

**AMENDMENT IN THE NATURE OF A SUBSTITUTE
TO H.R. 2328
OFFERED BY M . _____**

Strike all after the enacting clause and insert the following:

1 SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

2 (a) SHORT TITLE.—This Act may be cited as the
3 “Reauthorizing and Extending America’s Community
4 Health Act” or the “REACH Act”.

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

Sec. 1. Short title; table of contents.

TITLE I—PUBLIC HEALTH EXTENDERS

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

Sec. 102. Extension for special diabetes programs.

Sec. 103. Extension for Family to Family Health Information Centers.

Sec. 104. Extension of Personal Responsibility Education Program.

Sec. 105. Extension of sexual risk avoidance education program.

TITLE II—MEDICARE EXTENDERS

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

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

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

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

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

- Sec. 206. Transitional coverage and retroactive Medicare part D coverage for certain low-income beneficiaries.
- Sec. 207. Health Equity and Access for Returning Troops and Servicemembers Act of 2019.
- Sec. 208. Exclusion of complex rehabilitative manual wheelchairs from Medicare competitive acquisition program; Non-application of Medicare fee-schedule adjustments for certain wheelchair accessories and cushions.

TITLE III—MEDICAID PROVISIONS

- Sec. 301. Modification of reductions in Medicaid DSH allotments.
- Sec. 302. Public availability of hospital upper payment limit demonstrations.
- Sec. 303. Report by Comptroller General.
- Sec. 304. Sense of Congress regarding the need to develop a more permanent legislative solution to provide the territories with a reliable and consistent source of Federal funding under the Medicaid program.

TITLE IV—NO SURPRISES ACT

- Sec. 401. Short title.
- Sec. 402. Preventing surprise medical bills.
- Sec. 403. Government Accountability Office study on profit- and revenue-sharing in health care.
- Sec. 404. State All Payer Claims Databases.
- Sec. 405. Simplifying emergency air ambulance billing.
- Sec. 406. Report by Secretary of Labor.

TITLE V—TERRITORIES HEALTH CARE IMPROVEMENT ACT

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

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

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

7 (a) COMMUNITY HEALTH CENTERS.—Section
 8 10503(b)(1)(F) of the Patient Protection and Affordable
 9 Care Act (42 U.S.C. 254b–2(b)(1)(F)) is amended by

1 striking “fiscal year 2019” and inserting “each of fiscal
2 years 2019 through 2023”.

3 (b) NATIONAL HEALTH SERVICE CORPS.—Section
4 10503(b)(2)(F) of the Patient Protection and Affordable
5 Care Act (42 U.S.C. 254b–2(b)(2)(F)) is amended by
6 striking “2018 and 2019” and inserting “2019 through
7 2023”.

8 (c) TEACHING HEALTH CENTERS THAT OPERATE
9 GRADUATE MEDICAL EDUCATION PROGRAMS.—Section
10 340H(g)(1) of the Public Health Service Act (42 U.S.C.
11 256h(g)(1)) is amended by striking “2018 and 2019” and
12 inserting “2019 through 2023”.

13 (d) APPLICATION.—Amounts appropriated for a pro-
14 gram pursuant to the amendments made by subsection
15 (a), (b), or (c) for fiscal years 2020 through 2023 are sub-
16 ject to the requirements and limitations of the most re-
17 cently enacted regular or full-year continuing appropria-
18 tions Act or resolution (as of the date of obligation of cur-
19 rent funds) applicable to the respective program.

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

21 (a) REAUTHORIZATION OF SPECIAL DIABETES PRO-
22 GRAMS FOR TYPE I DIABETES.—Section 330B(b)(2)(D)
23 of the Public Health Service Act (42 U.S.C. 254c–
24 2(b)(2)(D)) is amended by striking “for each of fiscal

1 years 2018 and 2019” and inserting “fiscal years 2019
2 through 2023”.

3 (b) REAUTHORIZATION OF SPECIAL DIABETES PRO-
4 GRAMS FOR INDIANS FOR DIABETES SERVICES.—Section
5 330C(c)(2)(D) of the Public Health Service Act (42
6 U.S.C. 254c–3(c)(2)(D)) is amended by striking “fiscal
7 years 2018 and 2019” and inserting “fiscal years 2019
8 through 2023”.

9 **SEC. 103. EXTENSION FOR FAMILY TO FAMILY HEALTH IN-**
10 **FORMATION CENTERS.**

11 Section 501(c)(1)(A)(vii) of the Social Security Act
12 (42 U.S.C. 701(c)(1)(A)(vii)) is amended by striking “and
13 2019” and inserting “through 2023”.

14 **SEC. 104. EXTENSION OF PERSONAL RESPONSIBILITY EDU-**
15 **CATION PROGRAM.**

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

18 (1) in paragraphs (1)(A) and (4)(A) of sub-
19 section (a), by striking “2019” and inserting
20 “2023” each place it appears;

21 (2) in subsection (a)(4)(B)(i), by striking
22 “2019” and inserting “2023”; and

23 (3) in subsection (f), by striking “2019” and
24 inserting “2023”.

1 **SEC. 105. EXTENSION OF SEXUAL RISK AVOIDANCE EDU-**
2 **CATION PROGRAM.**

3 Section 510 of the Social Security Act (42 U.S.C.
4 710) is amended by striking “fiscal years 2018 and 2019”
5 each place it appears in subsections (a)(1), (a)(2)(A),
6 (f)(1) and (f)(2) and inserting “fiscal years 2019 through
7 2023”.

8 **TITLE II—MEDICARE**
9 **EXTENDERS**

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

12 Section 1848(e)(1)(E) of the Social Security Act (42
13 U.S.C. 1395w-4(e)(1)(E)) is amended by striking “2020”
14 and inserting “2023”.

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

17 (a) **ADDITIONAL FUNDING FOR STATE HEALTH IN-**
18 **SURANCE PROGRAMS.**—Subsection (a)(1)(B) of section
19 119 of the Medicare Improvements for Patients and Pro-
20 viders Act of 2008 (42 U.S.C. 1395b-3 note), as amended
21 by section 3306 of the Patient Protection and Affordable
22 Care Act (Public Law 111-148), section 610 of the Amer-
23 ican Taxpayer Relief Act of 2012 (Public Law 112-240),
24 section 1110 of the Pathway for SGR Reform Act of 2013
25 (Public Law 113-67), section 110 of the Protecting Ac-
26 cess to Medicare Act of 2014 (Public Law 113-93), sec-

1 tion 208 of the Medicare Access and CHIP Reauthoriza-
2 tion Act of 2015 (Public Law 114–10), and section 50207
3 of the Bipartisan Budget Act of 2018 (Public Law 115–
4 123), is amended—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 (2) by striking “and 2019.” and inserting “and
9 2019, and \$30,000,000 for each of fiscal years 2020
10 through 2022.”.

11 (b) INPUT FOR REMOVAL OF MEASURES.—Section
12 1890(b) of the Social Security Act (42 U.S.C. 1395aaa(b))
13 is amended by inserting after paragraph (3) the following:

14 “(4) REMOVAL OF MEASURES.—The entity
15 may, through the multistakeholder groups convened
16 under paragraph (7)(A), provide input to the Sec-
17 retary on quality and efficiency measures described
18 in paragraph (7)(B) that could be considered for re-
19 moval.”.

20 (c) PRIORITIZATION OF MEASURE ENDORSEMENT.—
21 Section 1890(b) of the Social Security Act (42 U.S.C.
22 1395aaa(b)), as amended by subsection (b), is further
23 amended by adding at the end the following:

24 “(9) PRIORITIZATION OF MEASURE ENDORSE-
25 MENT.—The entity—

1 “(A) during the period beginning on the
2 date of the enactment of this paragraph and
3 ending on December 31, 2023, shall prioritize
4 the endorsement of measures relating to mater-
5 nal morbidity and mortality by the entity with
6 a contract under subsection (a) in connection
7 with endorsement of measures described in
8 paragraph (2); and

9 “(B) on and after January 1, 2024, may
10 prioritize the endorsement of such measures by
11 such entity.”.

12 **SEC. 204. EXTENSION OF THE INDEPENDENCE AT HOME**
13 **MEDICAL PRACTICE DEMONSTRATION PRO-**
14 **GRAM UNDER THE MEDICARE PROGRAM.**

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

18 (b) EFFECTIVE DATE.—The amendment made by
19 subsection (a) shall take effect as if included in the enact-
20 ment of Public Law 111–148.

21 **SEC. 205. EXTENSION OF APPROPRIATIONS AND TRANS-**
22 **FERS TO THE PATIENT-CENTERED OUT-**
23 **COMES RESEARCH TRUST FUND; EXTENSION**
24 **OF CERTAIN HEALTH INSURANCE FEES.**

25 (a) IN GENERAL.—

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

3 (A) in subsection (b)(1)(E), by striking
4 “2014” and all that follows through “2019”
5 and inserting “2014 through 2022”;

6 (B) in subsection (d)(2)(A), by striking
7 “2019” and inserting “2022”; and

8 (C) in subsection (f), by striking “2019”
9 and inserting “2022”.

10 (2) TITLE XI.—Section 1183(a)(2) of the Social
11 Security Act (42 U.S.C. 1320e–2(a)(2)) is amended
12 by striking “2014” and all that follows through
13 “2019” and inserting “2014 through 2022”.

