) with respect to items and services furnished by a provider or facility and included in a specified claim, the certified IDR entity may not consider the amount that would have been billed by such provider or facility with respect to such

items and services had the provisions of section 2799 or 2799A (as applicable) not applied.

"(iii) EFFECT OF DETERMINATION.—A determination of a certified IDR entity under clause (i)—

"(I) shall be binding; and

"(II) shall not be subject to judicial review, except in a case described in any of paragraphs (1) through (4) of section 10(a) of title 9, United States Code.

"(iv) COSTS OF INDEPENDENT DISPUTE RESOLUTION PROCESS.—In the case of a specified claim made by a nonparticipating provider, nonparticipating emergency facility, or health plan and submitted to a certified IDR entity—

"(I) if such entity makes a determination with respect to such claim under clause (i), the party whose offer is not chosen under such clause shall be responsible for paying all fees charged by such entity; and

"(II) if the parties reach a settlement with respect to such claim prior to such a determination, such fees shall be divided equally between the parties, unless the parties otherwise agree.

"(v) PAYMENT.—Not later than 30 days after a determination described in clause (i) is made with respect to a specified claim of a nonparticipating provider, nonparticipating emergency facility, or health plan—

"(I) in the case that such determination finds that the amount paid with respect to such specified claim by the health plan should have been greater than the amount so paid, such plan shall pay directly to the provider or facility (as applicable) the difference between the amount so paid and the amount so determined; and

"(II) in the case that such determination finds that the amount paid with respect to such specified claim by the health plan should have been less than the amount so paid, the provider

or facility (as applicable) shall pay directly to the plan the difference between the amount so paid and the amount so determined.

"(5) PUBLICATION OF INFORMATION RELATING TO DISPUTES.—

"(A) IN GENERAL.—For 2021 and each subsequent year, the Secretary and the Secretary of Labor shall publish on the public website of the Department of Health and Human Services and the Department of Labor, respectively—

"(i) the number of specified claims filed during such year;

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

"(iii) the information described in subparagraph (B) with respect to each specified claim with respect to which such a decision was so made.

"(B) INFORMATION WITH RESPECT TO SPECIFIED CLAIMS.—For purposes of subparagraph (A), the information described in this subparagraph is, with respect to a specified claim

of a nonparticiapting provider, nonparticipating emergency facility, or health plan—

"(i) a description of each item and service included in such claim;

"(ii) the amount of the offer submitted under paragraph (4)(C)(i) by the health plan and by the nonparticipating provider or nonparticipating emergency facility (as applicable);

"(iii) whether the offer selected by the certified IDR entity under such paragraph was the offer submitted by such plan or by such provider or facility (as applicable) and the amount of such offer so selected; and

"(iv) the category and practice specialty of each such provider or facility involved in furnishing such items and services.

"(C) CONFIDENTIALITY OF PARTIES.—None of the information published under this paragraph may specify the identity of a health plan, provider, facility, or individual with respect to a specified claim.".

(c) PROVIDER DIRECTORY REQUIREMENTS; DISCLOSURE ON PATIENT PROTECTIONS.—Section 2719A of the

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

"(g) PROVIDER DIRECTORY INFORMATION REQUIREMENTS.—

"(1) IN GENERAL.—Not later than 1 year after the date of the enactment of this subsection, each group health plan and health insurance issuer offering group or individual health insurance coverage shall—

"(A) establish the verification process described in paragraph (2);

"(B) establish the response protocol described in paragraph (3);

"(C) establish the database described in paragraph (4); and

"(D) include in any print directory containing provider directory information with respect to such plan or such coverage the information described in paragraph (5).

"(2) VERIFICATION PROCESS.—The verification process described in this paragraph is, with respect to a group health plan or a health insurance issuer offering group or individual health insurance coverage, a process—

"(A) under which not less frequently than once every 90 days, such plan or such issuer (as applicable) verifies and updates the provider directory information included on the database described in paragraph (4) of such plan or issuer of each health care provider and health care facility included in such database; and

"(B) that establishes a procedure for the removal of such a provider or facility with respect to which such plan or issuer has been unable to verify such information during a period specified by the plan or issuer.

"(3) RESPONSE PROTOCOL.—The response protocol described in this paragraph is, in the case of an individual enrolled under a group health plan or group or individual health insurance coverage offered by a health insurance issuer who requests information on whether a health care provider or health care facility has a contractual relationship to furnish items and services under such plan or such coverage, a protocol under which such plan or such issuer (as applicable), in the case such request is made through a telephone call—

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

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

"(B) retains such communication in such individual's file for at least 2 years following such response.

