

One Hundred Eleventh Congress  
of the  
United States of America

AT THE FIRST SESSION

*Begun and held at the City of Washington on Tuesday,  
the sixth day of January, two thousand and nine*

An Act

Making supplemental appropriations for job preservation and creation, infrastructure investment, energy efficiency and science, assistance to the unemployed, and State and local fiscal stabilization, for the fiscal year ending September 30, 2009, and for other purposes.

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

**SECTION 1. SHORT TITLE.**

This Act may be cited as the “American Recovery and Reinvestment Act of 2009”.

**SEC. 2. TABLE OF CONTENTS.**

The table of contents for this Act is as follows:

DIVISION A—APPROPRIATIONS PROVISIONS

TITLE I—AGRICULTURE, RURAL DEVELOPMENT, FOOD AND DRUG ADMINISTRATION, AND RELATED AGENCIES

TITLE II—COMMERCE, JUSTICE, SCIENCE, AND RELATED AGENCIES

TITLE III—DEPARTMENT OF DEFENSE

TITLE IV—ENERGY AND WATER DEVELOPMENT

TITLE V—FINANCIAL SERVICES AND GENERAL GOVERNMENT

TITLE VI—DEPARTMENT OF HOMELAND SECURITY

TITLE VII—INTERIOR, ENVIRONMENT, AND RELATED AGENCIES

TITLE VIII—DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES

TITLE IX—LEGISLATIVE BRANCH

TITLE X—MILITARY CONSTRUCTION AND VETERANS AFFAIRS AND RELATED AGENCIES

TITLE XI—STATE, FOREIGN OPERATIONS, AND RELATED PROGRAMS

TITLE XII—TRANSPORTATION, HOUSING AND URBAN DEVELOPMENT, AND RELATED AGENCIES

TITLE XIII—HEALTH INFORMATION TECHNOLOGY

TITLE XIV—STATE FISCAL STABILIZATION FUND

TITLE XV—ACCOUNTABILITY AND TRANSPARENCY

TITLE XVI—GENERAL PROVISIONS—THIS ACT

DIVISION B—TAX, UNEMPLOYMENT, HEALTH, STATE FISCAL RELIEF, AND OTHER PROVISIONS

TITLE I—TAX PROVISIONS

TITLE II—ASSISTANCE FOR UNEMPLOYED WORKERS AND STRUGGLING FAMILIES

TITLE III—PREMIUM ASSISTANCE FOR COBRA BENEFITS

TITLE IV—MEDICARE AND MEDICAID HEALTH INFORMATION TECHNOLOGY; MISCELLANEOUS MEDICARE PROVISIONS

TITLE V—STATE FISCAL RELIEF

TITLE VI—BROADBAND TECHNOLOGY OPPORTUNITIES PROGRAM

TITLE VII—LIMITS ON EXECUTIVE COMPENSATION

**SEC. 3. PURPOSES AND PRINCIPLES.**

(a) STATEMENT OF PURPOSES.—The purposes of this Act include the following:

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(1) To preserve and create jobs and promote economic recovery.

(2) To assist those most impacted by the recession.

(3) To provide investments needed to increase economic efficiency by spurring technological advances in science and health.

(4) To invest in transportation, environmental protection, and other infrastructure that will provide long-term economic benefits.

(5) To stabilize State and local government budgets, in order to minimize and avoid reductions in essential services and counterproductive state and local tax increases.

(b) **GENERAL PRINCIPLES CONCERNING USE OF FUNDS.**—The President and the heads of Federal departments and agencies shall manage and expend the funds made available in this Act so as to achieve the purposes specified in subsection (a), including commencing expenditures and activities as quickly as possible consistent with prudent management.

**SEC. 4. REFERENCES.**

Except as expressly provided otherwise, any reference to “this Act” contained in any division of this Act shall be treated as referring only to the provisions of that division.

**SEC. 5. EMERGENCY DESIGNATIONS.**

(a) **IN GENERAL.**—Each amount in this Act is designated as an emergency requirement and necessary to meet emergency needs pursuant to section 204(a) of S. Con. Res. 21 (110th Congress) and section 301(b)(2) of S. Con. Res. 70 (110th Congress), the concurrent resolutions on the budget for fiscal years 2008 and 2009.

(b) **PAY-AS-YOU-GO.**—All applicable provisions in this Act are designated as an emergency for purposes of pay-as-you-go principles.

**DIVISION A—APPROPRIATIONS  
PROVISIONS**

That the following sums are appropriated, out of any money in the Treasury not otherwise appropriated, for the fiscal year ending September 30, 2009, and for other purposes, namely:

**TITLE I—AGRICULTURE, RURAL DEVELOPMENT, FOOD AND  
DRUG ADMINISTRATION, AND RELATED AGENCIES**

**DEPARTMENT OF AGRICULTURE**

**AGRICULTURE BUILDINGS AND FACILITIES AND RENTAL PAYMENTS**

For an additional amount for “Agriculture Buildings and Facilities and Rental Payments”, \$24,000,000, for necessary construction, repair, and improvement activities.

**OFFICE OF INSPECTOR GENERAL**

For an additional amount for “Office of Inspector General”, \$22,500,000, to remain available until September 30, 2013, for

and technical assistance to such programs consistent with section 645A(g)(2) of such Act, and up to 3 percent shall be available for monitoring the operation of such programs consistent with section 641A of such Act.

(3) \$1,000,000,000 for carrying out activities under sections 674 through 679 of the Community Services Block Grant Act, of which no part shall be subject to section 674(b)(3) of such Act: *Provided*, That notwithstanding section 675C(a)(1) and 675C(b) of such Act, 1 percent of the funds made available to each State from this additional amount shall be used for benefits enrollment coordination activities relating to the identification and enrollment of eligible individuals and families in Federal, State, and local benefit programs: *Provided further*, That all funds remaining available to a State from this additional amount after application of the previous proviso shall be distributed to eligible entities as defined in section 673(1) of such Act: *Provided further*, That for services furnished under such Act during fiscal years 2009 and 2010, States may apply the last sentence of section 673(2) of such Act by substituting “200 percent” for “125 percent”.

(4) \$50,000,000 for carrying out activities under section 1110 of the Social Security Act.

ADMINISTRATION ON AGING

AGING SERVICES PROGRAMS

For an additional amount for “Aging Services Programs” under subparts 1 and 2 of part C, of title III, and under title VI, of the Older Americans Act of 1965, \$100,000,000, of which \$65,000,000 shall be for Congregate Nutrition Services, \$32,000,000 shall be for Home-Delivered Nutrition Services and \$3,000,000 shall be for Nutrition Services for Native Americans.

OFFICE OF THE SECRETARY

OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION  
TECHNOLOGY

(INCLUDING TRANSFER OF FUNDS)

For an additional amount for “Office of the National Coordinator for Health Information Technology”, \$2,000,000,000, to carry out title XIII of this Act, to remain available until expended: *Provided*, That of such amount, the Secretary of Health and Human Services shall transfer \$20,000,000 to the Director of the National Institute of Standards and Technology in the Department of Commerce for continued work on advancing health care information enterprise integration through activities such as technical standards analysis and establishment of conformance testing infrastructure, so long as such activities are coordinated with the Office of the National Coordinator for Health Information Technology: *Provided further*, That \$300,000,000 is to support regional or sub-national efforts toward health information exchange: *Provided further*, That 0.25 percent of the funds provided in this paragraph may be used for administration of such funds: *Provided further*, That funds available under this heading shall become available for obligation only upon submission of an annual operating plan by the Secretary

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to the Committees on Appropriations of the House of Representatives and the Senate: *Provided further*, That the fiscal year 2009 operating plan shall be provided not later than 90 days after enactment of this Act and that subsequent annual operating plans shall be provided not later than November 1 of each year: *Provided further*, That these operating plans shall describe how expenditures are aligned with the specific objectives, milestones, and metrics of the Federal Health Information Technology Strategic Plan, including any subsequent updates to the Plan; the allocation of resources within the Department of Health and Human Services and other Federal agencies; and the identification of programs and activities that are supported: *Provided further*, That the Secretary shall provide to the Committees on Appropriations of the House of Representatives and the Senate a report on the actual obligations, expenditures, and unobligated balances for each major set of activities not later than November 1, 2009, and every 6 months thereafter as long as funding provided under this heading is available for obligation or expenditure.

OFFICE OF INSPECTOR GENERAL

For an additional amount for the “Office of Inspector General”, \$17,000,000 which shall remain available until September 30, 2012.

PUBLIC HEALTH AND SOCIAL SERVICES EMERGENCY FUND

For an additional amount for “Public Health and Social Services Emergency Fund” to improve information technology security at the Department of Health and Human Services, \$50,000,000.

PREVENTION AND WELLNESS FUND

(INCLUDING TRANSFER OF FUNDS)

For necessary expenses for a “Prevention and Wellness Fund” to be administered through the Department of Health and Human Services, Office of the Secretary, \$1,000,000,000: *Provided*, That of the amount provided in this paragraph, \$300,000,000 shall be transferred to the Centers for Disease Control and Prevention (“CDC”) as an additional amount to carry out the immunization program (“section 317 immunization program”) authorized by section 317(a), (j), and (k)(1) of the Public Health Service Act (“PHS Act”): *Provided further*, That of the amount provided in this paragraph, \$650,000,000 shall be to carry out evidence-based clinical and community-based prevention and wellness strategies authorized by the PHS Act, as determined by the Secretary, that deliver specific, measurable health outcomes that address chronic disease rates: *Provided further*, That funds appropriated in the preceding proviso may be transferred to other appropriation accounts of the Department of Health and Human Services, as determined by the Secretary to be appropriate: *Provided further*, That of the amount appropriated in this paragraph, \$50,000,000 shall be provided to States for an additional amount to carry out activities to implement healthcare associated infections reduction strategies: *Provided further*, That not more than 0.5 percent of funds made available in this paragraph may be used for management and oversight expenses in the office or division of the Department of Health and Human Services administering the funds: *Provided further*,

## **TITLE IV—MEDICARE AND MEDICAID HEALTH INFORMATION TECH- NOLOGY; MISCELLANEOUS MEDICARE PROVISIONS**

### **SEC. 4001. TABLE OF CONTENTS OF TITLE.**

The table of contents of this title is as follows:

#### **TITLE IV—MEDICARE AND MEDICAID HEALTH INFORMATION TECHNOLOGY; MISCELLANEOUS MEDICARE PROVISIONS**

Sec. 4001. Table of contents of title.