14 (b) EXTENSION OF CERTAIN HEALTH INSURANCE
15 FEES.—

16 (1) HEALTH INSURANCE POLICIES.—Section
17 4375(e) of the Internal Revenue Code of 1986 is
18 amended by striking “2019” and inserting “2022”.

19 (2) SELF-INSURED HEALTH PLANS.—Section
20 4376(e) of the Internal Revenue Code of 1986 is
21 amended by striking “2019” and inserting “2022”.

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

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

6 (1) by redesignating subsection (e) as sub-
7 section (f); and

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

10 “(e) LIMITED INCOME NEWLY ELIGIBLE TRANSI-
11 TION PROGRAM.—

12 “(1) IN GENERAL.—Beginning not later than
13 January 1, 2021, the Secretary shall carry out a
14 program to provide transitional coverage for covered
15 part D drugs for LI NET eligible individuals in ac-
16 cordance with this subsection.

17 “(2) LI NET ELIGIBLE INDIVIDUAL DEFINED.—
18 For purposes of this subsection, the term ‘LI NET
19 eligible individual’ means a part D eligible individual
20 who—

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

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

1 “(3) TRANSITIONAL COVERAGE.—For purposes
2 of this subsection, the term ‘transitional coverage’
3 means, with respect to an LI NET eligible indi-
4 vidual—

5 “(A) immediate access to covered part D
6 drugs at the point of sale during the period
7 that begins on the first day of the month such
8 individual is determined to meet the require-
9 ments of clauses (ii) and (iii) of subsection
10 (a)(3)(A) and ends on the date that coverage
11 under a prescription drug plan or MA–PD plan
12 takes effect with respect to such individual; and

13 “(B) in the case of an LI NET eligible in-
14 dividual who is a full-benefit dual eligible indi-
15 vidual (as defined in section 1935(c)(6)) or a
16 recipient of supplemental security income bene-
17 fits under title XVI, retroactive coverage (in the
18 form of reimbursement of the amounts that
19 would have been paid under this part had such
20 individual been enrolled in a prescription drug
21 plan or MA–PD plan) of covered part D drugs
22 purchased by such individual during the period
23 that begins on the date that is the later of—

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

4 “(ii) the date that is 36 months prior
5 to the date such individual enrolls in a pre-
6 scription drug plan or MA–PD plan,
7 and ends on the date that coverage under such
8 plan takes effect.

9 “(4) PROGRAM ADMINISTRATION.—

10 “(A) SINGLE POINT OF CONTACT.—The
11 Secretary shall, to the extent feasible, admin-
12 ister the program under this subsection through
13 a contract with a single program administrator.

14 “(B) BENEFIT DESIGN.—The Secretary
15 shall ensure that the transitional coverage pro-
16 vided to LI NET eligible individuals under this
17 subsection—

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

20 “(ii) permits all pharmacies deter-
21 mined by the Secretary to be in good
22 standing to process claims under the pro-
23 gram;

24 “(iii) is consistent with such require-
25 ments as the Secretary considers necessary

1 to improve patient safety and ensure ap-
2 propriate dispensing of medication; and

3 “(iv) meets such other requirements
4 as the Secretary may establish.

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

7 “(A) IN GENERAL.—The following provi-
8 sions shall not apply with respect to the pro-
9 gram under this subsection:

10 “(i) Paragraphs (1) and (3)(B) of sec-
11 tion 1860D–4(a) (relating to dissemination
12 of general information; availability of infor-
13 mation on changes in formulary through
14 the internet).

15 “(ii) Subparagraphs (A) and (B) of
16 section 1860D–4(b)(3) (relating to require-
17 ments on development and application of
18 formularies; formulary development).

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

22 “(B) WAIVER AUTHORITY.—The Secretary
23 may waive such other requirements of titles XI
24 and this title as may be necessary to carry out

1 the purposes of the program established under
2 this subsection.”.

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

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

9 (1) TRICARE ELIGIBILITY.—

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

14 “(6)(A) The requirement in paragraph (2)(A)
15 to enroll in the supplementary medical insurance
16 program under part B of title XVIII of the Social
17 Security Act (42 U.S.C. 1395j et seq.) shall not
18 apply to a person described in subparagraph (B)
19 during any month in which such person is not enti-
20 tled to a benefit described in subparagraph (A) of
21 section 226(b)(2) of the Social Security Act (42
22 U.S.C. 426(b)(2)) if such person has received the
23 counseling and information under subparagraph (C).

24 “(B) A person described in this subpara-
25 graph is a person—

1 “(i) who is under 65 years of age;

2 “(ii) who is entitled to hospital insur-
3 ance benefits under part A of title XVIII
4 of the Social Security Act pursuant to sub-
5 paragraph (A) or (C) of section 226(b)(2)
6 of such Act (42 U.S.C. 426(b)(2));

7 “(iii) whose entitlement to a benefit
8 described in subparagraph (A) of such sec-
9 tion has terminated due to performance of
10 substantial gainful activity; and

11 “(iv) who is retired under chapter 61
12 of this title.

13 “(C) The Secretary of Defense shall co-
14 ordinate with the Secretary of Health and
15 Human Services and the Commissioner of So-
16 cial Security to notify persons described in sub-
17 paragraph (B) of, and provide information and
18 counseling regarding, the effects of not enroll-
19 ing in the supplementary medical insurance
20 program under part B of title XVIII of the So-
21 cial Security Act (42 U.S.C. 1395j et seq.), as
22 described in subparagraph (A).”.

23 (B) CONFORMING AMENDMENT.—Para-
24 graph (2)(A) of such subsection is amended by

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

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

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

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

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

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

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

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

20 (B) the number of individuals who—

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

24 (ii) are entitled to hospital insurance
25 benefits under part A of title XVIII of the

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

5 (iii) because of such entitlement, are
6 no longer enrolled in TRICARE Standard,
7 TRICARE Prime, TRICARE Extra, or
8 TRICARE Select under chapter 55 of title
9 10, United States Code.

10 (4) DEPOSIT OF SAVINGS INTO MEDICARE IM-
11 PROVEMENT FUND.—Section 1898(b)(1) of the So-
12 cial Security Act (42 U.S.C. 1395iii(b)(1)) is amend-
13 ed by striking “during and after fiscal year 2021,
14 \$0” and inserting “during and after fiscal year
15 2024, \$5,000,000”.

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

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

23 (1) BENEFIT.—

1 (A) COVERAGE.—Section 1861 of the So-
2 cial Security Act (42 U.S.C. 1395x) is amend-
3 ed—

4 (i) in subsection (s)(2)—

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

7 (II) in subparagraph (HH), by
8 striking the period and inserting “;
9 and”;

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

12 “(II) a prostate cancer DNA Specimen Prove-
13 nance Assay test (DSPA test) (as defined in sub-
14 section (kkk));”;

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

17 “(kkk) PROSTATE CANCER DNA SPECIMEN PROVE-
18 NANCE ASSAY TEST.—The term ‘prostate cancer DNA
19 Specimen Provenance Assay Test’ (DSPA test) means a
20 test that, after a determination of cancer in one or more
21 prostate biopsy specimens obtained from an individual, as-
22 sesses the identity of the DNA in such specimens by com-
23 paring such DNA with the DNA that was separately taken
24 from such individual at the time of the biopsy.”.

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

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

6 (ii) in subparagraph (P), by striking
7 the semicolon at the end and inserting “,
8 and”; and

9 (iii) by adding at the end the fol-
10 lowing new subparagraph:

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

18 (2) PAYMENT AMOUNT AND RELATED REQUIRE-
19 MENTS.—Section 1834 of the Social Security Act
20 (42 U.S.C. 1395m) is amended by adding at the end
21 the following new subsection:

22 “(x) PROSTATE CANCER DNA SPECIMEN PROVE-
23 NANCE ASSAY TESTS.—

24 “(1) PAYMENT FOR COVERED TESTS.—

1 “(A) IN GENERAL.—Subject to subpara-
2 graph (B), the payment amount for a prostate
3 cancer DNA Specimen Provenance Assay test
4 (DSPA test) (as defined in section 1861(kkk))
5 shall be \$200. Such payment shall be payment
6 for all of the specimens obtained from the bi-
7 opsy furnished to an individual that are tested.

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

11 “(C) PROHIBITION ON SEPARATE PAY-
12 MENT.—No separate payment shall be made for
13 obtaining DNA that was separately taken from
14 an individual at the time of a biopsy described
15 in subparagraph (A).

16 “(2) HCPCS CODE AND MODIFIER ASSIGN-
17 MENT.—

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

23 “(B) IDENTIFICATION OF DNA MATCH ON
24 CLAIM.—The Secretary shall require an indica-
25 tion on a claim for a prostate cancer DNA

1 Specimen Provenance Assay test of whether the
2 DNA of the prostate biopsy specimens match
3 the DNA of the individual diagnosed with pros-
4 tate cancer. Such indication may be made
5 through use of a HCPCS code, a modifier, or
6 other means, as determined appropriate by the
7 Secretary.

8 “(3) DNA MATCH REVIEW.—

9 “(A) IN GENERAL.—The Secretary shall
10 review at least three years of claims under part
11 B for prostate cancer DNA Specimen Prove-
12 nance Assay tests to identify whether the DNA
13 of the prostate biopsy specimens match the
14 DNA of the individuals diagnosed with prostate
15 cancer.