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

"(A) a list of each health care provider and health care facility with which such plan or such issuer has a contractual relationship for furnishing items and services under such plan or such coverage; and

"(B) provider directory information with respect to each such provider and facility.

"(5) INFORMATION.—The information described in this paragraph is, with respect to a print directory containing provider directory information with respect to a group health plan or individual or group health insurance coverage offered by a health insurance issuer, a notification that such information contained in such directory was accurate as of the date of publication of such directory and that an indi-

vidual enrolled under such plan or such coverage should consult the database described in paragraph (4) with respect to such plan or such coverage or contact such plan or the issuer of such coverage to obtain the most current provider directory information with respect to such plan or such coverage.

"(6) DEFINITION.—For purposes of this subsection, the term 'provider directory information' includes, with respect to a group health plan and a health insurance issuer offering group or individual health insurance coverage, the name, address, specialty, and telephone number of each health care provider or health care facility with which such plan or such issuer has a contractual relationship for furnishing items and services under such plan or such coverage.

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

"(1) information in plain language on—

"(A) the requirements and prohibitions applied under sections 2799 and 2799A (relating to

prohibitions on balance billing in certain circumstances);

"(B) if provided for under applicable State law, any other requirements on providers and facilities regarding the amounts such providers and facilities may, with respect to an item or service, charge a participant, beneficiary, or enrollee of such plan or coverage with respect to which such a provider or facility does not have a contractual relationship for furnishing such item or service under the plan or coverage after receiving payment from the plan or coverage for such item or service and any applicable cost-sharing payment from such participant, beneficiary, or enrollee; and

"(C) the requirements applied under subsections (b) and (e); and

"(2) information on contacting appropriate State and Federal agencies in the case that an individual believes that such a provider or facility has violated any requirement described in paragraph (1) with respect to such individual.".

(d) PREVENTING CERTAIN CASES OF BALANCE BILLING.—Title XXVII of the Public Health Service Act is amended by adding at the end the following new part:

"PART D—PREVENTING CERTAIN CASES OF BALANCE BILLING

"SEC. 2799. BALANCE BILLING IN CASES OF EMERGENCY SERVICES.

"(a) IN GENERAL.—In the case of a participant, beneficiary, or enrollee with benefits under a health plan who is furnished on or after January 1, 2021, emergency services with respect to an emergency medical condition during a visit at an emergency department of a hospital or an independent freestanding emergency department—

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

"(2) a health care provider shall not hold such participant, beneficiary, or enrollee liable for a payment amount for an emergency service furnished to such individual by such provider with respect to such emergency medical condition and visit for which the individual receives emergency services at the hospital or emergency department that is more than the cost-sharing amount for such services furnished by the

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

"(b) DEFINITIONS.—In this section:

"(1) The terms 'emergency department of a hospital', 'emergency medical condition', 'emergency services', and 'independent freestanding emergency department' have the meanings given such terms, respectively, in section 2719A(b)(3).

"(2) The term 'health plan' has the meaning given such term in section 2719A(e).

"(3) The term 'during a visit' shall have such meaning as applied to such term for purposes of section 2719A(e).

"SEC. 2799A. BALANCE BILLING IN CASES OF NON-EMERGENCY SERVICES PERFORMED BY NON-PARTICIPATING PROVIDERS AT CERTAIN PARTICIPATING FACILITIES.

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

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

"(b) EXCEPTION.—

"(1) IN GENERAL.—Subsection (a) shall not apply to a nonparticipating provider (other than a specified provider at a participating health care facility), with respect to items or services furnished by the provider to a participant, beneficiary, or enrollee of a health plan, if the provider is in compliance with the notice and consent requirements of subsection (d).

"(2) SPECIFIED PROVIDER DEFINED.—For purposes of paragraph (1), the term 'specified provider', with respect to a participating health care facility—

"(A) means a facility-based provider, including emergency medicine providers, anesthesiologists, pathologists, radiologists, neonatologists, assistant surgeons, hospitalists, intensivists, or other providers as determined by the Secretary; and

"(B) includes, with respect to an item or service, a nonparticipating provider if there is

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

"(c) CLARIFICATION.—In the case of a nonparticipating provider (other than a specified provider at a participating health care facility) that complies with the notice and consent requirements of subsection (d) with respect to an item or service (referred to in this subsection as a 'covered item or service'), such notice and consent requirements may not be construed as applying with respect to any item or service that is furnished as a result of unforeseen medical needs that arise at the time such covered item or service is furnished.