##### **Subtitle A—Medicare Incentives**

- Sec. 4101. Incentives for eligible professionals.
- Sec. 4102. Incentives for hospitals.
- Sec. 4103. Treatment of payments and savings; implementation funding.
- Sec. 4104. Studies and reports on health information technology.

##### **Subtitle B—Medicaid Incentives**

- Sec. 4201. Medicaid provider HIT adoption and operation payments; implementa-  
tion funding.

##### **Subtitle C—Miscellaneous Medicare Provisions**

- Sec. 4301. Moratoria on certain Medicare regulations.
- Sec. 4302. Long-term care hospital technical corrections.

### **Subtitle A—Medicare Incentives**

#### **SEC. 4101. INCENTIVES FOR ELIGIBLE PROFESSIONALS.**

(a) INCENTIVE PAYMENTS.—Section 1848 of the Social Security Act (42 U.S.C. 1395w-4) is amended by adding at the end the following new subsection:

“(o) INCENTIVES FOR ADOPTION AND MEANINGFUL USE OF CER-  
TIFIED EHR TECHNOLOGY.—

“(1) INCENTIVE PAYMENTS.—

“(A) IN GENERAL.—

“(i) IN GENERAL.—Subject to the succeeding sub-  
paragraphs of this paragraph, with respect to covered  
professional services furnished by an eligible profes-  
sional during a payment year (as defined in subpara-  
graph (E)), if the eligible professional is a meaningful  
EHR user (as determined under paragraph (2)) for  
the EHR reporting period with respect to such year,  
in addition to the amount otherwise paid under this  
part, there also shall be paid to the eligible professional  
(or to an employer or facility in the cases described  
in clause (A) of section 1842(b)(6)), from the Federal  
Supplementary Medical Insurance Trust Fund estab-  
lished under section 1841 an amount equal to 75 per-  
cent of the Secretary’s estimate (based on claims sub-  
mitted not later than 2 months after the end of the  
payment year) of the allowed charges under this part  
for all such covered professional services furnished by  
the eligible professional during such year.

“(ii) NO INCENTIVE PAYMENTS WITH RESPECT TO  
YEARS AFTER 2016.—No incentive payments may be

made under this subsection with respect to a year after 2016.

“(B) LIMITATIONS ON AMOUNTS OF INCENTIVE PAYMENTS.—

“(i) IN GENERAL.—In no case shall the amount of the incentive payment provided under this paragraph for an eligible professional for a payment year exceed the applicable amount specified under this subparagraph with respect to such eligible professional and such year.

“(ii) AMOUNT.—Subject to clauses (iii) through (v), the applicable amount specified in this subparagraph for an eligible professional is as follows:

“(I) For the first payment year for such professional, \$15,000 (or, if the first payment year for such eligible professional is 2011 or 2012, \$18,000).

“(II) For the second payment year for such professional, \$12,000.

“(III) For the third payment year for such professional, \$8,000.

“(IV) For the fourth payment year for such professional, \$4,000.

“(V) For the fifth payment year for such professional, \$2,000.

“(VI) For any succeeding payment year for such professional, \$0.

“(iii) PHASE DOWN FOR ELIGIBLE PROFESSIONALS FIRST ADOPTING EHR AFTER 2013.—If the first payment year for an eligible professional is after 2013, then the amount specified in this subparagraph for a payment year for such professional is the same as the amount specified in clause (ii) for such payment year for an eligible professional whose first payment year is 2013.

“(iv) INCREASE FOR CERTAIN ELIGIBLE PROFESSIONALS.—In the case of an eligible professional who predominantly furnishes services under this part in an area that is designated by the Secretary (under section 332(a)(1)(A) of the Public Health Service Act) as a health professional shortage area, the amount that would otherwise apply for a payment year for such professional under subclauses (I) through (V) of clause (ii) shall be increased by 10 percent. In implementing the preceding sentence, the Secretary may, as determined appropriate, apply provisions of subsections (m) and (u) of section 1833 in a similar manner as such provisions apply under such subsection.

“(v) NO INCENTIVE PAYMENT IF FIRST ADOPTING AFTER 2014.—If the first payment year for an eligible professional is after 2014 then the applicable amount specified in this subparagraph for such professional for such year and any subsequent year shall be \$0.

“(C) NON-APPLICATION TO HOSPITAL-BASED ELIGIBLE PROFESSIONALS.—

“(i) IN GENERAL.—No incentive payment may be made under this paragraph in the case of a hospital-based eligible professional.

“(ii) HOSPITAL-BASED ELIGIBLE PROFESSIONAL.—For purposes of clause (i), the term ‘hospital-based eligible professional’ means, with respect to covered professional services furnished by an eligible professional during the EHR reporting period for a payment year, an eligible professional, such as a pathologist, anesthesiologist, or emergency physician, who furnishes substantially all of such services in a hospital setting (whether inpatient or outpatient) and through the use of the facilities and equipment, including qualified electronic health records, of the hospital. The determination of whether an eligible professional is a hospital-based eligible professional shall be made on the basis of the site of service (as defined by the Secretary) and without regard to any employment or billing arrangement between the eligible professional and any other provider.

“(D) PAYMENT.—

“(i) FORM OF PAYMENT.—The payment under this paragraph may be in the form of a single consolidated payment or in the form of such periodic installments as the Secretary may specify.

“(ii) COORDINATION OF APPLICATION OF LIMITATION FOR PROFESSIONALS IN DIFFERENT PRACTICES.—In the case of an eligible professional furnishing covered professional services in more than one practice (as specified by the Secretary), the Secretary shall establish rules to coordinate the incentive payments, including the application of the limitation on amounts of such incentive payments under this paragraph, among such practices.

“(iii) COORDINATION WITH MEDICAID.—The Secretary shall seek, to the maximum extent practicable, to avoid duplicative requirements from Federal and State governments to demonstrate meaningful use of certified EHR technology under this title and title XIX. The Secretary may also adjust the reporting periods under such title and such subsections in order to carry out this clause.

“(E) PAYMENT YEAR DEFINED.—

“(i) IN GENERAL.—For purposes of this subsection, the term ‘payment year’ means a year beginning with 2011.

“(ii) FIRST, SECOND, ETC. PAYMENT YEAR.—The term ‘first payment year’ means, with respect to covered professional services furnished by an eligible professional, the first year for which an incentive payment is made for such services under this subsection. The terms ‘second payment year’, ‘third payment year’, ‘fourth payment year’, and ‘fifth payment year’ mean, with respect to covered professional services furnished by such eligible professional, each successive year immediately following the first payment year for such professional.

“(2) MEANINGFUL EHR USER.—

“(A) IN GENERAL.—For purposes of paragraph (1), an eligible professional shall be treated as a meaningful EHR

user for an EHR reporting period for a payment year (or, for purposes of subsection (a)(7), for an EHR reporting period under such subsection for a year) if each of the following requirements is met:

“(i) MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—The eligible professional demonstrates to the satisfaction of the Secretary, in accordance with subparagraph (C)(i), that during such period the professional is using certified EHR technology in a meaningful manner, which shall include the use of electronic prescribing as determined to be appropriate by the Secretary.

“(ii) INFORMATION EXCHANGE.—The eligible professional demonstrates to the satisfaction of the Secretary, in accordance with subparagraph (C)(i), that during such period such certified EHR technology is connected in a manner that provides, in accordance with law and standards applicable to the exchange of information, for the electronic exchange of health information to improve the quality of health care, such as promoting care coordination.

“(iii) REPORTING ON MEASURES USING EHR.—Subject to subparagraph (B)(ii) and using such certified EHR technology, the eligible professional submits information for such period, in a form and manner specified by the Secretary, on such clinical quality measures and such other measures as selected by the Secretary under subparagraph (B)(i).

The Secretary may provide for the use of alternative means for meeting the requirements of clauses (i), (ii), and (iii) in the case of an eligible professional furnishing covered professional services in a group practice (as defined by the Secretary). The Secretary shall seek to improve the use of electronic health records and health care quality over time by requiring more stringent measures of meaningful use selected under this paragraph.

“(B) REPORTING ON MEASURES.—

“(i) SELECTION.—The Secretary shall select measures for purposes of subparagraph (A)(iii) but only consistent with the following:

“(I) The Secretary shall provide preference to clinical quality measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a).

“(II) Prior to any measure being selected under this subparagraph, the Secretary shall publish in the Federal Register such measure and provide for a period of public comment on such measure.

“(ii) LIMITATION.—The Secretary may not require the electronic reporting of information on clinical quality measures under subparagraph (A)(iii) unless the Secretary has the capacity to accept the information electronically, which may be on a pilot basis.

“(iii) COORDINATION OF REPORTING OF INFORMATION.—In selecting such measures, and in establishing the form and manner for reporting measures under subparagraph (A)(iii), the Secretary shall seek to avoid



redundant or duplicative reporting otherwise required, including reporting under subsection (k)(2)(C).

“(C) DEMONSTRATION OF MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY AND INFORMATION EXCHANGE.—

“(i) IN GENERAL.—A professional may satisfy the demonstration requirement of clauses (i) and (ii) of subparagraph (A) through means specified by the Secretary, which may include—

“(I) an attestation;

“(II) the submission of claims with appropriate coding (such as a code indicating that a patient encounter was documented using certified EHR technology);

“(III) a survey response;

“(IV) reporting under subparagraph (A)(iii);

and

“(V) other means specified by the Secretary.

“(ii) USE OF PART D DATA.—Notwithstanding sections 1860D–15(d)(2)(B) and 1860D–15(f)(2), the Secretary may use data regarding drug claims submitted for purposes of section 1860D–15 that are necessary for purposes of subparagraph (A).

“(3) APPLICATION.—

“(A) PHYSICIAN REPORTING SYSTEM RULES.—Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of this subsection in the same manner as they apply for purposes of such subsection.