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

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

1 (A) by striking “and (CC)” and inserting
2 “(CC)”; and

3 (B) by inserting before the semicolon at
4 the end the following: “, and (DD) with respect
5 to a prostate cancer DNA Specimen Provenance
6 Assay test (DSPA test) (as defined in section
7 1861(kkk)), the amount paid shall be an
8 amount equal to 80 percent of the lesser of the
9 actual charge for the test or the amount speci-
10 fied under section 1834(x)”.

11 **SEC. 208. EXCLUSION OF COMPLEX REHABILITATIVE MAN-**
12 **UAL WHEELCHAIRS FROM MEDICARE COM-**
13 **PETITIVE ACQUISITION PROGRAM; NON-AP-**
14 **PLICATION OF MEDICARE FEE-SCHEDULE**
15 **ADJUSTMENTS FOR CERTAIN WHEELCHAIR**
16 **ACCESSORIES AND CUSHIONS.**

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

21 (1) by inserting “, complex rehabilitative man-
22 ual wheelchairs (as determined by the Secretary),
23 and certain manual wheelchairs (identified, as of Oc-
24 tober 1, 2018, by HCPCS codes E1235, E1236,

1 E1237, E1238, and K0008 or any successor to such
2 codes)” after “group 3 or higher”; and

3 (2) by striking “such wheelchairs” and insert-
4 ing “such complex rehabilitative power wheelchairs,
5 complex rehabilitative manual wheelchairs, and cer-
6 tain manual wheelchairs”.

7 (b) NON-APPLICATION OF MEDICARE FEE SCHED-
8 ULE ADJUSTMENTS FOR WHEELCHAIR ACCESSORIES AND
9 SEAT AND BACK CUSHIONS WHEN FURNISHED IN CON-
10 NECTION WITH COMPLEX REHABILITATIVE MANUAL
11 WHEELCHAIRS.—

12 (1) IN GENERAL.—Notwithstanding any other
13 provision of law, the Secretary of Health and
14 Human Services shall not, during the period begin-
15 ning on January 1, 2020, and ending on December
16 31, 2020, use information on the payment deter-
17 mined under the competitive acquisition programs
18 under section 1847 of the Social Security Act (42
19 U.S.C. 1395w–3) to adjust the payment amount
20 that would otherwise be recognized under section
21 1834(a)(1)(B)(ii) of such Act (42 U.S.C.
22 1395m(a)(1)(B)(ii)) for wheelchair accessories (in-
23 cluding seating systems) and seat and back cushions
24 when furnished in connection with complex rehabili-
25 tative manual wheelchairs (as determined by the

1 Secretary), and certain manual wheelchairs (identi-
2 fied, as of October 1, 2018, by HCPCS codes
3 E1235, E1236, E1237, E1238, and K0008 or any
4 successor to such codes).

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

8 **TITLE III—MEDICAID**

9 **PROVISIONS**

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

11 **DSH ALLOTMENTS.**

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

14 (1) in clause (i), in the matter preceding sub-
15 clause (I), by striking “2020” and inserting “2022”;
16 and

17 (2) in clause (ii)—

18 (A) in subclause (I), by striking “2020”
19 and inserting “2022”; and

20 (B) in subclause (II), by striking “for each
21 of fiscal years 2021 through 2025” and insert-
22 ing “for each of fiscal years 2023 through
23 2025”.

1 **SEC. 302. PUBLIC AVAILABILITY OF HOSPITAL UPPER PAY-**
2 **MENT LIMIT DEMONSTRATIONS.**

3 Section 1903 of the Social Security Act (42 U.S.C.
4 1396b) is amended by adding at the end the following new
5 subsection:

6 “(bb) PUBLIC AVAILABILITY OF HOSPITAL UPPER
7 PAYMENT LIMIT DEMONSTRATIONS.—The Secretary shall
8 make publicly available upper payment limit demonstra-
9 tions for hospital services that a State submits with re-
10 spect to a fiscal year of the State (beginning with State
11 fiscal year 2022) to the Administrator of the Centers for
12 Medicare & Medicaid Services.”.

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

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

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

24 (2) Expenditures of a State with respect to hos-
25 pitals, including payment adjustments made under
26 such section 1923 to disproportionate share hos-

1 pitals (as defined under the State plan under title
2 XIX of such Act (42 U.S.C. 1396 et seq.) pursuant
3 to subsection (a)(1)(A) of such section 1923), upper
4 payment limit supplemental payments, and other re-
5 lated payments that hospitals may receive from the
6 State.

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

10 **SEC. 304. SENSE OF CONGRESS REGARDING THE NEED TO**
11 **DEVELOP A MORE PERMANENT LEGISLATIVE**
12 **SOLUTION TO PROVIDE THE TERRITORIES**
13 **WITH A RELIABLE AND CONSISTENT SOURCE**
14 **OF FEDERAL FUNDING UNDER THE MED-**
15 **ICAID PROGRAM.**

16 It is the sense of Congress that—

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

22 (2) as a result of these Federal funding caps,
23 which have not been adjusted over time, the terri-
24 tories continue to struggle in managing their Med-
25 icaid programs, including planning for their respec-

1 tive financial obligations and managing health care
2 services for low-income adults, children, pregnant
3 women, elderly adults, and persons with disabilities;

4 (3) to address this disparate funding treatment
5 and to provide the territories with some measure of
6 relief, Congress has had to enact legislation six
7 times in the last 15 years, including multiple tem-
8 porary increases in the Federal funding caps, higher
9 Federal medical assistance percentage rates, and bil-
10 lions of dollars in supplemental block grants;

11 (4) the supplemental funding provided to the
12 territories under this title with respect to their Med-
13 icaid programs continues Congress' commitment to
14 ensuring the sustainability of these critically impor-
15 tant programs and the people these programs serve;
16 and

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

23 **TITLE IV—NO SURPRISES ACT**

24 **SEC. 401. SHORT TITLE.**

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

1 **SEC. 402. PREVENTING SURPRISE MEDICAL BILLS.**

2 (a) COVERAGE OF EMERGENCY SERVICES.—Section
3 2719A(b) of the Public Health Service Act (42 U.S.C.
4 300gg–19a(b)) is amended—

5 (1) in paragraph (1)—

6 (A) in the matter preceding subparagraph

7 (A)—

8 (i) by striking “a group health plan,
9 or a health insurance issuer offering group
10 or individual health insurance issuer,” and
11 inserting “a health plan (as defined in sub-
12 section (e)(2)(A))”;

13 (ii) by inserting “or, for plan year
14 2021 or a subsequent plan year, with re-
15 spect to emergency services in an inde-
16 pendent freestanding emergency depart-
17 ment (as defined in paragraph (3)(D))”
18 after “emergency department of a hos-
19 pital”;

20 (iii) by striking “the plan or issuer”
21 and inserting “the plan”; and

22 (iv) by striking “paragraph (2)(B)”
23 and inserting “paragraph (3)(C)”;

24 (B) in subparagraph (B), by inserting “or
25 a participating emergency facility, as applica-
26 ble,” after “participating provider”; and

1 (C) in subparagraph (C)—

2 (i) in the matter preceding clause (i),
3 by inserting “by a nonparticipating pro-
4 vider or a nonparticipating emergency fa-
5 cility” after “enrollee”;

6 (ii) by striking clause (i);

7 (iii) by striking “(ii)(I) such services”
8 and inserting “(i) such services”;

9 (iv) by striking “where the provider of
10 services does not have a contractual rela-
11 tionship with the plan for the providing of
12 services”;

13 (v) by striking “emergency depart-
14 ment services received from providers who
15 do have such a contractual relationship
16 with the plan; and” and inserting “emer-
17 gency services received from participating
18 providers and participating emergency fa-
19 cilities with respect to such plan;”;

20 (vi) by striking “(II) if such services”
21 and all that follows through “were pro-
22 vided in-network” and inserting the fol-
23 lowing:

24 “(ii) the cost-sharing requirement (ex-
25 pressed as a copayment amount or coinsur-

1 ance rate) is not greater than the require-
2 ment that would apply if such services
3 were provided by a participating provider
4 or a participating emergency facility;” and
5 (vii) by adding at the end the fol-
6 lowing new clauses:

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

12 “(I) in the case of such services
13 furnished in a State described in
14 paragraph (3)(H)(ii), the median con-
15 tracted rate (as defined in paragraph
16 (3)(E)(i)) for such services; and

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

20 “(aa) the amount deter-
21 mined by such State for such
22 services in accordance with the
23 method described in such para-
24 graph; and

1 “(bb) the median contracted
2 rate (as so defined) for such
3 services;

4 “(iv) the health plan pays to such pro-
5 vider or facility, respectively, the amount
6 by which the recognized amount (as de-
7 fined in paragraph (3)(H)) for such serv-
8 ices exceeds the cost-sharing amount for
9 such services (as determined in accordance
10 with clauses (ii) and (iii)); and

11 “(v) any cost-sharing payments made
12 by the participant, beneficiary, or enrollee
13 with respect to such emergency services so
14 furnished shall be counted toward any in-
15 network deductible or out-of-pocket maxi-
16 mums applied under the plan in the same
17 manner as if such cost-sharing payments
18 were with respect to emergency services
19 furnished by a participating provider and a
20 participating emergency facility; and”;

