



ITUP

INSURE THE UNINSURED
PROJECT

Section-by-Section Guide to Health Reform:
H.R. 3590 – The Patient Protection and Affordable Care Act
and
H.R. 4872 – The Health Care and Education Reconciliation Act

April 12, 2010

Note: All amendments contained in the reconciliation bill and title X of H.R. 3590 are applied throughout this document.

Insure the Uninsured Project
2444 Wilshire Blvd., Suite 412
Santa Monica, CA 90403
310.828.0338
www.itup.org | info@itup.org

Table of Contents

TITLE I: QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS	5
<hr/>	
SUBTITLE A: IMMEDIATE IMPROVEMENTS IN HEALTH CARE COVERAGE FOR ALL AMERICANS	5
SUBTITLE B: IMMEDIATE ACTION TO MAKE COVERAGE MORE AFFORDABLE AND MORE AVAILABLE	6
SUBTITLE C: QUALITY HEALTH INSURANCE COVERAGE FOR ALL AMERICANS	6
PART I – HEALTH INSURANCE MARKET REFORMS	6
PART II – OTHER PROVISIONS	7
SUBTITLE D: AVAILABLE COVERAGE FOR ALL AMERICANS	7
PART I – ESTABLISHMENT OF QUALIFIED HEALTH PLANS	7
PART II – CONSUMER CHOICES AND INSURANCE COMPETITION THROUGH HEALTH BENEFIT EXCHANGES	8
PART III – STATE FLEXIBILITY RELATING TO EXCHANGES	8
PART IV – STATE FLEXIBILITY TO ESTABLISH ALTERNATE PROGRAMS	9
PART V – REINSURANCE AND RISK ADJUSTMENT	9
SUBTITLE E: AFFORDABLE COVERAGE CHOICES FOR ALL AMERICANS	10
PART I – PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS	10
PART II – SMALL BUSINESS TAX CREDIT	11
SUBTITLE F – SHARED RESPONSIBILITY FOR HEALTH CARE	11
PART I: INDIVIDUAL RESPONSIBILITY	11
PART II – EMPLOYER RESPONSIBILITIES	12
SUBTITLE G – MISCELLANEOUS PROVISIONS	13
TITLE II – ROLE OF PUBLIC PROGRAMS	15
<hr/>	
SUBTITLE A – IMPROVED ACCESS TO MEDICAID	15
SUBTITLE B – ENHANCED SUPPORT FOR THE CHILDREN’S HEALTH INSURANCE PROGRAM	16
SUBTITLE C – MEDICAID AND CHIP ENROLLMENT SIMPLIFICATION	17
SUBTITLE D – IMPROVEMENTS TO MEDICAID SERVICES	17
SUBTITLE E – NEW OPTIONS FOR STATES TO PROVIDE LONG-TERM SERVICES AND SUPPORTS	17
SUBTITLE F – MEDICAID PRESCRIPTION DRUG COVERAGE	18
SUBTITLE G – MEDICAID DISPROPORTIONATE SHARE HOSPITAL PAYMENTS	18
SUBTITLE H – IMPROVED COORDINATION FOR DUAL ELIGIBLE BENEFICIARIES.	19
SUBTITLE I – IMPROVING THE QUALITY OF MEDICAID FOR PATIENTS AND PROVIDERS	19
SUBTITLE J – IMPROVEMENTS TO THE MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION (MACPAC).	20
SUBTITLE K – PROTECTIONS FOR AMERICAN INDIAN AND ALASKA NATIVES	20
SUBTITLE L – MATERNAL AND CHILD HEALTH SERVICES	20
TITLE III: IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE	21
<hr/>	
SUBTITLE A—TRANSFORMING THE HEALTH CARE DELIVERY SYSTEM	21
PART I: LINKING PAYMENT TO QUALITY OUTCOMES UNDER THE MEDICARE PROGRAM	21
PART II: NATIONAL STRATEGY TO IMPROVE HEALTH CARE QUALITY	23
PART III: ENCOURAGING DEVELOPMENT OF NEW PATIENT CARE MODEL	25
SUBTITLE B—IMPROVING MEDICARE FOR PATIENTS AND PROVIDERS	28
PART I: ENSURING BENEFICIARY ACCESS TO PHYSICIAN CARE AND OTHER SERVICES	28
PART II—RURAL PROTECTIONS	29