“(B) COORDINATION WITH OTHER PAYMENTS.—The provisions of this subsection shall not be taken into account in applying the provisions of subsection (m) of this section and of section 1833(m) and any payment under such provisions shall not be taken into account in computing allowable charges under this subsection.

“(C) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of—

“(i) the methodology and standards for determining payment amounts under this subsection and payment adjustments under subsection (a)(7)(A), including the limitation under paragraph (1)(B) and coordination under clauses (ii) and (iii) of paragraph (1)(D);

“(ii) the methodology and standards for determining a meaningful EHR user under paragraph (2), including selection of measures under paragraph (2)(B), specification of the means of demonstrating meaningful EHR use under paragraph (2)(C), and the hardship exception under subsection (a)(7)(B);

“(iii) the methodology and standards for determining a hospital-based eligible professional under paragraph (1)(C); and

“(iv) the specification of reporting periods under paragraph (5) and the selection of the form of payment under paragraph (1)(D)(i).

“(D) POSTING ON WEBSITE.—The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format, a list of the names, business addresses, and business phone

numbers of the eligible professionals who are meaningful EHR users and, as determined appropriate by the Secretary, of group practices receiving incentive payments under paragraph (1).

“(4) CERTIFIED EHR TECHNOLOGY DEFINED.—For purposes of this section, the term ‘certified EHR technology’ means a qualified electronic health record (as defined in section 3000(13) of the Public Health Service Act) that is certified pursuant to section 3001(c)(5) of such Act as meeting standards adopted under section 3004 of such Act that are applicable to the type of record involved (as determined by the Secretary, such as an ambulatory electronic health record for office-based physicians or an inpatient hospital electronic health record for hospitals).

“(5) DEFINITIONS.—For purposes of this subsection:

“(A) COVERED PROFESSIONAL SERVICES.—The term ‘covered professional services’ has the meaning given such term in subsection (k)(3).

“(B) EHR REPORTING PERIOD.—The term ‘EHR reporting period’ means, with respect to a payment year, any period (or periods) as specified by the Secretary.

“(C) ELIGIBLE PROFESSIONAL.—The term ‘eligible professional’ means a physician, as defined in section 1861(r).”

(b) INCENTIVE PAYMENT ADJUSTMENT.—Section 1848(a) of the Social Security Act (42 U.S.C. 1395w-4(a)) is amended by adding at the end the following new paragraph:

“(7) INCENTIVES FOR MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—

“(A) ADJUSTMENT.—

“(i) IN GENERAL.—Subject to subparagraphs (B) and (D), with respect to covered professional services furnished by an eligible professional during 2015 or any subsequent payment year, if the eligible professional is not a meaningful EHR user (as determined under subsection (o)(2)) for an EHR reporting period for the year, the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraph (3) but without regard to this paragraph).

“(ii) APPLICABLE PERCENT.—Subject to clause (iii), for purposes of clause (i), the term ‘applicable percent’ means—

“(I) for 2015, 99 percent (or, in the case of an eligible professional who was subject to the application of the payment adjustment under section 1848(a)(5) for 2014, 98 percent);

“(II) for 2016, 98 percent; and

“(III) for 2017 and each subsequent year, 97 percent.

“(iii) AUTHORITY TO DECREASE APPLICABLE PERCENTAGE FOR 2018 AND SUBSEQUENT YEARS.—For 2018 and each subsequent year, if the Secretary finds

that the proportion of eligible professionals who are meaningful EHR users (as determined under subsection (o)(2)) is less than 75 percent, the applicable percent shall be decreased by 1 percentage point from the applicable percent in the preceding year, but in no case shall the applicable percent be less than 95 percent.

“(B) SIGNIFICANT HARDSHIP EXCEPTION.—The Secretary may, on a case-by-case basis, exempt an eligible professional from the application of the payment adjustment under subparagraph (A) if the Secretary determines, subject to annual renewal, that compliance with the requirement for being a meaningful EHR user would result in a significant hardship, such as in the case of an eligible professional who practices in a rural area without sufficient Internet access. In no case may an eligible professional be granted an exemption under this subparagraph for more than 5 years.

“(C) APPLICATION OF PHYSICIAN REPORTING SYSTEM RULES.—Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of this paragraph in the same manner as they apply for purposes of such subsection.

“(D) NON-APPLICATION TO HOSPITAL-BASED ELIGIBLE PROFESSIONALS.—No payment adjustment may be made under subparagraph (A) in the case of hospital-based eligible professionals (as defined in subsection (o)(1)(C)(ii)).

“(E) DEFINITIONS.—For purposes of this paragraph:

“(i) COVERED PROFESSIONAL SERVICES.—The term ‘covered professional services’ has the meaning given such term in subsection (k)(3).

“(ii) EHR REPORTING PERIOD.—The term ‘EHR reporting period’ means, with respect to a year, a period (or periods) specified by the Secretary.

“(iii) ELIGIBLE PROFESSIONAL.—The term ‘eligible professional’ means a physician, as defined in section 1861(r).”

(c) APPLICATION TO CERTAIN MA-AFFILIATED ELIGIBLE PROFESSIONALS.—Section 1853 of the Social Security Act (42 U.S.C. 1395w-23) is amended by adding at the end the following new subsection:

“(1) APPLICATION OF ELIGIBLE PROFESSIONAL INCENTIVES FOR CERTAIN MA ORGANIZATIONS FOR ADOPTION AND MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—

“(1) IN GENERAL.—Subject to paragraphs (3) and (4), in the case of a qualifying MA organization, the provisions of sections 1848(o) and 1848(a)(7) shall apply with respect to eligible professionals described in paragraph (2) of the organization who the organization attests under paragraph (6) to be meaningful EHR users in a similar manner as they apply to eligible professionals under such sections. Incentive payments under paragraph (3) shall be made to and payment adjustments under paragraph (4) shall apply to such qualifying organizations.

“(2) ELIGIBLE PROFESSIONAL DESCRIBED.—With respect to a qualifying MA organization, an eligible professional described in this paragraph is an eligible professional (as defined for purposes of section 1848(o)) who—

“(A)(i) is employed by the organization; or

“(ii)(I) is employed by, or is a partner of, an entity that through contract with the organization furnishes at least 80 percent of the entity’s Medicare patient care services to enrollees of such organization; and

“(II) furnishes at least 80 percent of the professional services of the eligible professional covered under this title to enrollees of the organization; and

“(B) furnishes, on average, at least 20 hours per week of patient care services.

“(3) ELIGIBLE PROFESSIONAL INCENTIVE PAYMENTS.—

“(A) IN GENERAL.—In applying section 1848(o) under paragraph (1), instead of the additional payment amount under section 1848(o)(1)(A) and subject to subparagraph (B), the Secretary may substitute an amount determined by the Secretary to the extent feasible and practical to be similar to the estimated amount in the aggregate that would be payable if payment for services furnished by such professionals was payable under part B instead of this part.

“(B) AVOIDING DUPLICATION OF PAYMENTS.—

“(i) IN GENERAL.—In the case of an eligible professional described in paragraph (2)—

“(I) that is eligible for the maximum incentive payment under section 1848(o)(1)(A) for the same payment period, the payment incentive shall be made only under such section and not under this subsection; and

“(II) that is eligible for less than such maximum incentive payment for the same payment period, the payment incentive shall be made only under this subsection and not under section 1848(o)(1)(A).

“(ii) METHODS.—In the case of an eligible professional described in paragraph (2) who is eligible for an incentive payment under section 1848(o)(1)(A) but is not described in clause (i) for the same payment period, the Secretary shall develop a process—

“(I) to ensure that duplicate payments are not made with respect to an eligible professional both under this subsection and under section 1848(o)(1)(A); and

“(II) to collect data from Medicare Advantage organizations to ensure against such duplicate payments.

“(C) FIXED SCHEDULE FOR APPLICATION OF LIMITATION ON INCENTIVE PAYMENTS FOR ALL ELIGIBLE PROFESSIONALS.—In applying section 1848(o)(1)(B)(ii) under subparagraph (A), in accordance with rules specified by the Secretary, a qualifying MA organization shall specify a year (not earlier than 2011) that shall be treated as the first payment year for all eligible professionals with respect to such organization.

“(4) PAYMENT ADJUSTMENT.—

“(A) IN GENERAL.—In applying section 1848(a)(7) under paragraph (1), instead of the payment adjustment being an applicable percent of the fee schedule amount for a year under such section, subject to subparagraph (D), the

payment adjustment under paragraph (1) shall be equal to the percent specified in subparagraph (B) for such year of the payment amount otherwise provided under this section for such year.

“(B) SPECIFIED PERCENT.—The percent specified under this subparagraph for a year is 100 percent minus a number of percentage points equal to the product of—

“(i) the number of percentage points by which the applicable percent (under section 1848(a)(7)(A)(ii)) for the year is less than 100 percent; and

“(ii) the Medicare physician expenditure proportion specified in subparagraph (C) for the year.

“(C) MEDICARE PHYSICIAN EXPENDITURE PROPORTION.—The Medicare physician expenditure proportion under this subparagraph for a year is the Secretary’s estimate of the proportion, of the expenditures under parts A and B that are not attributable to this part, that are attributable to expenditures for physicians’ services.

“(D) APPLICATION OF PAYMENT ADJUSTMENT.—In the case that a qualifying MA organization attests that not all eligible professionals of the organization are meaningful EHR users with respect to a year, the Secretary shall apply the payment adjustment under this paragraph based on the proportion of all such eligible professionals of the organization that are not meaningful EHR users for such year.

“(5) QUALIFYING MA ORGANIZATION DEFINED.—In this subsection and subsection (m), the term ‘qualifying MA organization’ means a Medicare Advantage organization that is organized as a health maintenance organization (as defined in section 2791(b)(3) of the Public Health Service Act).

“(6) MEANINGFUL EHR USER ATTESTATION.—For purposes of this subsection and subsection (m), a qualifying MA organization shall submit an attestation, in a form and manner specified by the Secretary which may include the submission of such attestation as part of submission of the initial bid under section 1854(a)(1)(A)(iv), identifying—

“(A) whether each eligible professional described in paragraph (2), with respect to such organization is a meaningful EHR user (as defined in section 1848(o)(2)) for a year specified by the Secretary; and

“(B) whether each eligible hospital described in subsection (m)(1), with respect to such organization, is a meaningful EHR user (as defined in section 1886(n)(3)) for an applicable period specified by the Secretary.