"(d) COMPLIANCE WITH NOTICE AND CONSENT REQUIREMENTS.—

"(1) IN GENERAL.—A nonparticipating provider or nonparticipating facility is in compliance with this subsection, with respect to items or services furnished by the provider or facility to a participant, beneficiary, or enrollee of a health plan, if the provider (or, if applicable, the participating health care facility on behalf of such provider) or nonparticipating facility—

"(A) provides to the participant, beneficiary, or enrollee (or to an authorized representative of the participant, beneficiary, or en-

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

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

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

"(I) contains the information required under paragraph (2); and

"(II) is signed and dated by the participant, beneficiary, or enrollee (or by an authorized representative of the participant, beneficiary, or enrollee) and, with respect to items or services to be furnished by such a provider that are not poststabilization services described in section 2719A(b)(3)(C)(ii), is so signed and dated not less than 72 hours prior to the participant, bene-

ficiary, or enrollee being furnished such items or services by such provider; and

"(B) obtains from the participant, beneficiary, or enrollee (or from such an authorized representative) the consent described in paragraph (3).

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

"(A) Notification, as applicable, that the health care provider is a nonparticipating provider with respect to the health plan or the health care facility is a nonparticipating facility with respect to the health plan.

"(B) Notification of the estimated amount that such provider or facility may charge the participant, beneficiary, or enrollee for such items and services involved.

"(C) In the case of a nonparticipating facility, a list of any participating providers at the facility who are able to furnish such items and

services involved and notification that the participant, beneficiary, or enrollee may be referred, at their option, to such a participating provider.

"(3) CONSENT DESCRIBED.—For purposes of paragraph (1)(B), the consent described in this paragraph, with respect to a participant, beneficiary, or enrollee of a health plan who is to be furnished items or services by a nonparticipating provider or nonparticipating facility, is a document specified by the Secretary through rulemaking that—

"(A) is signed by the participant, beneficiary, or enrollee (or by an authorized representative of the participant, beneficiary, or enrollee) and, with respect to items or services to be furnished by such a provider or facility that are not poststabilization services described in section 2719A(b)(3)(C)(ii), is so signed not less than 72 hours prior to the participant, beneficiary, or enrollee being furnished such items or services by such provider or facility;

"(B) acknowledges that the participant, beneficiary, or enrollee has been—

"(i) provided with a written estimate and an oral explanation of the charge that the participant, beneficiary, or enrollee will

be assessed for the items or services anticipated to be furnished to the participant, beneficiary, or enrollee by such provider or facility; and

"(ii) informed that the payment of such charge by the participant, beneficiary, or enrollee may not accrue toward meeting any limitation that the health plan places on cost-sharing; and

"(C) documents the consent of the participant, beneficiary, or enrollee to—

"(i) be furnished with such items or services by such provider or facility; and

"(ii) in the case that the individual is so furnished such items or services, be charged an amount that may be greater than the amount that would otherwise be charged the individual if furnished by a participating provider or participating facility with respect to such items or services and plan.

"(e) RETENTION OF CERTAIN DOCUMENTS.—A nonparticipating provider (or, in the case of a nonparticipating provider at a participating health care facility, such facility) or nonparticipating facility that obtains from a

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

''(f) DEFINITIONS.—In this section:

''(1) The terms 'nonparticipating provider' and 'participating provider' have the meanings given such terms, respectively, in subsection (b)(3) of section 2719A.

''(2) The terms 'participating health care facility' and 'health plan' have the meanings given such terms, respectively, in subsection (e)(2) of section 2719A.

''(3) The term 'nonparticipating facility' means—

''(A) with respect to emergency services (as defined in section 2719A(b)(3)(C)(i)) and a health plan, an emergency department of a hospital, or an independent freestanding emergency department, that does not have a contractual relationship with the plan (or, if applicable, issuer

offering the plan) for furnishing such services under the plan; and

"(B) with respect to poststabilization services described in section 2719A(b)(3)(C)(ii) and a health plan, an emergency department of a hospital (or other department of such hospital), or an independent freestanding emergency department, that does not have a contractual relationship with the plan (or, if applicable, issuer offering the plan) for furnishing such services under the plan.