21 (2) by redesignating paragraph (2) as para-
22 graph (3);

23 (3) by inserting after paragraph (1) the fol-
24 lowing new paragraph:

1 “(2) AUDIT PROCESS FOR MEDIAN CON-
2 TRACTED RATES.—Not later than July 1, 2020, the
3 Secretary shall, in consultation with appropriate
4 State agencies, establish through rulemaking a proc-
5 ess under which sponsors and issuers of health plans
6 are audited to ensure that such sponsors and issuers
7 are in compliance with the requirement of applying
8 a median contracted rate under this section that sat-
9 isfies the definition under paragraph (3)(E).”; and
10 (4) in paragraph (3), as redesignated by para-
11 graph (2) of this subsection—
12 (A) in the matter preceding subparagraph
13 (A), by inserting “and subsection (e)” after
14 “this subsection”;
15 (B) by redesignating subparagraphs (A)
16 through (C) as subparagraphs (B) through (D),
17 respectively;
18 (C) by inserting before subparagraph (B),
19 as redesignated by subparagraph (B) of this
20 paragraph, the following new subparagraph:
21 “(A) EMERGENCY DEPARTMENT OF A HOS-
22 PITAL.—The term ‘emergency department of a
23 hospital’ includes a hospital outpatient depart-
24 ment that provides emergency services.”;

1 (D) by amending subparagraph (C), as re-
2 designated by subparagraph (B) of this para-
3 graph, to read as follows:

4 “(C) EMERGENCY SERVICES.—

5 “(i) IN GENERAL.—The term ‘emer-
6 gency services’, with respect to an emer-
7 gency medical condition, means—

8 “(I) a medical screening exam-
9 ination (as required under section
10 1867 of the Social Security Act, or as
11 would be required under such section
12 if such section applied to an inde-
13 pendent freestanding emergency de-
14 partment) that is within the capability
15 of the emergency department of a hos-
16 pital or of an independent free-
17 standing emergency department, as
18 applicable, including ancillary services
19 routinely available to the emergency
20 department to evaluate such emer-
21 gency medical condition; and

22 “(II) within the capabilities of
23 the staff and facilities available at the
24 hospital or the independent free-
25 standing emergency department, as

1 applicable, such further medical exam-
2 ination and treatment as are required
3 under section 1867 of such Act, or as
4 would be required under such section
5 if such section applied to an inde-
6 pendent freestanding emergency de-
7 partment, to stabilize the patient.

8 “(ii) INCLUSION OF
9 POSTSTABILIZATION SERVICES.—For pur-
10 poses of this subsection and section 2799,
11 in the case of an individual enrolled in a
12 health plan who is furnished services de-
13 scribed in clause (i) by a provider or facil-
14 ity to stabilize such individual with respect
15 to an emergency medical condition, the
16 term ‘emergency services’ shall include
17 such items and services in addition to
18 those described in clause (i) that such a
19 provider or facility determines are needed
20 to be furnished to such individual during
21 the visit in which such individual is so sta-
22 bilized after such stabilization, unless each
23 of the following conditions are met:

24 “(I) Such a provider or facility
25 determines such individual is able to

1 travel using nonmedical transpor-
2 tation or nonemergency medical trans-
3 portation.

4 “(II) Such provider furnishing
5 such additional items and services is
6 in compliance with section 2799A(d)
7 with respect to such items and serv-
8 ices.”;

9 (E) by redesignating subparagraph (D), as
10 redesignated by subparagraph (B) of this para-
11 graph, as subparagraph (I); and

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

15 “(D) INDEPENDENT FREESTANDING
16 EMERGENCY DEPARTMENT.—The term ‘inde-
17 pendent freestanding emergency department’
18 means a facility that—

19 “(i) is geographically separate and
20 distinct and licensed separately from a hos-
21 pital under applicable State law; and

22 “(ii) provides emergency services.

23 “(E) MEDIAN CONTRACTED RATE.—

24 “(i) IN GENERAL.—The term ‘median
25 contracted rate’ means, with respect to an

1 item or service and a health plan (as de-
2 fined in subsection (e)(2)(A))—

3 “(I) for 2021, the median of the
4 negotiated rates recognized by the
5 sponsor or issuer of such plan (deter-
6 mined with respect to all such plans
7 of such sponsor or such issuer that
8 are within the same line of business)
9 as the total maximum payment (in-
10 cluding the cost-sharing amount im-
11 posed for such services (as determined
12 in accordance with clauses (ii) and
13 (iii) of paragraph (1)(C) or subpara-
14 graphs (A) and (B) of subsection
15 (e)(1), as applicable) and the amount
16 to be paid by the plan or issuer)
17 under such plans in 2019 for the
18 same or a similar item or service that
19 is provided by a provider in the same
20 or similar specialty and provided in
21 the geographic region in which the
22 item or service is furnished, consistent
23 with the methodology established by
24 the Secretary under section 402(e) of
25 the No Surprises Act, increased by

1 the percentage increase in the con-
2 sumer price index for all urban con-
3 sumers (United States city average)
4 over 2019 and 2020; and

5 “(II) for 2022 and each subse-
6 quent year, the median contracted
7 rate for the previous year, increased
8 by the percentage increase in the con-
9 sumer price index for all urban con-
10 sumers (United States city average)
11 over such previous year.

12 “(ii) SPECIAL RULE; RULE OF CON-
13 STRUCTION.—

14 “(I) CERTAIN INSURERS.—The
15 Secretary shall provide pursuant to
16 rulemaking described in section
17 402(e) of the No Surprises Act that—

18 “(aa) if the sponsor or
19 issuer of a health plan does not
20 have sufficient information to
21 calculate a median contracted
22 rate for an item or service or
23 provider type, or amount of,
24 claims for items or services (as
25 determined by the Secretary)

1 provided in a particular geo-
2 graphic area (other than in a
3 case described in item (bb)), such
4 sponsor or issuer shall dem-
5 onstrate that such sponsor or
6 issuer will use any database free
7 of conflicts of interest that has
8 sufficient information reflecting
9 allowed amounts paid to a health
10 care provider for relevant services
11 provided in the applicable geo-
12 graphic region (such as State All
13 Payer Claims Databases (as de-
14 fined in section 404(d) of such
15 Act)), and that such sponsor or
16 issuer will use any such database
17 to determine a median contracted
18 rate and cover the cost of access-
19 ing any such database; and

20 “(bb) in the case of a spon-
21 sor or issuer offering a health
22 plan in a geographic region that
23 did not offer any health plan in
24 such region during 2019, such
25 sponsor or issuer shall use a

1 methodology established by the
2 Secretary for determining the
3 median contracted rate for items
4 and services covered by such plan
5 for the first year in which such
6 plan is offered in such region,
7 and that, for each succeeding
8 year, the median contracted rate
9 for such items and services under
10 such plan shall be the median
11 contracted rate for such items
12 and services under such plan for
13 the previous year, increased by
14 the percentage increase in the
15 consumer price index for all
16 urban consumers (United States
17 city average) over such previous
18 year.

19 “(II) RULE OF CONSTRUC-
20 TION.—Nothing in this subparagraph
21 shall prevent the sponsor or issuer of
22 a health plan from establishing sepa-
23 rate calculations of a median con-
24 tracted rate under this subparagraph
25 for items and services delivered in

1 non-hospital facilities, including inde-
2 pendent freestanding emergency de-
3 partments.

4 “(F) NONPARTICIPATING EMERGENCY FA-
5 CILITY; PARTICIPATING EMERGENCY FACIL-
6 ITY.—

7 “(i) NONPARTICIPATING EMERGENCY
8 FACILITY.—The term ‘nonparticipating
9 emergency facility’ means, with respect to
10 an item or service and a health plan, an
11 emergency department of a hospital, or an
12 independent freestanding emergency de-
13 partment, that does not have a contractual
14 relationship with the plan (or, if applicable,
15 issuer offering the plan) for furnishing
16 such item or service under the plan.

17 “(ii) PARTICIPATING EMERGENCY FA-
18 CILITY.—The term ‘participating emer-
19 gency facility’ means, with respect to an
20 item or service and a health plan, an emer-
21 gency department of a hospital, or an inde-
22 pendent freestanding emergency depart-
23 ment, that has a contractual relationship
24 with the plan (or, if applicable, issuer of-

1 fering the plan) for furnishing such item
2 or service under the plan.

3 “(G) NONPARTICIPATING PROVIDERS; PAR-
4 TICIPATING PROVIDERS.—

5 “(i) NONPARTICIPATING PROVIDER.—

6 The term ‘nonparticipating provider’
7 means, with respect to an item or service
8 and a health plan, a physician or other
9 health care provider who is acting within
10 the scope of practice of that provider’s li-
11 cense or certification under applicable
12 State law and who does not have a con-
13 tractual relationship with the plan (or, if
14 applicable, issuer offering the plan) for
15 furnishing such item or service under the
16 plan.

17 “(ii) PARTICIPATING PROVIDER.—The
18 term ‘participating provider’ means, with
19 respect to an item or service and a health
20 plan, a physician or other health care pro-
21 vider who is acting within the scope of
22 practice of that provider’s license or certifi-
23 cation under applicable State law and who
24 has a contractual relationship with the
25 plan (or, if applicable, issuer offering the

1 plan) for furnishing such item or service
2 under the plan.