“(7) POSTING ON WEBSITE.—The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format, a list of the names, business addresses, and business phone numbers of—

“(A) each qualifying MA organization receiving an incentive payment under this subsection for eligible professionals of the organization; and

“(B) the eligible professionals of such organization for which such incentive payment is based.

“(8) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of—

“(A) the methodology and standards for determining payment amounts and payment adjustments under this subsection, including avoiding duplication of payments under paragraph (3)(B) and the specification of rules for the fixed schedule for application of limitation on incentive payments for all eligible professionals under paragraph (3)(C);

“(B) the methodology and standards for determining eligible professionals under paragraph (2); and

“(C) the methodology and standards for determining a meaningful EHR user under section 1848(o)(2), including specification of the means of demonstrating meaningful EHR use under section 1848(o)(3)(C) and selection of measures under section 1848(o)(3)(B).”

(d) STUDY AND REPORT RELATING TO MA ORGANIZATIONS.—

(1) STUDY.—The Secretary of Health and Human Services shall conduct a study on the extent to which and manner in which payment incentives and adjustments (such as under sections 1848(o) and 1848(a)(7) of the Social Security Act) could be made available to professionals, as defined in 1861(r), who are not eligible for HIT incentive payments under section 1848(o) and receive payments for Medicare patient services nearly-exclusively through contractual arrangements with one or more Medicare Advantage organizations, or an intermediary organization or organizations with contracts with Medicare Advantage organizations. Such study shall assess approaches for measuring meaningful use of qualified EHR technology among such professionals and mechanisms for delivering incentives and adjustments to those professionals, including through incentive payments and adjustments through Medicare Advantage organizations or intermediary organizations.

(2) REPORT.—Not later than 120 days after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report on the findings and the conclusions of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(e) CONFORMING AMENDMENTS.—Section 1853 of the Social Security Act (42 U.S.C. 1395w–23) is amended—

(1) in subsection (a)(1)(A), by striking “and (i)” and inserting “(i), and (1)”;

(2) in subsection (c)—

(A) in paragraph (1)(D)(i), by striking “section 1886(h)” and inserting “sections 1848(o) and 1886(h)”;

(B) in paragraph (6)(A), by inserting after “under part B,” the following: “excluding expenditures attributable to subsections (a)(7) and (o) of section 1848,”; and

(3) in subsection (f), by inserting “and for payments under subsection (l)” after “with the organization”.

(f) CONFORMING AMENDMENTS TO E-PRESCRIBING.—

(1) Section 1848(a)(5)(A) of the Social Security Act (42 U.S.C. 1395w–4(a)(5)(A)) is amended—

(A) in clause (i), by striking “or any subsequent year” and inserting “, 2013 or 2014”; and

(B) in clause (ii), by striking “and each subsequent year”.

(2) Section 1848(m)(2) of such Act (42 U.S.C. 1395w-4(m)(2)) is amended—

(A) in subparagraph (A), by striking “For 2009” and inserting “Subject to subparagraph (D), for 2009”; and

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

“(D) LIMITATION WITH RESPECT TO EHR INCENTIVE PAYMENTS.—The provisions of this paragraph shall not apply to an eligible professional (or, in the case of a group practice under paragraph (3)(C), to the group practice) if, for the EHR reporting period the eligible professional (or group practice) receives an incentive payment under subsection (o)(1)(A) with respect to a certified EHR technology (as defined in subsection (o)(4)) that has the capability of electronic prescribing.”.

**SEC. 4102. INCENTIVES FOR HOSPITALS.**

(a) INCENTIVE PAYMENT.—

(1) IN GENERAL.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

“(n) INCENTIVES FOR ADOPTION AND MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—

“(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, with respect to inpatient hospital services furnished by an eligible hospital during a payment year (as defined in paragraph (2)(G)), if the eligible hospital is a meaningful EHR user (as determined under paragraph (3)) for the EHR reporting period with respect to such year, in addition to the amount otherwise paid under this section, there also shall be paid to the eligible hospital, from the Federal Hospital Insurance Trust Fund established under section 1817, an amount equal to the applicable amount specified in paragraph (2)(A) for the hospital for such payment year.

“(2) PAYMENT AMOUNT.—

“(A) IN GENERAL.—Subject to the succeeding subparagraphs of this paragraph, the applicable amount specified in this subparagraph for an eligible hospital for a payment year is equal to the product of the following:

“(i) INITIAL AMOUNT.—The sum of—

“(I) the base amount specified in subparagraph (B); plus

“(II) the discharge related amount specified in subparagraph (C) for a 12-month period selected by the Secretary with respect to such payment year.

“(ii) MEDICARE SHARE.—The Medicare share as specified in subparagraph (D) for the eligible hospital for a period selected by the Secretary with respect to such payment year.

“(iii) TRANSITION FACTOR.—The transition factor specified in subparagraph (E) for the eligible hospital for the payment year.

“(B) BASE AMOUNT.—The base amount specified in this subparagraph is \$2,000,000.

“(C) DISCHARGE RELATED AMOUNT.—The discharge related amount specified in this subparagraph for a 12-

month period selected by the Secretary shall be determined as the sum of the amount, estimated based upon total discharges for the eligible hospital (regardless of any source of payment) for the period, for each discharge up to the 23,000th discharge as follows:

“(i) For the first through 1,149th discharge, \$0.

“(ii) For the 1,150th through the 23,000th discharge, \$200.

“(iii) For any discharge greater than the 23,000th, \$0.

“(D) MEDICARE SHARE.—The Medicare share specified under this subparagraph for an eligible hospital for a period selected by the Secretary for a payment year is equal to the fraction—

“(i) the numerator of which is the sum (for such period and with respect to the eligible hospital) of—

“(I) the estimated number of inpatient-bed-days (as established by the Secretary) which are attributable to individuals with respect to whom payment may be made under part A; and

“(II) the estimated number of inpatient-bed-days (as so established) which are attributable to individuals who are enrolled with a Medicare Advantage organization under part C; and

“(ii) the denominator of which is the product of—

“(I) the estimated total number of inpatient-bed-days with respect to the eligible hospital during such period; and

“(II) the estimated total amount of the eligible hospital's charges during such period, not including any charges that are attributable to charity care (as such term is used for purposes of hospital cost reporting under this title), divided by the estimated total amount of the hospital's charges during such period.

Insofar as the Secretary determines that data are not available on charity care necessary to calculate the portion of the formula specified in clause (ii)(II), the Secretary shall use data on uncompensated care and may adjust such data so as to be an appropriate proxy for charity care including a downward adjustment to eliminate bad debt data from uncompensated care data. In the absence of the data necessary, with respect to a hospital, for the Secretary to compute the amount described in clause (ii)(II), the amount under such clause shall be deemed to be 1. In the absence of data, with respect to a hospital, necessary to compute the amount described in clause (i)(II), the amount under such clause shall be deemed to be 0.

“(E) TRANSITION FACTOR SPECIFIED.—

“(i) IN GENERAL.—Subject to clause (ii), the transition factor specified in this subparagraph for an eligible hospital for a payment year is as follows:

“(I) For the first payment year for such hospital, 1.

“(II) For the second payment year for such hospital,  $\frac{3}{4}$ .



“(III) For the third payment year for such hospital,  $\frac{1}{2}$ .

“(IV) For the fourth payment year for such hospital,  $\frac{1}{4}$ .

“(V) For any succeeding payment year for such hospital, 0.

“(ii) PHASE DOWN FOR ELIGIBLE HOSPITALS FIRST ADOPTING EHR AFTER 2013.—If the first payment year for an eligible hospital is after 2013, then the transition factor specified in this subparagraph for a payment year for such hospital is the same as the amount specified in clause (i) for such payment year for an eligible hospital for which the first payment year is 2013. If the first payment year for an eligible hospital is after 2015 then the transition factor specified in this subparagraph for such hospital and for such year and any subsequent year shall be 0.

“(F) FORM OF PAYMENT.—The payment under this subsection for a payment year may be in the form of a single consolidated payment or in the form of such periodic installments as the Secretary may specify.

“(G) PAYMENT YEAR DEFINED.—

“(i) IN GENERAL.—For purposes of this subsection, the term ‘payment year’ means a fiscal year beginning with fiscal year 2011.

“(ii) FIRST, SECOND, ETC. PAYMENT YEAR.—The term ‘first payment year’ means, with respect to inpatient hospital services furnished by an eligible hospital, the first fiscal year for which an incentive payment is made for such services under this subsection. The terms ‘second payment year’, ‘third payment year’, and ‘fourth payment year’ mean, with respect to an eligible hospital, each successive year immediately following the first payment year for that hospital.

“(3) MEANINGFUL EHR USER.—

“(A) IN GENERAL.—For purposes of paragraph (1), an eligible hospital shall be treated as a meaningful EHR user for an EHR reporting period for a payment year (or, for purposes of subsection (b)(3)(B)(ix), for an EHR reporting period under such subsection for a fiscal year) if each of the following requirements are met:

“(i) MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—The eligible hospital demonstrates to the satisfaction of the Secretary, in accordance with subparagraph (C)(i), that during such period the hospital is using certified EHR technology in a meaningful manner.

“(ii) INFORMATION EXCHANGE.—The eligible hospital demonstrates to the satisfaction of the Secretary, in accordance with subparagraph (C)(i), that during such period such certified EHR technology is connected in a manner that provides, in accordance with law and standards applicable to the exchange of information, for the electronic exchange of health information to improve the quality of health care, such as promoting care coordination.

“(iii) REPORTING ON MEASURES USING EHR.—Subject to subparagraph (B)(ii) and using such certified EHR technology, the eligible hospital submits information for such period, in a form and manner specified by the Secretary, on such clinical quality measures and such other measures as selected by the Secretary under subparagraph (B)(i).

The Secretary shall seek to improve the use of electronic health records and health care quality over time by requiring more stringent measures of meaningful use selected under this paragraph.