"(4) The term 'participating facility' means—

"(A) with respect to emergency services (as defined in section 2719A(b)(3)(C)(i)) and a health plan, an emergency department of a hospital, or an independent freestanding emergency department, that has a contractual relationship with the plan (or, if applicable, issuer offering the plan) for furnishing such services under the plan; and

"(B) with respect to poststabilization services described in section 2719A(b)(3)(C)(ii) and a health plan, an emergency department of a hospital (or other department of such hospital), or an independent freestanding emergency de-

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

"SEC. 2799B. PROVIDER REQUIREMENTS WITH RESPECT TO PROVIDER DIRECTORY INFORMATION.

"Not later than 1 year after the date of the enactment of this section, each health care provider and health care facility shall establish a process under which such provider or facility transmits, to each health insurance issuer offering group or individual health insurance coverage and group health plan with which such provider or facility has in effect a contractual relationship for furnishing items and services under such coverage or such plan, provider directory information (as defined in section 2719A(g)(6)) with respect to such provider or facility, as applicable. Such provider or facility shall so transmit such information to such issuer offering such coverage or such group health plan—

"(1) when the provider or facility enters into such a relationship with respect to such coverage offered by such issuer or with respect to such plan;

"(2) when the provider or facility terminates such relationship with respect to such coverage offered by such issuer or with respect to such plan;

"(3) when there are any other material changes to such provider directory information of the provider or facility with respect to such coverage offered by such issuer or with respect to such plan; and

"(4) at any other time (including upon the request of such issuer or plan) determined appropriate by the provider, facility, or the Secretary.

"SEC. 2799C. PROVIDER REQUIREMENT WITH RESPECT TO PUBLIC PROVISION OF INFORMATION.

"Each health care provider and health care facility shall make publicly available, and (if applicable) post on a public website of such provider or facility—

"(1) information in plain language on—

"(A) the requirements and prohibitions of such provider or facility under sections 2799 and 2799A (relating to prohibitions on balance billing in certain circumstances); and

"(B) if provided for under applicable State law, any other requirements on such provider or facility regarding the amounts such provider or facility may, with respect to an item or service, charge a participant, beneficiary, or enrollee of a health plan (as defined in section 2719A(e)(2)) with respect to which such provider or facility does not have a contractual relationship for fur-

nishing such item or service under the plan after receiving payment from the plan for such item or service and any applicable cost-sharing payment from such participant, beneficiary, or enrollee; and

"(2) information on contacting appropriate State and Federal agencies in the case that an individual believes that such provider or facility has violated any requirement described in paragraph (1) with respect to such individual.

"SEC. 2799D. ENFORCEMENT.

"(a) STATE ENFORCEMENT.—

"(1) STATE AUTHORITY.—Each State may require a provider or health care facility subject to the requirements of sections 2719A(f), 2799, 2799A, 2799B, or 2799C to satisfy such requirements applicable to the provider or facility.

"(2) FAILURE TO IMPLEMENT REQUIREMENTS.—In the case of a determination by the Secretary that a State has failed to substantially enforce the requirements specified in paragraph (1) with respect to applicable providers and facilities in the State, the Secretary shall enforce such requirements under subsection (b) insofar as they relate to violations of such requirements occurring in such State.

"(b) SECRETARIAL ENFORCEMENT AUTHORITY.—

"(1) IN GENERAL.—If a provider or facility is found to be in violation specified in subsection (a)(1) by the Secretary, the Secretary may apply a civil monetary penalty with respect to such provider or facility in an amount not to exceed $10,000 per violation. The provisions of subsections (c), (d), (e), (g), (h), (k), and (l) of section 1128A of the Social Security Act shall apply to a civil monetary penalty or assessment under this subsection in the same manner as such provisions apply to a penalty, assessment, or proceeding under subsection (a) of such section.

"(2) LIMITATION.—The provisions of paragraph (1) shall apply to enforcement of a provision (or provisions) specified in subsection (a)(1) only as provided under subsection (a)(2).

"(3) COMPLAINT PROCESS.—The Secretary shall, through rulemaking, establish a process to receive consumer complaints of violations of such provisions and resolve such complaints within 60 days of receipt of such complaints.

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

lated, section 2799 or 2799A with respect to a participant, beneficiary, or enrollee, if such facility or practitioner, within 30 days of the violation, withdraws the bill that was in violation of such provision and reimburses the health plan or enrollee, as applicable, in an amount equal to the difference between the amount billed and the amount allowed to be billed under the provision, plus interest, at an interest rate determined by the Secretary.

"(5) HARDSHIP EXEMPTION.—The Secretary may establish a hardship exemption to the penalties under this subsection.

"(c) CONTINUED APPLICABILITY OF STATE LAW.—The sections specified in subsection (a)(1) shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any requirement or prohibition except to the extent that such requirement or prohibition prevents the application of a requirement or prohibition of such a section.".