3 “(H) RECOGNIZED AMOUNT.—The term
4 ‘recognized amount’ means, with respect to an
5 item or service—

6 “(i) in the case of such item or service
7 furnished in a State that has in effect a
8 State law that provides for a method for
9 determining the amount of payment that is
10 required to be covered by a health plan
11 regulated by such State in the case of a
12 participant, beneficiary, or enrollee covered
13 under such plan and receiving such item or
14 service from a nonparticipating provider or
15 facility, not more than the amount deter-
16 mined in accordance with such law plus
17 the cost-sharing amount imposed under the
18 plan for such item or service (as deter-
19 mined in accordance with clauses (ii) and
20 (iii) of paragraph (1)(C) or subparagraphs
21 (A) and (B) of subsection (e)(1), as appli-
22 cable); or

23 “(ii) in the case of such item or serv-
24 ice furnished in a State that does not have
25 in effect such a law, an amount that is at

1 least the median contracted rate (as de-
2 fined in subparagraph (E)(i) and deter-
3 mined in accordance with rulemaking de-
4 scribed in section 402(e) of the No Sur-
5 prises Act) for such item or service.”.

6 (b) COVERAGE OF NON-EMERGENCY SERVICES PER-
7 FORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN
8 PARTICIPATING FACILITIES.—Section 2719A of the Pub-
9 lic Health Service Act (42 U.S.C. 300gg–19a) is amended
10 by adding at the end the following new subsection:

11 “(e) COVERAGE OF NON-EMERGENCY SERVICES PER-
12 FORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN
13 PARTICIPATING FACILITIES.—

14 “(1) IN GENERAL.—Subject to paragraph (3),
15 in the case of items or services (other than emer-
16 gency services to which subsection (b) applies) fur-
17 nished to a participant, beneficiary, or enrollee of a
18 health plan (as defined in paragraph (2)(A)) by a
19 nonparticipating provider (as defined in subsection
20 (b)(3)(G)(i)) during a visit (as defined by the Sec-
21 retary in accordance with paragraph (2)(C)) at a
22 participating health care facility (as defined in para-
23 graph (2)(B)), with respect to such plan, the plan—

24 “(A) shall not impose on such participant,
25 beneficiary, or enrollee a cost-sharing amount

1 (expressed as a copayment amount or coinsur-
2 ance rate) for such items and services so fur-
3 nished that is greater than the cost-sharing
4 amount that would apply under such plan had
5 such items or services been furnished by a par-
6 ticipating provider (as defined in subsection
7 (b)(3)(G)(ii));

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

12 “(i) in the case of such items and
13 services furnished in a State described in
14 subsection (b)(3)(H)(ii), the median con-
15 tracted rate (as defined in subsection
16 (b)(3)(E)(i)) for such items and services;
17 and

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

21 “(I) the amount determined by
22 such State for such items and services
23 in accordance with the method de-
24 scribed in such subsection; and

1 “(II) the median contracted rate
2 (as so defined) for such items and
3 services;

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

13 “(D) shall count toward any in-network
14 deductible or out-of-pocket maximums applied
15 under the plan any cost-sharing payments made
16 by the participant, beneficiary, or enrollee with
17 respect to such items and services so furnished
18 in the same manner as if such cost-sharing pay-
19 ments were with respect to items and services
20 furnished by a participating provider.

21 “(2) DEFINITIONS.—In this subsection and
22 subsection (b):

23 “(A) HEALTH PLAN.—The term ‘health
24 plan’ means a group health plan and health in-
25 surance coverage offered by a health insurance

1 issuer in the group or individual market and in-
2 cludes a grandfathered health plan (as defined
3 in section 1251(e) of the Patient Protection and
4 Affordable Care Act).

5 “(B) PARTICIPATING HEALTH CARE FACIL-
6 ITY.—

7 “(i) IN GENERAL.—The term ‘partici-
8 pating health care facility’ means, with re-
9 spect to an item or service and a health
10 plan, a health care facility described in
11 clause (ii) that has a contractual relation-
12 ship with the plan (or, if applicable, issuer
13 offering the plan) for furnishing such item
14 or service.

15 “(ii) HEALTH CARE FACILITY DE-
16 SCRIBED.—A health care facility described
17 in this clause is each of the following:

18 “(I) A hospital (as defined in
19 1861(e) of the Social Security Act).

20 “(II) A critical access hospital
21 (as defined in section 1861(mm) of
22 such Act).

23 “(III) An ambulatory surgical
24 center (as defined in section
25 1833(i)(1)(A) of such Act).

1 “(IV) A laboratory.

2 “(V) A radiology facility or imag-
3 ing center.

4 “(C) DURING A VISIT.—The term ‘during
5 a visit’ shall, with respect to items and services
6 furnished to an individual at a participating
7 health care facility, include equipment and de-
8 vices, telemedicine services, imaging services,
9 laboratory services, and such other items and
10 services as the Secretary may specify, regard-
11 less of whether or not the provider furnishing
12 such items or services is at the facility.

13 “(3) EXCEPTION.—Paragraph (1) shall not
14 apply to a health plan in the case of items or serv-
15 ices (other than emergency services to which sub-
16 section (b) applies) furnished to a participant, bene-
17 ficiary, or enrollee of a health plan (as defined in
18 paragraph (2)(A)) by a nonparticipating provider (as
19 defined in subsection (b)(3)(G)(i)) during a visit (as
20 defined by the Secretary in accordance with para-
21 graph (2)(C)) at a participating health care facility
22 (as defined in paragraph (2)(B)) if such provider is
23 in compliance with section 2799A(d) with respect to
24 such items and services.”.

1 (c) PROVIDER DIRECTORY REQUIREMENTS; DISCLO-
2 SURE ON PATIENT PROTECTIONS.—Section 2719A of the
3 Public Health Service Act, as amended by subsection (b),
4 is further amended by adding at the end the following new
5 subsections:

6 “(f) PROVIDER DIRECTORY INFORMATION REQUIRE-
7 MENTS.—

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

13 “(A) establish the verification process de-
14 scribed in paragraph (2);

15 “(B) establish the response protocol de-
16 scribed in paragraph (3);

17 “(C) establish the database described in
18 paragraph (4); and

19 “(D) include in any print directory con-
20 taining provider directory information with re-
21 spect to such plan or such coverage the infor-
22 mation described in paragraph (5).

23 “(2) VERIFICATION PROCESS.—The verification
24 process described in this paragraph is, with respect
25 to a group health plan or a health insurance issuer

1 offering group or individual health insurance cov-
2 erage, a process—

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

10 “(B) that establishes a procedure for the
11 removal of such a provider or facility with re-
12 spect to which such plan or issuer has been un-
13 able to verify such information during a period
14 specified by the plan or issuer.

15 “(3) RESPONSE PROTOCOL.—The response pro-
16 tocol described in this paragraph is, in the case of
17 an individual enrolled under a group health plan or
18 group or individual health insurance coverage of-
19 fered by a health insurance issuer who requests in-
20 formation on whether a health care provider or
21 health care facility has a contractual relationship to
22 furnish items and services under such plan or such
23 coverage, a protocol under which such plan or such
24 issuer (as applicable), in the case such request is
25 made through a telephone call—

1 “(A) responds to such individual as soon
2 as practicable and in no case later than 1 busi-
3 ness day after such call is received through a
4 written electronic communication; and

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

8 “(4) DATABASE.—The database described in
9 this paragraph is, with respect to a group health
10 plan or health insurance issuer offering group or in-
11 dividual health insurance coverage, a database on
12 the public website of such plan or issuer that con-
13 tains—

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

19 “(B) provider directory information with
20 respect to each such provider and facility.

21 “(5) INFORMATION.—The information de-
22 scribed in this paragraph is, with respect to a print
23 directory containing provider directory information
24 with respect to a group health plan or individual or
25 group health insurance coverage offered by a health

1 insurance issuer, a notification that such informa-
2 tion contained in such directory was accurate as of
3 the date of publication of such directory and that an
4 individual enrolled under such plan or such coverage
5 should consult the database described in paragraph
6 (4) with respect to such plan or such coverage or
7 contact such plan or the issuer of such coverage to
8 obtain the most current provider directory informa-
9 tion with respect to such plan or such coverage.

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

20 “(g) DISCLOSURE ON PATIENT PROTECTIONS.—
21 Each group health plan and health insurance issuer offer-
22 ing group or individual health insurance coverage shall
23 make publicly available, and (if applicable) post on a pub-
24 lic website of such plan or issuer—

25 “(1) information in plain language on—

1 “(A) the requirements and prohibitions ap-
2 plied under sections 2799 and 2799A (relating
3 to prohibitions on balance billing in certain cir-
4 cumstances);

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

18 “(C) the requirements applied under sub-
19 sections (b) and (e); and

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

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

4 **“PART D—PREVENTING CERTAIN CASES OF**
5 **BALANCE BILLING**

6 **“SEC. 2799. BALANCE BILLING IN CASES OF EMERGENCY**
7 **SERVICES.**

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

14 “(1) the emergency department of a hospital or
15 independent freestanding emergency department
16 shall not hold the participant, beneficiary, or enrollee
17 liable for a payment amount for such emergency
18 services so furnished that is more than the cost-
19 sharing amount for such services (as determined in
20 accordance with clauses (ii) and (iii) of section
21 2719A(b)(1)(C)); and

22 “(2) a health care provider shall not hold such
23 participant, beneficiary, or enrollee liable for a pay-
24 ment amount for an emergency service furnished to
25 such individual by such provider with respect to such

1 emergency medical condition and visit for which the
2 individual receives emergency services at the hospital
3 or emergency department that is more than the cost-
4 sharing amount for such services furnished by the
5 provider (as determined in accordance with clauses
6 (ii) and (iii) of section 2719A(b)(1)(C)).