“(B) REPORTING ON MEASURES.—

“(i) SELECTION.—The Secretary shall select measures for purposes of subparagraph (A)(iii) but only consistent with the following:

“(I) The Secretary shall provide preference to clinical quality measures that have been selected for purposes of applying subsection (b)(3)(B)(viii) or that have been endorsed by the entity with a contract with the Secretary under section 1890(a).

“(II) Prior to any measure (other than a clinical quality measure that has been selected for purposes of applying subsection (b)(3)(B)(viii)) being selected under this subparagraph, the Secretary shall publish in the Federal Register such measure and provide for a period of public comment on such measure.

“(ii) LIMITATIONS.—The Secretary may not require the electronic reporting of information on clinical quality measures under subparagraph (A)(iii) unless the Secretary has the capacity to accept the information electronically, which may be on a pilot basis.

“(iii) COORDINATION OF REPORTING OF INFORMATION.—In selecting such measures, and in establishing the form and manner for reporting measures under subparagraph (A)(iii), the Secretary shall seek to avoid redundant or duplicative reporting with reporting otherwise required, including reporting under subsection (b)(3)(B)(viii).

“(C) DEMONSTRATION OF MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY AND INFORMATION EXCHANGE.—

“(i) IN GENERAL.—An eligible hospital may satisfy the demonstration requirement of clauses (i) and (ii) of subparagraph (A) through means specified by the Secretary, which may include—

“(I) an attestation;

“(II) the submission of claims with appropriate coding (such as a code indicating that inpatient care was documented using certified EHR technology);

“(III) a survey response;

“(IV) reporting under subparagraph (A)(iii);

and

“(V) other means specified by the Secretary.

“(ii) USE OF PART D DATA.—Notwithstanding sections 1860D–15(d)(2)(B) and 1860D–15(f)(2), the Secretary may use data regarding drug claims submitted for purposes of section 1860D–15 that are necessary for purposes of subparagraph (A).

“(4) APPLICATION.—

“(A) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of—

“(i) the methodology and standards for determining payment amounts under this subsection and payment adjustments under subsection (b)(3)(B)(ix), including selection of periods under paragraph (2) for determining, and making estimates or using proxies of, discharges under paragraph (2)(C) and inpatient-bed-days, hospital charges, charity charges, and Medicare share under paragraph (2)(D);

“(ii) the methodology and standards for determining a meaningful EHR user under paragraph (3), including selection of measures under paragraph (3)(B), specification of the means of demonstrating meaningful EHR use under paragraph (3)(C), and the hardship exception under subsection (b)(3)(B)(ix)(II); and

“(iii) the specification of EHR reporting periods under paragraph (6)(B) and the selection of the form of payment under paragraph (2)(F).

“(B) POSTING ON WEBSITE.—The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format, a list of the names of the eligible hospitals that are meaningful EHR users under this subsection or subsection (b)(3)(B)(ix) (and a list of the names of critical access hospitals to which paragraph (3) or (4) of section 1814(l) applies), and other relevant data as determined appropriate by the Secretary. The Secretary shall ensure that an eligible hospital (or critical access hospital) has the opportunity to review the other relevant data that are to be made public with respect to the hospital (or critical access hospital) prior to such data being made public.

“(5) CERTIFIED EHR TECHNOLOGY DEFINED.—The term ‘certified EHR technology’ has the meaning given such term in section 1848(o)(4).

“(6) DEFINITIONS.—For purposes of this subsection:

“(A) EHR REPORTING PERIOD.—The term ‘EHR reporting period’ means, with respect to a payment year, any period (or periods) as specified by the Secretary.

“(B) ELIGIBLE HOSPITAL.—The term ‘eligible hospital’ means a subsection (d) hospital.”

(2) CRITICAL ACCESS HOSPITALS.—Section 1814(l) of the Social Security Act (42 U.S.C. 1395f(l)) is amended—

(A) in paragraph (1), by striking “paragraph (2)” and inserting “the subsequent paragraphs of this subsection”; and

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

“(3)(A) The following rules shall apply in determining payment and reasonable costs under paragraph (1) for costs described in subparagraph (C) for a critical access hospital that would be a

meaningful EHR user (as would be determined under paragraph (3) of section 1886(n)) for an EHR reporting period for a cost reporting period beginning during a payment year if such critical access hospital was treated as an eligible hospital under such section:

“(i) The Secretary shall compute reasonable costs by expensing such costs in a single payment year and not depreciating such costs over a period of years (and shall include as costs with respect to cost reporting periods beginning during a payment year costs from previous cost reporting periods to the extent they have not been fully depreciated as of the period involved).

“(ii) There shall be substituted for the Medicare share that would otherwise be applied under paragraph (1) a percent (not to exceed 100 percent) equal to the sum of—

“(I) the Medicare share (as would be specified under paragraph (2)(D) of section 1886(n)) for such critical access hospital if such critical access hospital was treated as an eligible hospital under such section; and

“(II) 20 percentage points.

“(B) The payment under this paragraph with respect to a critical access hospital shall be paid through a prompt interim payment (subject to reconciliation) after submission and review of such information (as specified by the Secretary) necessary to make such payment, including information necessary to apply this paragraph. In no case may payment under this paragraph be made with respect to a cost reporting period beginning during a payment year after 2015 and in no case may a critical access hospital receive payment under this paragraph with respect to more than 4 consecutive payment years.

“(C) The costs described in this subparagraph are costs for the purchase of certified EHR technology to which purchase depreciation (excluding interest) would apply if payment was made under paragraph (1) and not under this paragraph.

“(D) For purposes of this paragraph, paragraph (4), and paragraph (5), the terms ‘certified EHR technology’, ‘eligible hospital’, ‘EHR reporting period’, and ‘payment year’ have the meanings given such terms in sections 1886(n).”.

(b) INCENTIVE MARKET BASKET ADJUSTMENT.—

(1) IN GENERAL.—Section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)) is amended—

(A) in clause (viii)(I), by inserting “(or, beginning with fiscal year 2015, by one-quarter)” after “2.0 percentage points”; and

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

“(ix)(I) For purposes of clause (i) for fiscal year 2015 and each subsequent fiscal year, in the case of an eligible hospital (as defined in subsection (n)(6)(A)) that is not a meaningful EHR user (as defined in subsection (n)(3)) for an EHR reporting period for such fiscal year, three-quarters of the applicable percentage increase otherwise applicable under clause (i) for such fiscal year shall be reduced by  $33\frac{1}{3}$  percent for fiscal year 2015,  $66\frac{2}{3}$  percent for fiscal year 2016, and 100 percent for fiscal year 2017 and each subsequent fiscal year. Such reduction shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the applicable percentage increase under clause (i) for a subsequent fiscal year.

“(II) The Secretary may, on a case-by-case basis, exempt a subsection (d) hospital from the application of subclause (I) with respect to a fiscal year if the Secretary determines, subject to annual renewal, that requiring such hospital to be a meaningful EHR user during such fiscal year would result in a significant hardship, such as in the case of a hospital in a rural area without sufficient Internet access. In no case may a hospital be granted an exemption under this subclause for more than 5 years.

“(III) For fiscal year 2015 and each subsequent fiscal year, a State in which hospitals are paid for services under section 1814(b)(3) shall adjust the payments to each subsection (d) hospital in the State that is not a meaningful EHR user (as defined in subsection (n)(3)) in a manner that is designed to result in an aggregate reduction in payments to hospitals in the State that is equivalent to the aggregate reduction that would have occurred if payments had been reduced to each subsection (d) hospital in the State in a manner comparable to the reduction under the previous provisions of this clause. The State shall report to the Secretary the methodology it will use to make the payment adjustment under the previous sentence.

“(IV) For purposes of this clause, the term ‘EHR reporting period’ means, with respect to a fiscal year, any period (or periods) as specified by the Secretary.”

(2) CRITICAL ACCESS HOSPITALS.—Section 1814(l) of the Social Security Act (42 U.S.C. 1395f(l)), as amended by subsection (a)(2), is further amended by adding at the end the following new paragraphs:

“(4)(A) Subject to subparagraph (C), for cost reporting periods beginning in fiscal year 2015 or a subsequent fiscal year, in the case of a critical access hospital that is not a meaningful EHR user (as would be determined under paragraph (3) of section 1886(n) if such critical access hospital was treated as an eligible hospital under such section) for an EHR reporting period with respect to such fiscal year, paragraph (1) shall be applied by substituting the applicable percent under subparagraph (B) for the percent described in such paragraph (1).

“(B) The percent described in this subparagraph is—

“(i) for fiscal year 2015, 100.66 percent;

“(ii) for fiscal year 2016, 100.33 percent; and

“(iii) for fiscal year 2017 and each subsequent fiscal year, 100 percent.

“(C) The provisions of subclause (II) of section 1886(b)(3)(B)(ix) shall apply with respect to subparagraph (A) for a critical access hospital with respect to a cost reporting period beginning in a fiscal year in the same manner as such subclause applies with respect to subclause (I) of such section for a subsection (d) hospital with respect to such fiscal year.

“(5) There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of—

“(A) the methodology and standards for determining the amount of payment and reasonable cost under paragraph (3) and payment adjustments under paragraph (4), including selection of periods under section 1886(n)(2) for determining, and making estimates or using proxies of, inpatient-bed-days, hospital charges, charity charges, and Medicare share under subparagraph (D) of section 1886(n)(2);

“(B) the methodology and standards for determining a meaningful EHR user under section 1886(n)(3) as would apply if the hospital was treated as an eligible hospital under section 1886(n), and the hardship exception under paragraph (4)(C);

“(C) the specification of EHR reporting periods under section 1886(n)(6)(B) as applied under paragraphs (3) and (4); and

“(D) the identification of costs for purposes of paragraph (3)(C).”