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

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

2719A of the Public Health Service Act (42 U.S.C. 300gg–19a), as added by subsection (b) of this section) shall use to determine the median contracted rate (as defined in section 2719A(b) of such Act, as amended by subsection (a) of this section), differentiating by business line;

(2) the information such sponsor or issuer shall share with the nonparticipating provider (as defined in such section) involved when making such a determination; and

(3) the geographic regions applied for purposes of subparagraph (E) of section 2719A(b)(3), as amended by subsection (a) of this section, taking into account the needs of rural and underserved areas, including health professional shortage areas.

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

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

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

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

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

(A) involve one or more—

(i) physician groups that practice within a hospital included in the profit- or revenue-sharing relationship, or refer patients to such hospital;

(ii) laboratory, radiology, or pharmacy services that are delivered to privately insured patients of such hospital;

(iii) surgical services;

(iv) hospitals or group purchasing organizations; or

(v) rehabilitation or physical therapy facilities or services; and

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

(2) describe Federal oversight of such relationships, including authorities of the Department of Health and Human Services and the Federal Trade Commission to review such relationships and their potential to increase costs for patients, and identify limitations in such oversight; and

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

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

SEC. 404. STATE ALL PAYER CLAIMS DATABASES.

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

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

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

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

(c) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), a State shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary specifies. Such information shall include, with respect to an All Payer Claims Database for the State, at least specifics on how the State will ensure uniform data collection through the database and the security of such data submitted to and maintained in the database.

(d) ALL PAYER CLAIMS DATABASE.—For purposes of this section, the term "All Payer Claims Database" means, with respect to a State, a State database that may include medical claims, pharmacy claims, dental claims, and eligibility and provider files, which are collected from private and public payers.

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

SEC. 405. AIR AMBULANCE COST DATA REPORTING PROGRAM.

(a) COST DATA REPORTING PROGRAM.—

(1) IN GENERAL.—Not later than 6 months after the date of the promulgation of the rule under subsection (c), and annually thereafter, a provider of emergency air medical services shall submit to the Secretary of Health and Human Services the information specified in subsection (b) with respect to the preceding 180-day period (in the case of the initial period) and the preceding 1-year period (in each subsequent period).

(2) PUBLICATION.—Not later than 180 days after the date the Secretary of Health and Human Services receives from a provider described in paragraph (1) the information specified in subsection (b), the Secretary shall make publicly available such information.

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

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

(A) identified as paid by health insurance coverage offered in the group or individual market or a group health plan (including a self-insured plan);

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

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

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

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

(F) identified as furnished by a provider of emergency air medical services that has a contractual relationship with the plan or coverage of an individual for which such item or service is provided and such a provider that does not have a contractual relationship with the plan or coverage or such an individual; and

(2) cost data for an air ambulance service furnished by such a provider of emergency air medical services that the Secretary of Health and Human Services, in consultation with suppliers and providers of such services, determines appropriate, separated by the cost of air travel and the cost of emergency medical services and supplies.

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

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

(d) CIVIL MONETARY PENALTIES.—

(1) IN GENERAL.—A provider of emergency air medical services who violates the requirements of subsection (a)(1) shall be subject to a civil monetary penalty of not more than $10,000 for each act constituting such violation.

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

(e) REPORTING.—

(1) SECRETARY OF HEALTH AND HUMAN SERVICES.—Not later than July 1, 2023, the Secretary of Health and Human Services shall submit to Congress a report summarizing the information and data specified in subsection (b).

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

States shall submit to Congress a report that includes—

(A) an analysis of the cost variation of providers of emergency air ambulance services by geography and status; and

(B) any other recommendations the Comptroller General determines appropriate, which may include a recommendation of an adequate amount of reimbursement for such services that reflects operational costs of such providers in order to preserve access to emergency air ambulance services.

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

SEC. 406. REPORT BY SECRETARY OF LABOR.

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

(1) conduct a study of—

(A) the effects of the provisions of, including amendments made by, this Act on premiums and out-of-pocket costs in group health plans, including out-of-pocket costs that are permitted by reason of compliance with section 2799A(d) of the

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

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

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

(2) submit a report on such study to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Education and Labor and the Committee on Energy and Commerce of the House of Representatives.

SEC. 407. BILLING STATUTE OF LIMITATIONS.