7 “(b) DEFINITIONS.—In this section:

8 “(1) The terms ‘emergency department of a
9 hospital’, ‘emergency medical condition’, ‘emergency
10 services’, and ‘independent freestanding emergency
11 department’ have the meanings given such terms, re-
12 spectively, in section 2719A(b)(3).

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

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

18 **“SEC. 2799A. BALANCE BILLING IN CASES OF NON-EMER-**
19 **GENCY SERVICES PERFORMED BY NON-**
20 **PARTICIPATING PROVIDERS AT CERTAIN**
21 **PARTICIPATING FACILITIES.**

22 “(a) IN GENERAL.—Subject to subsection (b), in the
23 case of a participant, beneficiary, or enrollee with benefits
24 under a health plan (as defined in section 2799(b)) who
25 is furnished on or after January 1, 2021, items or services

1 (other than emergency services to which section 2799 ap-
2 plies) at a participating health care facility by a non-
3 participating provider, such provider shall not hold such
4 participant, beneficiary, or enrollee liable for a payment
5 amount for such an item or service furnished by such pro-
6 vider during a visit at such facility that is more than the
7 cost-sharing amount for such item or service (as deter-
8 mined in accordance with subparagraphs (A) and (B) of
9 section 2719A(e)(1)).

10 “(b) EXCEPTION.—

11 “(1) IN GENERAL.—Subsection (a) shall not
12 apply to a nonparticipating provider (other than a
13 specified provider at a participating health care fa-
14 cility), with respect to items or services furnished by
15 the provider to a participant, beneficiary, or enrollee
16 of a health plan, if the provider is in compliance
17 with the notice and consent requirements of sub-
18 section (d).

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

22 “(A) means a facility-based provider, in-
23 cluding emergency medicine providers, anes-
24 siologists, pathologists, radiologists,
25 neonatologists, assistant surgeons, hospitalists,

1 intensivists, or other providers as determined by
2 the Secretary; and

3 “(B) includes, with respect to an item or
4 service, a nonparticipating provider if there is
5 no participating provider at such facility who
6 can furnish such item or service.

7 “(c) CLARIFICATION.—In the case of a nonpartici-
8 pating provider (other than a specified provider at a par-
9 ticipating health care facility) that complies with the no-
10 tice and consent requirements of subsection (d) with re-
11 spect to an item or service (referred to in this subsection
12 as a ‘covered item or service’), such notice and consent
13 requirements may not be construed as applying with re-
14 spect to any item or service that is furnished as a result
15 of unforeseen medical needs that arise at the time such
16 covered item or service is furnished.

17 “(d) COMPLIANCE WITH NOTICE AND CONSENT RE-
18 QUIREMENTS.—

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

1 facility on behalf of such provider) or nonparticipating facility—

2
3 “(A) provides to the participant, beneficiary, or enrollee (or to an authorized representative of the participant, beneficiary, or enrollee) on the date on which the individual is furnished such items or services and, in the case that the participant, beneficiary, or enrollee makes an appointment to be furnished such items or services, on such date the appointment is made—

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

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

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

22 “(II) is signed and dated by the participant, beneficiary, or enrollee (or by an authorized representative of the participant, beneficiary, or enrollee) and, with respect to items or services

1 to be furnished by such a provider
2 that are not poststabilization services
3 described in section
4 2719A(b)(3)(C)(ii), is so signed and
5 dated not less than 72 hours prior to
6 the participant, beneficiary, or en-
7 rollee being furnished such items or
8 services by such provider; and

9 “(B) obtains from the participant, bene-
10 ficiary, or enrollee (or from such an authorized
11 representative) the consent described in para-
12 graph (3).

13 “(2) INFORMATION REQUIRED UNDER WRITTEN
14 NOTICE.—For purposes of paragraph (1)(A)(ii)(I),
15 the information described in this paragraph, with re-
16 spect to a nonparticipating provider or nonpartici-
17 pating facility and a participant, beneficiary, or en-
18 rollee of a health plan, is each of the following:

19 “(A) Notification, as applicable, that the
20 health care provider is a nonparticipating pro-
21 vider with respect to the health plan or the
22 health care facility is a nonparticipating facility
23 with respect to the health plan.

24 “(B) Notification of the estimated amount
25 that such provider or facility may charge the

1 participant, beneficiary, or enrollee for such
2 items and services involved.

3 “(C) In the case of a nonparticipating fa-
4 cility, a list of any participating providers at the
5 facility who are able to furnish such items and
6 services involved and notification that the par-
7 ticipant, beneficiary, or enrollee may be re-
8 ferred, at their option, to such a participating
9 provider.

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

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

1 efficiary, or enrollee being furnished such items
2 or services by such provider or facility;

3 “(B) acknowledges that the participant,
4 beneficiary, or enrollee has been—

5 “(i) provided with a written estimate
6 and an oral explanation of the charge that
7 the participant, beneficiary, or enrollee will
8 be assessed for the items or services antici-
9 pated to be furnished to the participant,
10 beneficiary, or enrollee by such provider or
11 facility; and

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

17 “(C) documents the consent of the partici-
18 pant, beneficiary, or enrollee to—

19 “(i) be furnished with such items or
20 services by such provider or facility; and

21 “(ii) in the case that the individual is
22 so furnished such items or services, be
23 charged an amount that may be greater
24 than the amount that would otherwise be
25 charged the individual if furnished by a

1 participating provider or participating fa-
2 cility with respect to such items or services
3 and plan.

4 “(e) RETENTION OF CERTAIN DOCUMENTS.—A non-
5 participating provider (or, in the case of a nonpartici-
6 pating provider at a participating health care facility, such
7 facility) or nonparticipating facility that obtains from a
8 participant, beneficiary, or enrollee of a health plan (or
9 an authorized representative of such participant, bene-
10 ficiary, or enrollee) a written notice in accordance with
11 subsection (c)(1)(ii), with respect to furnishing an item
12 or service to such participant, beneficiary, or enrollee,
13 shall retain such notice for at least a 2-year period after
14 the date on which such item or service is so furnished.

15 “(f) DEFINITIONS.—In this section:

16 “(1) The terms ‘nonparticipating provider’ and
17 ‘participating provider’ have the meanings given
18 such terms, respectively, in subsection (b)(3) of sec-
19 tion 2719A.

20 “(2) The terms ‘participating health care facil-
21 ity’ and ‘health plan’ have the meanings given such
22 terms, respectively, in subsection (e)(2) of section
23 2719A.

24 “(3) The term ‘nonparticipating facility’
25 means—

1 “(A) with respect to emergency services (as
2 defined in section 2719A(b)(3)(C)(i)) and a
3 health plan, an emergency department of a hos-
4 pital, or an independent freestanding emergency
5 department, that does not have a contractual
6 relationship with the plan (or, if applicable,
7 issuer offering the plan) for furnishing such
8 services under the plan; and

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

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

19 “(A) with respect to emergency services (as
20 defined in section 2719A(b)(3)(C)(i)) and a
21 health plan, an emergency department of a hos-
22 pital, or an independent freestanding emergency
23 department, that has a contractual relationship
24 with the plan (or, if applicable, issuer offering

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

3 “(B) with respect to poststabilization serv-
4 ices described in section 2719A(b)(3)(C)(ii) and
5 a health plan, an emergency department of a
6 hospital (or other department of such hospital),
7 or an independent freestanding emergency de-
8 partment, that has a contractual relationship
9 with the plan (or, if applicable, issuer offering
10 the plan) for furnishing such services under the
11 plan.

12 **“SEC. 2799B. PROVIDER REQUIREMENTS WITH RESPECT TO**
13 **PROVIDER DIRECTORY INFORMATION.**

14 “Not later than 1 year after the date of the enact-
15 ment of this section, each health care provider and health
16 care facility shall establish a process under which such
17 provider or facility transmits, to each health insurance
18 issuer offering group or individual health insurance cov-
19 erage and group health plan with which such provider or
20 facility has in effect a contractual relationship for fur-
21 nishing items and services under such coverage or such
22 plan, provider directory information (as defined in section
23 2719A(f)(6)) with respect to such provider or facility, as
24 applicable. Such provider or facility shall so transmit such

1 information to such issuer offering such coverage or such
2 group health plan—

3 “(1) when the provider or facility enters into
4 such a relationship with respect to such coverage of-
5 fered by such issuer or with respect to such plan;

6 “(2) when the provider or facility terminates
7 such relationship with respect to such coverage of-
8 fered by such issuer or with respect to such plan;

9 “(3) when there are any other material changes
10 to such provider directory information of the pro-
11 vider or facility with respect to such coverage offered
12 by such issuer or with respect to such plan; and

13 “(4) at any other time (including upon the re-
14 quest of such issuer or plan) determined appropriate
15 by the provider, facility, or the Secretary.