(c) APPLICATION TO CERTAIN MA-AFFILIATED ELIGIBLE HOSPITALS.—Section 1853 of the Social Security Act (42 U.S.C. 1395w-23), as amended by section 4101(c), is further amended by adding at the end the following new subsection:

“(m) APPLICATION OF ELIGIBLE HOSPITAL INCENTIVES FOR CERTAIN MA ORGANIZATIONS FOR ADOPTION AND MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—

“(1) APPLICATION.—Subject to paragraphs (3) and (4), in the case of a qualifying MA organization, the provisions of sections 1886(n) and 1886(b)(3)(B)(ix) shall apply with respect to eligible hospitals described in paragraph (2) of the organization which the organization attests under subsection (1)(6) to be meaningful EHR users in a similar manner as they apply to eligible hospitals under such sections. Incentive payments under paragraph (3) shall be made to and payment adjustments under paragraph (4) shall apply to such qualifying organizations.

“(2) ELIGIBLE HOSPITAL DESCRIBED.—With respect to a qualifying MA organization, an eligible hospital described in this paragraph is an eligible hospital (as defined in section 1886(n)(6)(A)) that is under common corporate governance with such organization and serves individuals enrolled under an MA plan offered by such organization.

“(3) ELIGIBLE HOSPITAL INCENTIVE PAYMENTS.—

“(A) IN GENERAL.—In applying section 1886(n)(2) under paragraph (1), instead of the additional payment amount under section 1886(n)(2), there shall be substituted an amount determined by the Secretary to be similar to the estimated amount in the aggregate that would be payable if payment for services furnished by such hospitals was payable under part A instead of this part. In implementing the previous sentence, the Secretary—

“(i) shall, insofar as data to determine the discharge related amount under section 1886(n)(2)(C) for an eligible hospital are not available to the Secretary, use such alternative data and methodology to estimate such discharge related amount as the Secretary determines appropriate; and

“(ii) shall, insofar as data to determine the medicare share described in section 1886(n)(2)(D) for an eligible hospital are not available to the Secretary, use such alternative data and methodology to estimate such share, which data and methodology may include use of the inpatient-bed-days (or discharges) with respect to an eligible hospital during the appropriate period which are attributable to both individuals for

whom payment may be made under part A or individuals enrolled in an MA plan under a Medicare Advantage organization under this part as a proportion of the estimated total number of patient-bed-days (or discharges) with respect to such hospital during such period.

“(B) AVOIDING DUPLICATION OF PAYMENTS.—

“(i) IN GENERAL.—In the case of a hospital that for a payment year is an eligible hospital described in paragraph (2) and for which at least one-third of their discharges (or bed-days) of Medicare patients for the year are covered under part A, payment for the payment year shall be made only under section 1886(n) and not under this subsection.

“(ii) METHODS.—In the case of a hospital that is an eligible hospital described in paragraph (2) and also is eligible for an incentive payment under section 1886(n) but is not described in clause (i) for the same payment period, the Secretary shall develop a process—

“(I) to ensure that duplicate payments are not made with respect to an eligible hospital both under this subsection and under section 1886(n); and

“(II) to collect data from Medicare Advantage organizations to ensure against such duplicate payments.

“(4) PAYMENT ADJUSTMENT.—

“(A) Subject to paragraph (3), in the case of a qualifying MA organization (as defined in section 1853(l)(5)), if, according to the attestation of the organization submitted under subsection (l)(6) for an applicable period, one or more eligible hospitals (as defined in section 1886(n)(6)(A)) that are under common corporate governance with such organization and that serve individuals enrolled under a plan offered by such organization are not meaningful EHR users (as defined in section 1886(n)(3)) with respect to a period, the payment amount payable under this section for such organization for such period shall be the percent specified in subparagraph (B) for such period of the payment amount otherwise provided under this section for such period.

“(B) SPECIFIED PERCENT.—The percent specified under this subparagraph for a year is 100 percent minus a number of percentage points equal to the product of—

“(i) the number of the percentage point reduction effected under section 1886(b)(3)(B)(ix)(I) for the period; and

“(ii) the Medicare hospital expenditure proportion specified in subparagraph (C) for the year.

“(C) MEDICARE HOSPITAL EXPENDITURE PROPORTION.—The Medicare hospital expenditure proportion under this subparagraph for a year is the Secretary’s estimate of the proportion, of the expenditures under parts A and B that are not attributable to this part, that are attributable to expenditures for inpatient hospital services.

“(D) APPLICATION OF PAYMENT ADJUSTMENT.—In the case that a qualifying MA organization attests that not all eligible hospitals are meaningful EHR users with respect to an applicable period, the Secretary shall apply the payment adjustment under this paragraph based on a methodology specified by the Secretary, taking into account the proportion of such eligible hospitals, or discharges from such hospitals, that are not meaningful EHR users for such period.

“(5) POSTING ON WEBSITE.—The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format—

“(A) a list of the names, business addresses, and business phone numbers of each qualifying MA organization receiving an incentive payment under this subsection for eligible hospitals described in paragraph (2); and

“(B) a list of the names of the eligible hospitals for which such incentive payment is based.

“(6) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of—

“(A) the methodology and standards for determining payment amounts and payment adjustments under this subsection, including avoiding duplication of payments under paragraph (3)(B);

“(B) the methodology and standards for determining eligible hospitals under paragraph (2); and

“(C) the methodology and standards for determining a meaningful EHR user under section 1886(n)(3), including specification of the means of demonstrating meaningful EHR use under subparagraph (C) of such section and selection of measures under subparagraph (B) of such section.”.

(d) CONFORMING AMENDMENTS.—

(1) Section 1814(b) of the Social Security Act (42 U.S.C. 1395f(b)) is amended—

(A) in paragraph (3), in the matter preceding subparagraph (A), by inserting “, subject to section 1886(d)(3)(B)(ix)(III),” after “then”; and

(B) by adding at the end the following: “For purposes of applying paragraph (3), there shall be taken into account incentive payments, and payment adjustments under subsection (b)(3)(B)(ix) or (n) of section 1886.”.

(2) Section 1851(i)(1) of the Social Security Act (42 U.S.C. 1395w–21(i)(1)) is amended by striking “and 1886(h)(3)(D)” and inserting “1886(h)(3)(D), and 1853(m)”.

(3) Section 1853 of the Social Security Act (42 U.S.C. 1395w–23), as amended by section 4101(d), is amended—

(A) in subsection (c)—

(i) in paragraph (1)(D)(i), by striking “1848(o)” and inserting “, 1848(o), and 1886(n)”; and

(ii) in paragraph (6)(A), by inserting “and subsections (b)(3)(B)(ix) and (n) of section 1886” after “section 1848”; and

(B) in subsection (f), by inserting “and subsection (m)” after “under subsection (l)”.



**SEC. 4103. TREATMENT OF PAYMENTS AND SAVINGS; IMPLEMENTATION FUNDING.**

**(a) PREMIUM HOLD HARMLESS.—**

(1) **IN GENERAL.**—Section 1839(a)(1) of the Social Security Act (42 U.S.C. 1395r(a)(1)) is amended by adding at the end the following: “In applying this paragraph there shall not be taken into account additional payments under section 1848(o) and section 1853(l)(3) and the Government contribution under section 1844(a)(3).”.

(2) **PAYMENT.**—Section 1844(a) of such Act (42 U.S.C. 1395w(a)) is amended—

(A) in paragraph (2), by striking the period at the end and inserting “; plus”; and

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

“(3) a Government contribution equal to the amount of payment incentives payable under sections 1848(o) and 1853(l)(3).”.

**(b) MEDICARE IMPROVEMENT FUND.**—Section 1898 of the Social Security Act (42 U.S.C. 1395iii), as added by section 7002(a) of the Supplemental Appropriations Act, 2008 (Public Law 110–252) and as amended by section 188(a)(2) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275; 122 Stat. 2589) and by section 6 of the QI Program Supplemental Funding Act of 2008, is amended—

(1) in subsection (a)—

(A) by inserting “medicare” before “fee-for-service”; and

(B) by inserting before the period at the end the following: “including, but not limited to, an increase in the conversion factor under section 1848(d) to address, in whole or in part, any projected shortfall in the conversion factor for 2014 relative to the conversion factor for 2008 and adjustments to payments for items and services furnished by providers of services and suppliers under such original medicare fee-for-service program”; and

(2) in subsection (b)—

(A) in paragraph (1), by striking “during fiscal year 2014,” and all that follows and inserting the following: “during—

“(A) fiscal year 2014, \$22,290,000,000; and

“(B) fiscal year 2020 and each subsequent fiscal year, the Secretary’s estimate, as of July 1 of the fiscal year, of the aggregate reduction in expenditures under this title during the preceding fiscal year directly resulting from the reduction in payment amounts under sections 1848(a)(7), 1853(l)(4), 1853(m)(4), and 1886(b)(3)(B)(ix).”; and

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

“(4) **NO EFFECT ON PAYMENTS IN SUBSEQUENT YEARS.**—

In the case that expenditures from the Fund are applied to, or otherwise affect, a payment rate for an item or service under this title for a year, the payment rate for such item or service shall be computed for a subsequent year as if such application or effect had never occurred.”.

**(c) IMPLEMENTATION FUNDING.**—In addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services for the Center for Medicare & Medicaid Services

Program Management Account, \$100,000,000 for each of fiscal years 2009 through 2015 and \$45,000,000 for fiscal year 2016, which shall be available for purposes of carrying out the provisions of (and amendments made by) this subtitle. Amounts appropriated under this subsection for a fiscal year shall be available until expended.

**SEC. 4104. STUDIES AND REPORTS ON HEALTH INFORMATION TECHNOLOGY.**

(a) **STUDY AND REPORT ON APPLICATION OF EHR PAYMENT INCENTIVES FOR PROVIDERS NOT RECEIVING OTHER INCENTIVE PAYMENTS.**—

(1) **STUDY.**—

(A) **IN GENERAL.**—The Secretary of Health and Human Services shall conduct a study to determine the extent to which and manner in which payment incentives (such as under title XVIII or XIX of the Social Security Act) and other funding for purposes of implementing and using certified EHR technology (as defined in section 1848(o)(4) of the Social Security Act, as added by section 4101(a)) should be made available to health care providers who are receiving minimal or no payment incentives or other funding under this Act, under title XIII of division A, under title XVIII or XIX of such Act, or otherwise, for such purposes.