Notwithstanding any other provision of law, a health care provider or health care facility (or health insurance issuer offering health insurance coverage or group health plan) may not initiate a process to seek reimbursement from an individual for a service furnished by such provider or facility to such individual more than a year after such date of service. Any provider, facility, issuer, or plan that bills an individual in violation of the previous sentence shall be subject to a civil monetary penalty in such amount as specified by the Secretary of Health and Human Services.

SEC. 408. GAO REPORT ON IMPACT OF SURPRISE BILLING PROVISIONS.

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

(1) What is known about the impacts of the provisions of this Act, including the amendments made by this Act, on the incidence and prevalence of the furnishing of items and services to individuals enrolled under a group health plan or health insurance coverage by health care providers and health care facilities that do not have a contractual relationship with such plan or such coverage (as applicable) for furnishing such items and services to such an individual.

(2) What is known about such impacts on provider shortages and accessibility to such providers, focusing on rural and medically underserved communities.

(3) The number of grants that have been awarded under section 404 (relating to State All Payer Claims Databases) and for what purposes States have used funds made available under such grants.

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

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

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

(1) conduct a study of—

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

(B) the adequacy of provider networks with respect to individual health insurance coverage and small group health plans, taking into consideration maximum travel time and distance; and

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

(2) submit a report on such study to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Education and Labor and the Committee on Energy and Commerce of the House of Representatives.

TITLE V—TERRITORIES HEALTH CARE IMPROVEMENT ACT

SEC. 501. SHORT TITLE.

This title may be cited as the "Territories Health Care Improvement Act".

SEC. 502. MEDICAID PAYMENTS FOR PUERTO RICO AND THE OTHER TERRITORIES FOR CERTAIN FISCAL YEARS.

(a) TREATMENT OF CAP.—Section 1108(g) of the Social Security Act (42 U.S.C. 1308(g)) is amended—

(1) in paragraph (2)—

(A) in the matter preceding subparagraph (A), by striking "subject to and section 1323(a)(2) of the Patient Protection and Affordable Care Act paragraphs (3) and (5)" and inserting "subject to section 1323(a)(2) of the Patient Protection and Affordable Care Act and paragraphs (3) and (5)";

(B) in subparagraph (A)—

(i) by striking "Puerto Rico shall not exceed the sum of" and inserting "Puerto Rico shall not exceed—

"(i) except as provided in clause (ii), the sum of";

(ii) by striking "$100,000;" and inserting "$100,000; and"; and

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

"(ii) for each of fiscal years 2020 through 2023, the amount specified in paragraph (6) for each such fiscal year;";

(C) in subparagraph (B)—

(i) by striking "the Virgin Islands shall not exceed the sum of" and inserting "the Virgin Islands shall not exceed—

"(i) except as provided in clause (ii), the sum of";

(ii) by striking "$10,000;" and inserting "$10,000; and"; and

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

"(ii) for each of fiscal years 2020 through 2025, $126,000,000;";

(D) in subparagraph (C)—

(i) by striking "Guam shall not exceed the sum of" and inserting "Guam shall not exceed—

"(i) except as provided in clause (ii), the sum of";

(ii) by striking "$10,000;" and inserting "$10,000; and"; and

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

"(ii) for each of fiscal years 2020 through 2025, $127,000,000;";

(E) in subparagraph (D)—

(i) by striking "the Northern Mariana Islands shall not exceed the sum of" and inserting "the Northern Mariana Islands shall not exceed—

"(i) except as provided in clause (ii), the sum of"; and

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

"(ii) for each of fiscal years 2020 through 2025, $60,000,000; and"; and

(F) in subparagraph (E)—

(i) by striking "American Samoa shall not exceed the sum of" and inserting "American Samoa shall not exceed—

"(i) except as provided in clause (ii), the sum of";

(ii) by striking "$10,000." and inserting "$10,000; and"; and

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

"(ii) for each of fiscal years 2020 through 2025, $84,000,000."; and

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

"(6) APPLICATION TO PUERTO RICO FOR FISCAL YEARS 2020 THROUGH 2023.—For purposes of paragraph (2)(A)(ii), the amount specified in this paragraph is—

"(A) for fiscal year 2020, $2,823,188,000;

"(B) for fiscal year 2021, $2,919,072,000;

"(C) for fiscal year 2022, $3,012,610,000; and

"(D) for fiscal year 2023, $3,114,331,000.".