16 **“SEC. 2799C. PROVIDER REQUIREMENT WITH RESPECT TO**
17 **PUBLIC PROVISION OF INFORMATION.**

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

21 “(1) information in plain language on—

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

1 “(B) if provided for under applicable State
2 law, any other requirements on such provider or
3 facility regarding the amounts such provider or
4 facility may, with respect to an item or service,
5 charge a participant, beneficiary, or enrollee of
6 a health plan (as defined in section
7 2719A(e)(2)) with respect to which such pro-
8 vider or facility does not have a contractual re-
9 lationship for furnishing such item or service
10 under the plan after receiving payment from
11 the plan for such item or service and any appli-
12 cable cost-sharing payment from such partici-
13 pant, beneficiary, or enrollee; and

14 “(2) information on contacting appropriate
15 State and Federal agencies in the case that an indi-
16 vidual believes that such provider or facility has vio-
17 lated any requirement described in paragraph (1)
18 with respect to such individual.

19 **“SEC. 2799D. ENFORCEMENT.**

20 “(a) STATE ENFORCEMENT.—

21 “(1) STATE AUTHORITY.—Each State may re-
22 quire a provider or health care facility subject to the
23 requirements of sections 2799, 2799A, 2799B, or
24 2799C to satisfy such requirements applicable to the
25 provider or facility.

1 “(2) FAILURE TO IMPLEMENT REQUIRE-
2 MENTS.—In the case of a State that fails to sub-
3 stantially enforce the requirements set forth in this
4 part with respect to applicable providers and facili-
5 ties in the State, the Secretary shall enforce the re-
6 quirements of this part under subsection (b) insofar
7 as they relate to actions prohibited under this part
8 occurring in such State.

9 “(b) SECRETARIAL ENFORCEMENT AUTHORITY.—

10 “(1) IN GENERAL.—If a provider or facility is
11 found to be in violation of this part by the Sec-
12 retary, the Secretary may apply a civil monetary
13 penalty with respect to such provider or facility in
14 an amount not to exceed \$10,000 per violation. The
15 provisions of subsections (c), (d), (e), (g), (h), (k),
16 and (l) of section 1128A of the Social Security Act
17 shall apply to a civil monetary penalty or assessment
18 under this subsection in the same manner as such
19 provisions apply to a penalty, assessment, or pro-
20 ceeding under subsection (a) of such section.

21 “(2) LIMITATION.—The provisions of para-
22 graph (1) shall apply to enforcement of a provision
23 (or provisions) of this part only as provided under
24 subsection (a)(2).

1 “(3) COMPLAINT PROCESS.—The Secretary
2 shall, through rulemaking, establish a process to re-
3 ceive consumer complaints of violations of this part
4 and resolve such complaints within 60 days of re-
5 ceipt of such complaints.

6 “(4) EXCEPTION.—The Secretary shall waive
7 the penalties described under paragraph (1) with re-
8 spect to a facility or provider who does not know-
9 ingly violate, and should not have reasonably known
10 it violated, a provision of this part with respect to
11 a participant, beneficiary, or enrollee, if such facility
12 or practitioner, within 30 days of the violation, with-
13 draws the bill that was in violation of such provision
14 and reimburses the health plan or enrollee, as appli-
15 cable, in an amount equal to the difference between
16 the amount billed and the amount allowed to be
17 billed under the provision, plus interest, at an inter-
18 est rate determined by the Secretary.

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

22 “(c) CONTINUED APPLICABILITY OF STATE LAW.—
23 This part shall not be construed to supersede any provi-
24 sion of State law which establishes, implements, or con-
25 tinues in effect any requirement or prohibition except to

1 the extent that such requirement or prohibition prevents
2 the application of a requirement or prohibition of this
3 part.”.

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

8 (1) the methodology the sponsor or issuer of a
9 health plan (as defined in subsection (e) of section
10 2719A of the Public Health Service Act (42 U.S.C.
11 300gg–19a), as added by subsection (b) of this sec-
12 tion) shall use to determine the median contracted
13 rate (as defined in section 2719A(b) of such Act, as
14 amended by subsection (a) of this section), differen-
15 tiating by business line;

16 (2) the information such sponsor or issuer shall
17 share with the nonparticipating provider (as defined
18 in such section) involved when making such a deter-
19 mination; and

20 (3) the geographic regions applied for purposes
21 of subparagraph (E) of section 2719A(b)(3), as
22 amended by subsection (a) of this section.

23 Such rulemaking shall take into account payments that
24 are made by such sponsor or issuer that are not on a fee-
25 for-service basis.

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

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

7 (a) STUDY.—Not later than 1 year after the date of
8 enactment of this Act, the Comptroller General of the
9 United States shall conduct a study to—

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

14 (A) involve one or more—

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

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

22 (iii) surgical services;

23 (iv) hospitals or group purchasing or-
24 ganizations; or

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

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

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

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

15 (b) REPORT.—Not later than 1 year after the date
16 of enactment of this Act, the Comptroller General of the
17 United States shall prepare and submit a report on the
18 study conducted under subsection (a) to the Committee
19 on Health, Education, Labor, and Pensions of the Senate
20 and the Committee on Education and Labor and Com-
21 mittee on Energy and Commerce of the House of Rep-
22 resentatives.

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

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

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

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

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

11 (c) ELIGIBILITY.—To be eligible to receive a grant
12 under subsection (a), a State shall submit to the Secretary
13 an application at such time, in such manner, and con-
14 taining such information as the Secretary specifies. Such
15 information shall include, with respect to an All Payer
16 Claims Database for the State, at least specifies on how
17 the State will ensure uniform data collection through the
18 database and the security of such data submitted to and
19 maintained in the database.

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

1 (e) AUTHORIZATION OF APPROPRIATIONS.—To carry
2 out this section, there are authorized to be appropriated
3 \$50,000,000, to remain available until expended.

4 **SEC. 405. SIMPLIFYING EMERGENCY AIR AMBULANCE BILL-**
5 **ING.**

6 (a) IN GENERAL.—Providers of emergency air med-
7 ical services shall submit to a group health plan or health
8 insurance issuer offering group or individual health insur-
9 ance coverage, together with an electronic claims trans-
10 action with respect to an enrollee in such plan or coverage,
11 a description of charges for such services that are sepa-
12 rated by—

13 (1) the cost of air travel; and

14 (2) the cost of emergency medical services and
15 supplies.

16 (b) RULEMAKING.—Not later than 1 year after the
17 date of the enactment of this Act, the Secretary of Health
18 and Human Services shall determine the form and manner
19 for submitting the description of charges in subsection (a)
20 through notice and comment rulemaking.

21 (c) CIVIL MONETARY PENALTIES.—

22 (1) IN GENERAL.—A provider of emergency air
23 medical services who violates the requirement of sub-
24 section (a) shall be subject to a civil monetary pen-

1 alty of not more than \$10,000 for each act consti-
2 tuting such violation.

3 (2) PROCEDURE.—The provisions of section
4 1128A of the Social Security Act (42 U.S.C. 1320a-
5 7a), other than subsections (a) and (b) and the first
6 sentence of subsection (c)(1) of such section, shall
7 apply to civil money penalties under this subsection
8 in the same manner as such provisions apply to a
9 penalty or proceeding under section 1128A of the
10 Social Security Act.

11 (d) DEFINITIONS.—In this section, the terms “group
12 health plan”, “health insurance coverage”, and “health in-
13 surance issuer” have the meanings given such terms in
14 section 2791 of the Public Health Service Act (42 U.S.C.
15 300gg-91).

16 (e) EFFECTIVE DATE.—The requirement under sub-
17 section (a) shall take effect 6 months after the rules de-
18 scribed in subsection (b) are finalized.

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

20 Not later than one year after the date of the enact-
21 ment of this Act, and annually thereafter for each of the
22 following 5 years, the Secretary of Labor shall—

23 (1) conduct a study of—

24 (A) the effects of the provisions of, includ-
25 ing amendments made by, this Act on pre-

1 miums and out-of-pocket costs in group health
2 plans, including out-of-pocket costs that are
3 permitted by reason of compliance with section
4 2799A(d) of the Public Health Service Act, as
5 added by section 2(d);

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

8 (C) such other effects of such provisions,
9 and amendments, as the Secretary deems rel-
10 evant; and

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

16 **TITLE V—TERRITORIES HEALTH** 17 **CARE IMPROVEMENT ACT**

18 **SEC. 501. SHORT TITLE.**

19 This title may be cited as the “Territories Health
20 Care Improvement Act”.

21 **SEC. 502. MEDICAID PAYMENTS FOR PUERTO RICO AND** 22 **THE OTHER TERRITORIES FOR CERTAIN FIS-** 23 **CAL YEARS.**

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

1 (1) in paragraph (2)—

2 (A) in the matter preceding subparagraph
3 (A), by striking “subject to and section
4 1323(a)(2) of the Patient Protection and Af-
5 fordable Care Act paragraphs (3) and (5)” and
6 inserting “subject to section 1323(a)(2) of the
7 Patient Protection and Affordable Care Act and
8 paragraphs (3) and (5)”;

9 (B) in subparagraph (A)—

10 (i) by striking “Puerto Rico shall not
11 exceed the sum of” and inserting “Puerto
12 Rico shall not exceed—

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

15 (ii) by striking “\$100,000;” and in-
16 sserting “\$100,000; and”; and

17 (iii) by adding at the end the fol-
18 lowing new clause:

19 “(ii) for each of fiscal years 2020
20 through 2023, the amount specified in
21 paragraph (6) for each such fiscal year;”;

22 (C) in subparagraph (B)—

23 (i) by striking “the Virgin Islands
24 shall not exceed the sum of” and inserting
25 “the Virgin Islands shall not exceed—

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

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

5 (iii) by adding at the end the fol-
6 lowing new clause:

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

9 (D) in subparagraph (C)—

10 (i) by striking “Guam shall not exceed
11 the sum of” and inserting “Guam shall not
12 exceed—

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

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

17 (iii) by adding at the end the fol-
18 lowing new clause:

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

21 (E) in subparagraph (D)—

22 (i) by striking “the Northern Mariana
23 Islands shall not exceed the sum of” and
24 inserting “the Northern Mariana Islands
25 shall not exceed—

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

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

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

7 (F) in subparagraph (E)—

8 (i) by striking “American Samoa shall
9 not exceed the sum of” and inserting
10 “American Samoa shall not exceed—

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

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

15 (iii) by adding at the end the fol-
16 lowing new clause:

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

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

21 “(6) APPLICATION TO PUERTO RICO FOR FIS-
22 CAL YEARS 2020 THROUGH 2023.—For purposes of
23 paragraph (2)(A)(ii), the amount specified in this
24 paragraph is—

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

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

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

3 and

4 “(D) for fiscal year 2023,

5 \$3,114,331,000.”.

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

9 (1) in paragraph (1)(B), by striking “if the
10 State” and inserting “subject to paragraph (4), if
11 the State”;

12 (2) by redesignating paragraph (4) as para-
13 graph (5); and

14 (3) by inserting after paragraph (3) the fol-
15 lowing new paragraph:

16 “(4) TREATMENT OF FUNDING FOR CERTAIN
17 FISCAL YEARS.—

18 “(A) PUERTO RICO.—Notwithstanding
19 paragraph (1)(B), in the case that Puerto Rico
20 establishes and submits to the Secretary a plan
21 described in paragraph (2) with respect to any
22 of fiscal years 2020 through 2023, the amount
23 specified in paragraph (3) for Puerto Rico for
24 such a year shall be taken into account in ap-

1 plying subparagraph (A)(ii) of section
2 1108(g)(2) for such year.

3 “(B) OTHER TERRITORIES.—Notwith-
4 standing paragraph (1)(B), in the case that the
5 Virgin Islands, Guam, the Northern Mariana
6 Islands, or American Samoa establishes and
7 submits to the Secretary a plan described in
8 paragraph (2) with respect to any of fiscal
9 years 2020 through 2025, the amount specified
10 in paragraph (3) for the Virgin Islands, Guam,
11 the Northern Mariana Islands, or American
12 Samoa, as the case may be, shall be taken into
13 account in applying, as applicable, subpara-
14 graph (B)(ii), (C)(ii), (D)(ii), or (E)(ii) of sec-
15 tion 1108(g)(2) for such year.”.

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

18 (1) in subsection (b), by striking “and (aa)”
19 and inserting “(aa), and (ff)”; and

20 (2) by adding at the end the following new sub-
21 section:

22 “(ff) TEMPORARY INCREASE IN FMAP FOR TERRI-
23 TORIES FOR CERTAIN FISCAL YEARS.—

1 “(1) PUERTO RICO.—Notwithstanding sub-
2 section (b), the Federal medical assistance percent-
3 age for Puerto Rico shall be equal to—

4 “(A) 83 percent for fiscal years 2020 and
5 2021; and

6 “(B) 76 percent for fiscal years 2022 and
7 2023.

8 “(2) VIRGIN ISLANDS.—Notwithstanding sub-
9 section (b), the Federal medical assistance percent-
10 age for the Virgin Islands shall be equal to—

11 “(A) 100 percent for fiscal year 2020;

12 “(B) 83 percent for fiscal years 2021
13 through 2024; and

14 “(C) 76 percent for fiscal year 2025.

15 “(3) OTHER TERRITORIES.—Notwithstanding
16 subsection (b), the Federal medical assistance per-
17 centage for Guam, the Northern Mariana Islands,
18 and American Samoa shall be equal to—

19 “(A) 100 percent for fiscal years 2020 and
20 2021;

21 “(B) 83 percent for fiscal years 2022
22 through 2024; and

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

24 (d) ANNUAL REPORT.—Section 1108(g) of the Social
25 Security Act (42 U.S.C. 1308(g)), as amended by sub-

1 section (a), is further amended by adding at the end the
2 following new paragraph:

3 “(7) ANNUAL REPORT.—

4 “(A) IN GENERAL.—Not later than the
5 date that is 30 days after the end of each fiscal
6 year (beginning with fiscal year 2020 and end-
7 ing with fiscal year 2025), in the case that a
8 specified territory receives a Medicaid cap in-
9 crease, or an increase in the Federal medical
10 assistance percentage for such territory under
11 section 1905(ff), for such fiscal year, such terri-
12 tory shall submit to the Chair and Ranking
13 Member of the Committee on Energy and Com-
14 merce of the House of Representatives and the
15 Chair and Ranking Member of the Committee
16 on Finance of the Senate a report that de-
17 scribes how such territory has used such Med-
18 icaid cap increase, or such increase in the Fed-
19 eral medical assistance percentage, as applica-
20 ble, to increase access to health care under the
21 State Medicaid plan of such territory under title
22 XIX (or a waiver of such plan). Such report
23 may include—

1 “(i) the extent to which such territory
2 has, with respect to such plan (or waiv-
3 er)—

4 “(I) increased payments to health
5 care providers;

6 “(II) increased covered benefits;

7 “(III) expanded health care pro-
8 vider networks; or

9 “(IV) improved in any other
10 manner the carrying out of such plan
11 (or waiver); and

12 “(ii) any other information as deter-
13 mined necessary by such territory.

14 “(B) DEFINITIONS.—In this paragraph:

15 “(i) MEDICAID CAP INCREASE.—The
16 term ‘Medicaid cap increase’ means, with
17 respect to a specified territory and fiscal
18 year, any increase in the amounts other-
19 wise determined under this subsection for
20 such territory for such fiscal year by rea-
21 son of the amendments made by section
22 502(a) of the Territories Health Care Im-
23 provement Act.

24 “(ii) SPECIFIED TERRITORY.—The
25 term ‘specified territory’ means Puerto

1 Rico, the Virgin Islands, Guam, the North-
2 ern Mariana Islands, and American
3 Samoa.”.

4 **SEC. 503. APPLICATION OF CERTAIN REQUIREMENTS**
5 **UNDER MEDICAID PROGRAM TO CERTAIN**
6 **TERRITORIES.**

7 (a) APPLICATION OF PAYMENT ERROR RATE MEAS-
8 UREMENT REQUIREMENTS TO PUERTO RICO.—Section
9 1903(u)(4) of the Social Security Act (42 U.S.C.
10 1396b(u)(4)) is amended—

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

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

16 (b) APPLICATION OF ASSET VERIFICATION PROGRAM
17 REQUIREMENTS TO PUERTO RICO AND VIRGIN IS-
18 LANDS.—Section 1940(a) of the Social Security Act (42
19 U.S.C. 1396w(a)) is amended—

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

22 “(iii) IMPLEMENTATION IN PUERTO
23 RICO AND VIRGIN ISLANDS.—The Sec-
24 retary shall require Puerto Rico to imple-
25 ment an asset verification program under

1 this subsection by the end of fiscal year
2 2022 and the Virgin Islands to implement
3 such a program by the end of fiscal year
4 2023.”; and

5 (2) in paragraph (4)—

6 (A) in the paragraph heading, by striking
7 “EXEMPTION OF TERRITORIES” and inserting
8 “EXEMPTION OF CERTAIN TERRITORIES”; and

9 (B) by striking “and the District of Co-
10 lumbia” and inserting “, the District of Colum-
11 bia, Puerto Rico, and the Virgin Islands”.

12 (c) APPLICATION OF CERTAIN DATA REPORTING
13 AND PROGRAM INTEGRITY REQUIREMENTS TO NORTH-
14 ERN MARIANA ISLANDS, AMERICAN SAMOA, AND GUAM.—

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

18 “(qq) APPLICATION OF CERTAIN DATA REPORTING
19 AND PROGRAM INTEGRITY REQUIREMENTS TO NORTH-
20 ERN MARIANA ISLANDS, AMERICAN SAMOA, AND GUAM.—

21 Not later than October 1, 2023, the Northern Mariana
22 Islands, American Samoa, and Guam shall—

23 “(1) implement methods, satisfactory to the
24 Secretary, for the collection and reporting of reliable
25 data to the Transformed Medicaid Statistical Infor-

1 mation System (T-MSIS) (or a successor system);
2 and

3 “(2) demonstrate progress in establishing a
4 State medicaid fraud control unit described in sec-
5 tion 1903(q).”.

6 (2) CONFORMING AMENDMENT.—Section
7 1902(j) of the Social Security Act (42 U.S.C.
8 1396a(j)) is amended—

9 (A) by striking “or the requirement” and
10 inserting “, the requirement”; and

11 (B) by inserting before the period at the
12 end the following: “, or the requirements under
13 subsection (qq) (relating to data reporting and
14 program integrity)”.

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