(B) **DETAILS OF STUDY.**—Such study shall include an examination of—

(i) the adoption rates of certified EHR technology by such health care providers;

(ii) the clinical utility of such technology by such health care providers;

(iii) whether the services furnished by such health care providers are appropriate for or would benefit from the use of such technology;

(iv) the extent to which such health care providers work in settings that might otherwise receive an incentive payment or other funding under this Act, under title XIII of division A, under title XVIII or XIX of the Social Security Act, or otherwise;

(v) the potential costs and the potential benefits of making payment incentives and other funding available to such health care providers; and

(vi) any other issues the Secretary deems to be appropriate.

(2) **REPORT.**—Not later than June 30, 2010, the Secretary shall submit to Congress a report on the findings and conclusions of the study conducted under paragraph (1).

(b) **STUDY AND REPORT ON AVAILABILITY OF OPEN SOURCE HEALTH INFORMATION TECHNOLOGY SYSTEMS.**—

(1) **STUDY.**—

(A) **IN GENERAL.**—The Secretary of Health and Human Services shall, in consultation with the Under Secretary for Health of the Veterans Health Administration, the Director of the Indian Health Service, the Secretary of Defense, the Director of the Agency for Healthcare Research and Quality, the Administrator of the Health Resources and Services Administration, and the Chairman

of the Federal Communications Commission, conduct a study on—

- (i) the current availability of open source health information technology systems to Federal safety net providers (including small, rural providers);
- (ii) the total cost of ownership of such systems in comparison to the cost of proprietary commercial products available;
- (iii) the ability of such systems to respond to the needs of, and be applied to, various populations (including children and disabled individuals); and
- (iv) the capacity of such systems to facilitate interoperability.

(B) CONSIDERATIONS.—In conducting the study under subparagraph (A), the Secretary of Health and Human Services shall take into account the circumstances of smaller health care providers, health care providers located in rural or other medically underserved areas, and safety net providers that deliver a significant level of health care to uninsured individuals, Medicaid beneficiaries, SCHIP beneficiaries, and other vulnerable individuals.

(2) REPORT.—Not later than October 1, 2010, the Secretary of Health and Human Services shall submit to Congress a report on the findings and the conclusions of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

## Subtitle B—Medicaid Incentives

### SEC. 4201. MEDICAID PROVIDER HIT ADOPTION AND OPERATION PAYMENTS; IMPLEMENTATION FUNDING.

(a) IN GENERAL.—Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended—

(1) in subsection (a)(3)—

(A) by striking “and” at the end of subparagraph (D);

(B) by striking “plus” at the end of subparagraph (E) and inserting “and”; and

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

“(F)(i) 100 percent of so much of the sums expended during such quarter as are attributable to payments to Medicaid providers described in subsection (t)(1) to encourage the adoption and use of certified EHR technology; and

“(ii) 90 percent of so much of the sums expended during such quarter as are attributable to payments for reasonable administrative expenses related to the administration of payments described in clause (i) if the State meets the condition described in subsection (t)(9); plus”; and

(2) by inserting after subsection (s) the following new subsection:

“(t)(1) For purposes of subsection (a)(3)(F), the payments described in this paragraph to encourage the adoption and use of certified EHR technology are payments made by the State in accordance with this subsection —

“(A) to Medicaid providers described in paragraph (2)(A) not in excess of 85 percent of net average allowable costs (as defined in paragraph (3)(E)) for certified EHR technology (and support services including maintenance and training that is for, or is necessary for the adoption and operation of, such technology) with respect to such providers; and

“(B) to Medicaid providers described in paragraph (2)(B) not in excess of the maximum amount permitted under paragraph (5) for the provider involved.

“(2) In this subsection and subsection (a)(3)(F), the term ‘Medicaid provider’ means—

“(A) an eligible professional (as defined in paragraph (3)(B))—

“(i) who is not hospital-based and has at least 30 percent of the professional’s patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to individuals who are receiving medical assistance under this title;

“(ii) who is not described in clause (i), who is a pediatrician, who is not hospital-based, and who has at least 20 percent of the professional’s patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to individuals who are receiving medical assistance under this title; and

“(iii) who practices predominantly in a Federally qualified health center or rural health clinic and has at least 30 percent of the professional’s patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to needy individuals (as defined in paragraph (3)(F)); and

“(B)(i) a children’s hospital, or

“(ii) an acute-care hospital that is not described in clause (i) and that has at least 10 percent of the hospital’s patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to individuals who are receiving medical assistance under this title.

An eligible professional shall not qualify as a Medicaid provider under this subsection unless any right to payment under sections 1848(o) and 1853(l) with respect to the eligible professional has been waived in a manner specified by the Secretary. For purposes of calculating patient volume under subparagraph (A)(iii), insofar as it is related to uncompensated care, the Secretary may require the adjustment of such uncompensated care data so that it would be an appropriate proxy for charity care, including a downward adjustment to eliminate bad debt data from uncompensated care. In applying subparagraphs (A) and (B)(ii), the methodology established by the Secretary for patient volume shall include individuals enrolled in a Medicaid managed care plan (under section 1903(m) or section 1932).

“(3) In this subsection and subsection (a)(3)(F):

“(A) The term ‘certified EHR technology’ means a qualified electronic health record (as defined in 3000(13) of the Public Health Service Act) that is certified pursuant to section 3001(c)(5) of such Act as meeting standards adopted under section 3004 of such Act that are applicable to the type of record involved (as determined by the Secretary, such as an

ambulatory electronic health record for office-based physicians or an inpatient hospital electronic health record for hospitals).

“(B) The term ‘eligible professional’ means a—

“(i) physician;

“(ii) dentist;

“(iii) certified nurse mid-wife;

“(iv) nurse practitioner; and

“(v) physician assistant insofar as the assistant is practicing in a rural health clinic that is led by a physician assistant or is practicing in a Federally qualified health center that is so led.

“(C) The term ‘average allowable costs’ means, with respect to certified EHR technology of Medicaid providers described in paragraph (2)(A) for—

“(i) the first year of payment with respect to such a provider, the average costs for the purchase and initial implementation or upgrade of such technology (and support services including training that is for, or is necessary for the adoption and initial operation of, such technology) for such providers, as determined by the Secretary based upon studies conducted under paragraph (4)(C); and

“(ii) a subsequent year of payment with respect to such a provider, the average costs not described in clause (i) relating to the operation, maintenance, and use of such technology for such providers, as determined by the Secretary based upon studies conducted under paragraph (4)(C).

“(D) The term ‘hospital-based’ means, with respect to an eligible professional, a professional (such as a pathologist, anesthesiologist, or emergency physician) who furnishes substantially all of the individual’s professional services in a hospital setting (whether inpatient or outpatient) and through the use of the facilities and equipment, including qualified electronic health records, of the hospital. The determination of whether an eligible professional is a hospital-based eligible professional shall be made on the basis of the site of service (as defined by the Secretary) and without regard to any employment or billing arrangement between the eligible professional and any other provider.

“(E) The term ‘net average allowable costs’ means, with respect to a Medicaid provider described in paragraph (2)(A), average allowable costs reduced by any payment that is made to such Medicaid provider from any other source (other than under this subsection or by a State or local government) that is directly attributable to payment for certified EHR technology or support services described in subparagraph (C).

“(F) The term ‘needy individual’ means, with respect to a Medicaid provider, an individual—

“(i) who is receiving assistance under this title;

“(ii) who is receiving assistance under title XXI;

“(iii) who is furnished uncompensated care by the provider; or

“(iv) for whom charges are reduced by the provider on a sliding scale basis based on an individual’s ability to pay.

“(4)(A) With respect to a Medicaid provider described in paragraph (2)(A), subject to subparagraph (B), in no case shall—

“(i) the net average allowable costs under this subsection for the first year of payment (which may not be later than 2016), which is intended to cover the costs described in paragraph (3)(C)(i), exceed \$25,000 (or such lesser amount as the Secretary determines based on studies conducted under subparagraph (C));

“(ii) the net average allowable costs under this subsection for a subsequent year of payment, which is intended to cover costs described in paragraph (3)(C)(ii), exceed \$10,000; and

“(iii) payments be made for costs described in clause (ii) after 2021 or over a period of longer than 5 years.

“(B) In the case of Medicaid provider described in paragraph (2)(A)(ii), the dollar amounts specified in subparagraph (A) shall be  $\frac{2}{3}$  of the dollar amounts otherwise specified.

“(C) For the purposes of determining average allowable costs under this subsection, the Secretary shall study the average costs to Medicaid providers described in paragraph (2)(A) of purchase and initial implementation and upgrade of certified EHR technology described in paragraph (3)(C)(i) and the average costs to such providers of operations, maintenance, and use of such technology described in paragraph (3)(C)(ii). In determining such costs for such providers, the Secretary may utilize studies of such amounts submitted by States.

“(5)(A) In no case shall the payments described in paragraph (1)(B) with respect to a Medicaid provider described in paragraph (2)(B) exceed—

“(i) in the aggregate the product of—

“(I) the overall hospital EHR amount for the provider computed under subparagraph (B); and

“(II) the Medicaid share for such provider computed under subparagraph (C);

“(ii) in any year 50 percent of the product described in clause (i); and

“(iii) in any 2-year period 90 percent of such product.

“(B) For purposes of this paragraph, the overall hospital EHR amount, with respect to a Medicaid provider, is the sum of the applicable amounts specified in section 1886(n)(2)(A) for such provider for the first 4 payment years (as estimated by the Secretary) determined as if the Medicare share specified in clause (ii) of such section were 1. The Secretary shall establish, in consultation with the State, the overall hospital EHR amount for each such Medicaid provider eligible for payments under paragraph (1)(B). For purposes of this subparagraph in computing the amounts under section 1886(n)(2)(C) for payment years after the first payment year, the Secretary shall assume that in subsequent payment years discharges increase at the average annual rate of growth of the most recent 3 years for which discharge data are available per year.