(b) TREATMENT OF FUNDING UNDER ENHANCED ALLOTMENT PROGRAM.—Section 1935(e) of the Social Security Act (42 U.S.C. 1396u–5(e)) is amended—

(1) in paragraph (1)(B), by striking "if the State" and inserting "subject to paragraph (4), if the State";

(2) by redesignating paragraph (4) as paragraph (5); and

(3) by inserting after paragraph (3) the following new paragraph:

"(4) TREATMENT OF FUNDING FOR CERTAIN FISCAL YEARS.—

"(A) PUERTO RICO.—Notwithstanding paragraph (1)(B), in the case that Puerto Rico establishes and submits to the Secretary a plan described in paragraph (2) with respect to any of fiscal years 2020 through 2023, the amount specified in paragraph (3) for Puerto Rico for such a year shall be taken into account in applying subparagraph (A)(ii) of section 1108(g)(2) for such year.

"(B) OTHER TERRITORIES.—Notwithstanding paragraph (1)(B), in the case that the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa establishes and submits to the Secretary a plan described in paragraph (2) with respect to any of fiscal years 2020 through 2025, the amount specified in paragraph (3) for the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa, as the case may be, shall be taken into account in applying, as applicable, subparagraph (B)(ii), (C)(ii), (D)(ii), or (E)(ii) of section 1108(g)(2) for such year.".

(c) INCREASED FMAP.—Section 1905 of the Social Security Act (42 U.S.C. 1396d(b)) is amended—

(1) in subsection (b), by striking "and (aa)" and inserting "(aa), and (ff)"; and

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

"(ff) TEMPORARY INCREASE IN FMAP FOR TERRITORIES FOR CERTAIN FISCAL YEARS.—

"(1) PUERTO RICO.—Notwithstanding subsection (b) and subject to subsection (z)(2), the Federal medical assistance percentage for Puerto Rico shall be equal to—

"(A) 83 percent for fiscal years 2020 and 2021; and

"(B) 76 percent for fiscal years 2022 and 2023.

"(2) VIRGIN ISLANDS.—Notwithstanding subsection (b) and subject to subsection (z)(2), the Federal medical assistance percentage for the Virgin Islands shall be equal to—

"(A) 100 percent for fiscal year 2020;

"(B) 83 percent for fiscal years 2021 through 2024; and

"(C) 76 percent for fiscal year 2025.

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

"(A) 100 percent for fiscal years 2020 and 2021;

"(B) 83 percent for fiscal years 2022 through 2024; and

"(C) 76 percent for fiscal year 2025.".

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

"(7) ANNUAL REPORT.—

"(A) IN GENERAL.—Not later than the date that is 180 days after the end of each fiscal year (beginning with fiscal year 2020 and ending with fiscal year 2025), in the case that a specified territory receives a Medicaid cap increase, or an increase in the Federal medical assistance percentage for such territory under section 1905(ff), for such fiscal year, such territory shall submit to the Chair and Ranking Member of the Committee on Energy and Commerce of the

House of Representatives and the Chair and Ranking Member of the Committee on Finance of the Senate a report that describes how such territory has used such Medicaid cap increase, or such increase in the Federal medical assistance percentage, as applicable, to increase access to health care under the State Medicaid plan of such territory under title XIX (or a waiver of such plan). Such report may include—

"(i) the extent to which such territory has, with respect to such plan (or waiver)—

"(I) increased payments to health care providers;

"(II) increased covered benefits;

"(III) expanded health care provider networks; or

"(IV) improved in any other manner the carrying out of such plan (or waiver); and

"(ii) any other information as determined necessary by such territory.

"(B) DEFINITIONS.—In this paragraph:

"(i) MEDICAID CAP INCREASE.—The term 'Medicaid cap increase' means, with respect to a specified territory and fiscal

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

"(ii) SPECIFIED TERRITORY.—The term 'specified territory' means Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.".

SEC. 503. APPLICATION OF CERTAIN REQUIREMENTS UNDER MEDICAID PROGRAM TO CERTAIN TERRITORIES.

(a) APPLICATION OF PAYMENT ERROR RATE MEASUREMENT REQUIREMENTS TO PUERTO RICO.—Section 1903(u)(4) of the Social Security Act (42 U.S.C. 1396b(u)(4)) is amended—

(1) by striking "to Puerto Rico, Guam" and inserting "to Guam"; and

(2) by striking "or American Samoa." and inserting "or American Samoa, or, for fiscal years before fiscal year 2023, to Puerto Rico.".

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

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

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

"(iii) IMPLEMENTATION IN PUERTO RICO AND VIRGIN ISLANDS.—The Secretary shall require Puerto Rico to implement an asset verification program under this subsection by the end of fiscal year 2022 and the Virgin Islands to implement such a program by the end of fiscal year 2023."; and

(2) in paragraph (4)—

(A) in the paragraph heading, by striking "EXEMPTION OF TERRITORIES" and inserting "EXEMPTION OF CERTAIN TERRITORIES"; and

(B) by striking "and the District of Columbia" and inserting ", the District of Columbia, Puerto Rico, and the Virgin Islands".