“(C) The Medicaid share computed under this subparagraph, for a Medicaid provider for a period specified by the Secretary, shall be calculated in the same manner as the Medicare share under section 1886(n)(2)(D) for such a hospital and period, except that there shall be substituted for the numerator under clause (i) of such section the amount that is equal to the number of inpatient-bed-days (as established by the Secretary) which are attributable to individuals who are receiving medical assistance

under this title and who are not described in section 1886(n)(2)(D)(i). In computing inpatient-bed-days under the previous sentence, the Secretary shall take into account inpatient-bed-days attributable to inpatient-bed-days that are paid for individuals enrolled in a Medicaid managed care plan (under section 1903(m) or section 1932).

“(D) In no case may the payments described in paragraph (1)(B) with respect to a Medicaid provider described in paragraph (2)(B) be paid—

“(i) for any year beginning after 2016 unless the provider has been provided payment under paragraph (1)(B) for the previous year; and

“(ii) over a period of more than 6 years of payment.

“(6) Payments described in paragraph (1) are not in accordance with this subsection unless the following requirements are met:

“(A)(i) The State provides assurances satisfactory to the Secretary that amounts received under subsection (a)(3)(F) with respect to payments to a Medicaid provider are paid, subject to clause (ii), directly to such provider (or to an employer or facility to which such provider has assigned payments) without any deduction or rebate.

“(ii) Amounts described in clause (i) may also be paid to an entity promoting the adoption of certified EHR technology, as designated by the State, if participation in such a payment arrangement is voluntary for the eligible professional involved and if such entity does not retain more than 5 percent of such payments for costs not related to certified EHR technology (and support services including maintenance and training) that is for, or is necessary for the operation of, such technology.

“(B) A Medicaid provider described in paragraph (2)(A) is responsible for payment of the remaining 15 percent of the net average allowable cost.

“(C)(i) Subject to clause (ii), with respect to payments to a Medicaid provider—

“(I) for the first year of payment to the Medicaid provider under this subsection, the Medicaid provider demonstrates that it is engaged in efforts to adopt, implement, or upgrade certified EHR technology; and

“(II) for a year of payment, other than the first year of payment to the Medicaid provider under this subsection, the Medicaid provider demonstrates meaningful use of certified EHR technology through a means that is approved by the State and acceptable to the Secretary, and that may be based upon the methodologies applied under section 1848(o) or 1886(n).

“(ii) In the case of a Medicaid provider who has completed adopting, implementing, or upgrading such technology prior to the first year of payment to the Medicaid provider under this subsection, clause (i)(I) shall not apply and clause (i)(II) shall apply to each year of payment to the Medicaid provider under this subsection, including the first year of payment.

“(D) To the extent specified by the Secretary, the certified EHR technology is compatible with State or Federal administrative management systems.

For purposes of subparagraph (B), a Medicaid provider described in paragraph (2)(A) may accept payments for the costs described

in such subparagraph from a State or local government. For purposes of subparagraph (C), in establishing the means described in such subparagraph, which may include clinical quality reporting to the State, the State shall ensure that populations with unique needs, such as children, are appropriately addressed.

“(7) With respect to Medicaid providers described in paragraph (2)(A), the Secretary shall ensure coordination of payment with respect to such providers under sections 1848(o) and 1853(l) and under this subsection to assure no duplication of funding. Such coordination shall include, to the extent practicable, a data matching process between State Medicaid agencies and the Centers for Medicare & Medicaid Services using national provider identifiers. For such purposes, the Secretary may require the submission of such data relating to payments to such Medicaid providers as the Secretary may specify.

“(8) In carrying out paragraph (6)(C), the State and Secretary shall seek, to the maximum extent practicable, to avoid duplicative requirements from Federal and State governments to demonstrate meaningful use of certified EHR technology under this title and title XVIII. In doing so, the Secretary may deem satisfaction of requirements for such meaningful use for a payment year under title XVIII to be sufficient to qualify as meaningful use under this subsection. The Secretary may also specify the reporting periods under this subsection in order to carry out this paragraph.

“(9) In order to be provided Federal financial participation under subsection (a)(3)(F)(ii), a State must demonstrate to the satisfaction of the Secretary, that the State—

“(A) is using the funds provided for the purposes of administering payments under this subsection, including tracking of meaningful use by Medicaid providers;

“(B) is conducting adequate oversight of the program under this subsection, including routine tracking of meaningful use attestations and reporting mechanisms; and

“(C) is pursuing initiatives to encourage the adoption of certified EHR technology to promote health care quality and the exchange of health care information under this title, subject to applicable laws and regulations governing such exchange.

“(10) The Secretary shall periodically submit reports to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate on status, progress, and oversight of payments described in paragraph (1), including steps taken to carry out paragraph (7). Such reports shall also describe the extent of adoption of certified EHR technology among Medicaid providers resulting from the provisions of this subsection and any improvements in health outcomes, clinical quality, or efficiency resulting from such adoption.”

(b) IMPLEMENTATION FUNDING.—In addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services for the Centers for Medicare & Medicaid Services Program Management Account, \$40,000,000 for each of fiscal years 2009 through 2015 and \$20,000,000 for fiscal year 2016, which shall be available for purposes of carrying out the provisions of (and the amendments made by) this section. Amounts appropriated under this subsection for a fiscal year shall be available until expended.



## Subtitle C—Miscellaneous Medicare Provisions

### SEC. 4301. MORATORIA ON CERTAIN MEDICARE REGULATIONS.

(a) DELAY IN PHASE OUT OF MEDICARE HOSPICE BUDGET NEUTRALITY ADJUSTMENT FACTOR DURING FISCAL YEAR 2009.—Notwithstanding any other provision of law, including the final rule published on August 8, 2008, 73 Federal Register 46464 et seq., relating to Medicare Program; Hospice Wage Index for Fiscal Year 2009, the Secretary of Health and Human Services shall not phase out or eliminate the budget neutrality adjustment factor in the Medicare hospice wage index before October 1, 2009, and the Secretary shall recompute and apply the final Medicare hospice wage index for fiscal year 2009 as if there had been no reduction in the budget neutrality adjustment factor.

(b) NON-APPLICATION OF PHASED-OUT INDIRECT MEDICAL EDUCATION (IME) ADJUSTMENT FACTOR FOR FISCAL YEAR 2009.—

(1) IN GENERAL.—Section 412.322 of title 42, Code of Federal Regulations, shall be applied without regard to paragraph (c) of such section, and the Secretary of Health and Human Services shall recompute payments for discharges occurring on or after October 1, 2008, as if such paragraph had never been in effect.

(2) NO EFFECT ON SUBSEQUENT YEARS.—Nothing in paragraph (1) shall be construed as having any effect on the application of paragraph (d) of section 412.322 of title 42, Code of Federal Regulations.

(c) FUNDING FOR IMPLEMENTATION.—In addition to funds otherwise available, for purposes of implementing the provisions of subsections (a) and (b), including costs incurred in reprocessing claims in carrying out such provisions, the Secretary of Health and Human Services shall provide for the transfer from the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i) to the Centers for Medicare & Medicaid Services Program Management Account of \$2,000,000 for fiscal year 2009.

### SEC. 4302. LONG-TERM CARE HOSPITAL TECHNICAL CORRECTIONS.

(a) PAYMENT.—Subsection (c) of section 114 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173) is amended—

(1) in paragraph (1)—

(A) by amending the heading to read as follows: “DELAY IN APPLICATION OF 25 PERCENT PATIENT THRESHOLD PAYMENT ADJUSTMENT”;

(B) by striking “the date of the enactment of this Act” and inserting “July 1, 2007,”; and

(C) in subparagraph (A), by inserting “or to a long-term care hospital, or satellite facility, that as of December 29, 2007, was co-located with an entity that is a provider-based, off-campus location of a subsection (d) hospital which did not provide services payable under section 1886(d) of the Social Security Act at the off-campus location” after “freestanding long-term care hospitals”; and

(2) in paragraph (2)—

(A) in subparagraph (B)(ii), by inserting “or that is described in section 412.22(h)(3)(i) of such title” before the period; and

(B) in subparagraph (C), by striking “the date of the enactment of this Act” and inserting “October 1, 2007 (or July 1, 2007, in the case of a satellite facility described in section 412.22(h)(3)(i) of title 42, Code of Federal Regulations)”.

(b) **MORATORIUM.**—Subsection (d)(3)(A) of such section is amended by striking “if the hospital or facility” and inserting “if the hospital or facility obtained a certificate of need for an increase in beds that is in a State for which such certificate of need is required and that was issued on or after April 1, 2005, and before December 29, 2007, or if the hospital or facility”.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall be effective and apply as if included in the enactment of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173).

## **TITLE V—STATE FISCAL RELIEF**

### **SEC. 5000. PURPOSES; TABLE OF CONTENTS.**

(a) **PURPOSES.**—The purposes of this title are as follows:

(1) To provide fiscal relief to States in a period of economic downturn.

(2) To protect and maintain State Medicaid programs during a period of economic downturn, including by helping to avert cuts to provider payment rates and benefits or services, and to prevent constrictions of income eligibility requirements for such programs, but not to promote increases in such requirements.

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

#### **TITLE V—STATE FISCAL RELIEF**

Sec. 5000. Purposes; table of contents.

Sec. 5001. Temporary increase of Medicaid FMAP.

Sec. 5002. Temporary increase in DSH allotments during recession.

Sec. 5003. Extension of moratoria on certain Medicaid final regulations.

Sec. 5004. Extension of transitional medical assistance (TMA).

Sec. 5005. Extension of the qualifying individual (QI) program.

Sec. 5006. Protections for Indians under Medicaid and CHIP.

Sec. 5007. Funding for oversight and implementation.

Sec. 5008. GAO study and report regarding State needs during periods of national economic downturn.

### **SEC. 5001. TEMPORARY INCREASE OF MEDICAID FMAP.**

(a) **PERMITTING MAINTENANCE OF FMAP.**—Subject to subsections (e), (f), and (g), if the FMAP determined without regard to this section for a State for—

(1) fiscal year 2009 is less than the FMAP as so determined for fiscal year 2008, the FMAP for the State for fiscal year 2008 shall be substituted for the State’s FMAP for fiscal year 2009, before the application of this section;

(2) fiscal year 2010 is less than the FMAP as so determined for fiscal year 2008 or fiscal year 2009 (after the application of paragraph (1)), the greater of such FMAP for the State for fiscal year 2008 or fiscal year 2009 shall be substituted