(c) APPLICATION OF CERTAIN DATA REPORTING AND PROGRAM INTEGRITY REQUIREMENTS TO NORTHERN MARIANA ISLANDS, AMERICAN SAMOA, AND GUAM.—

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

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

"(1) implement methods, satisfactory to the Secretary, for the collection and reporting of reliable data to the Transformed Medicaid Statistical Information System (T–MSIS) (or a successor system); and

"(2) demonstrate progress in establishing a State medicaid fraud control unit described in section 1903(q).".

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

(A) by striking "or the requirement" and inserting ", the requirement"; and

(B) by inserting before the period at the end the following: ", or the requirement under subsection (qq)(1) (relating to data reporting)".

SEC. 504. ADDITIONAL PROGRAM INTEGRITY REQUIREMENTS.

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

the date of the enactment of this Act, the Inspector General of the Department of Health and Human Services (referred to in this section as the "Inspector General") shall conduct an audit of Puerto Rico with respect to any part of the administration of Puerto Rico's State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (or a waiver of such plan), such as contracting protocols, denials of care, and financial management, that the Inspector General determines to be at high risk for waste, fraud, or abuse.

(b) PLAN FOR AUDITS AND INVESTIGATIONS OF CONTRACTING PRACTICES.—Not later than the date that is one year after the date of the enactment of this Act, the Inspector General shall develop and submit to Congress a plan for auditing and investigating contracting practices relating to Puerto Rico's State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (or a waiver of such plan).

(c) REPORT ON CONTRACTING OVERSIGHT AND APPROVAL.—Not later than the date that is two years after the date of the enactment of this Act, the Comptroller General of the United States shall issue, and submit to the Chair and Ranking Member of the Committee on Energy and Commerce of the House of Representatives and the Chair and Ranking Member of the Committee on Finance of the Senate, a report on contracting oversight and ap-

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

(1) examine—

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

(B) which contracts are not subject to competitive bidding or requests for proposals under such plan (or waiver); and

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

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

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

(1) reevaluate any waiver approved (and in effect as of the date of the enactment of this Act) for Guam, the Northern Mariana Islands, or American

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

(2) determine whether any such waiver should continue to be approved with respect to Guam, the Northern Mariana Islands, or American Samoa, respectively, after October 1, 2023.

(e) SYSTEM FOR TRACKING FEDERAL FUNDING PROVIDED TO PUERTO RICO.—Section 1902 of the Social Security Act (42 U.S.C. 1396a), as amended by section 503(c), is further amended by adding at the end the following new subsection:

"(rr) PROGRAM INTEGRITY REQUIREMENTS FOR PUERTO RICO.—

"(1) SYSTEM FOR TRACKING FEDERAL FUNDING PROVIDED TO PUERTO RICO.—

"(A) IN GENERAL.—Puerto Rico shall establish and maintain a system for tracking any amounts paid by the Federal Government to Puerto Rico with respect to the State plan of Puerto Rico (or a waiver of such plan). Under such system, Puerto Rico shall ensure that information is available, with respect to each quarter

in a fiscal year (beginning with the first quarter beginning on or after the date that is one year after the date of the enactment of this subsection), on the following:

"(i) In the case of a quarter other than the first quarter of such fiscal year—

"(I) the total amount expended by Puerto Rico during any previous quarter of such fiscal year under the State plan of Puerto Rico (or a waiver of such plan); and

"(II) a description of how such amount was so expended.

"(ii) The total amount that Puerto Rico expects to expend during the quarter under the State plan of Puerto Rico (or a waiver of such plan), and a description of how Puerto Rico expects to expend such amount.

"(B) REPORT TO CMS.—For each quarter with respect to which Puerto Rico is required under subparagraph (A) to ensure that information described in such subparagraph is available, Puerto Rico shall submit to the Administrator of

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

"(2) SUBMISSION OF DOCUMENTATION ON CONTRACTS UPON REQUEST.—Puerto Rico shall, upon request, submit to the Administrator of the Centers for Medicare & Medicaid Services all documentation requested with respect to contracts awarded under the State plan of Puerto Rico (or a waiver of such 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

116TH CONGRESS
2D SESSION

H. R. 2328

[Report No. 116–332, Part I]

A BILL

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

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