PART III—IMPROVING PATIENT ACCURACY	30
SUBTITLE C—PROVISIONS RELATED TO PART C	32
SUBTITLE D—MEDICARE PART D IMPROVEMENTS FOR PRESCRIPTION DRUG PLANS AND MA-PD PLANS	33
SUBTITLE E—ENSURING MEDICARE SUSTAINABILITY	34
SUBTITLE F – HEALTH CARE QUALITY IMPROVEMENTS	35
SUBTITLE G – PROTECTING AND IMPROVING GUARANTEED MEDICARE BENEFITS	39
<u>TITLE IV – PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH</u>	<u>39</u>
SUBTITLE A – MODERNIZING DISEASE PREVENTION AND PUBLIC HEALTH SYSTEMS	39
SUBTITLE B – INCREASING ACCESS TO CLINICAL PREVENTIVE SERVICES	41
SUBTITLE C – CREATING HEALTHIER COMMUNITIES	44
SUBTITLE D – SUPPORT FOR PREVENTION AND PUBLIC HEALTH INNOVATION	45
SUBTITLE E – MISCELLANEOUS PROVISIONS	45
<u>TITLE V – HEALTH CARE WORKFORCE</u>	<u>46</u>
SUBTITLE A – PURPOSE AND DEFINITIONS	46
SUBTITLE B – INNOVATIONS IN THE HEALTH CARE WORKFORCE	46
SUBTITLE C – INCREASING THE SUPPLY OF THE HEALTH CARE WORKFORCE	46
SUBTITLE D – ENHANCING HEALTH CARE WORKFORCE EDUCATION AND TRAINING	47
SUBTITLE E – SUPPORTING THE EXISTING HEALTH CARE WORKFORCE	49
SUBTITLE F – STRENGTHENING PRIMARY CARE AND OTHER WORKFORCE IMPROVEMENTS	50
SUBTITLE G – IMPROVING ACCESS TO HEALTH CARE SERVICES	51
SUBTITLE H – GENERAL PROVISIONS	52
<u>TITLE VI – TRANSPARENCY AND PROGRAM INTEGRITY</u>	<u>52</u>
SUBTITLE A – PHYSICIAN OWNERSHIP AND OTHER TRANSPARENCY	52
SUBTITLE B – NURSING HOME TRANSPARENCY AND IMPROVEMENT	53
PART I – IMPROVING TRANSPARENCY OF INFORMATION	53
PART II – TARGETING ENFORCEMENT	54
PART III – IMPROVING STAFF TRAINING	54
SUBTITLE D – PATIENT-CENTERED OUTCOMES RESEARCH	54
SUBTITLE E – MEDICARE, MEDICAID, AND CHIP PROGRAM INTEGRITY PROVISIONS	54
SUBTITLE G – ADDITIONAL PROGRAM INTEGRITY PROVISIONS	57
SUBTITLE H – ELDER JUSTICE ACT	57
SUBTITLE I – SENSE OF THE SENATE REGARDING MEDICAL MALPRACTICE	58
<u>TITLE VII: IMPROVING ACCESS TO INNOVATIVE MEDICAL THERAPIES</u>	<u>58</u>
SUBTITLE A – BIOLOGICS PRICE COMPETITION AND INNOVATION	58
SUBTITLE B – MORE AFFORDABLE MEDICINES FOR CHILDREN AND UNDERSERVED COMMUNITIES	58
<u>TITLE VIII – COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS</u>	<u>58</u>

<u>TITLE IX – REVENUE PROVISIONS</u>	<u>58</u>
SUBTITLE A – REVENUE OFFSET PROVISIONS	58
SUBTITLE B – OTHER PROVISIONS	61
<u>TITLE X – STRENGTHENING QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS</u>	<u>61</u>

TITLE I: Quality, affordable health care for all Americans

Subtitle A: Immediate improvements in health care coverage for all Americans

§1001: amendments to the Public Health Service Act

- §2711: no lifetime or annual limits
 - Prohibits establishment of lifetime and annual limits after enactment
- §2712: prohibition on rescissions
 - Cannot rescind coverage except in instances of fraud or misrepresentation
- §2713: coverage of preventative health services
 - Requires plans to cover recommended preventative services/immunizations, child preventative services and women's preventative care/screening without cost-sharing
- §2714: extension of dependent coverage
 - Requires plans offering dependent coverage to allow unmarried individuals until age 26 to remain on parents' insurance
- §2715: development and utilization of uniform explanation of coverage documents and standardized definitions
 - Secretary to develop uniform and easily understandable standards
 - Includes definitions of standard insurance and medical terms
- §2715A: provision of additional information
 - Requires all plans to disclose information required in section 1311(e)
- §2716: prohibition of discrimination in favor of highly compensated individuals
- §2717: ensuring quality of care
 - Secretary of HHS shall develop reporting requirements for use by health plans and health insurers
 - Improve Health Outcomes: quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives.
 - Reduce / prevent hospital readmissions
 - Improve patient safety
 - Implement wellness and health promotion activities
 - Smoking cessation, weight and stress management, physical fitness, nutrition, heart disease prevention, healthy lifestyle support, and diabetes prevention.
 - Protects 2nd Amendment gun rights by precluding collection/disclosure of gun ownership information to determine premium rates
- §2718: bringing down the cost of health care coverage
 - Requires plans offering coverage in group/individual markets to report to Secretary the amount of premium revenue spent on clinical services, activities to improve quality and other non-claims costs
 - Beginning in 2011: large groups plans that spend <85% of premium revenue and small group/individual market plans that spend <80% of premium revenue on clinical services and quality must provide rebate to enrollees
 - Each US hospital to publish list of standard charges for items/services provided
- §2719: appeals process
 - Requires effective internal appeals process for coverage determinations + claims; if state does not have external review process, the plan implements one that meets minimum standards by Secretary
- §2719A: patient protections
 - Requires that enrollee be allowed to select PCP (or pediatrician for child) from any available participating PCPs
 - Precludes need for prior authorization or increased cost-sharing for emergency services or for patient seeking coverage for obstetrical/gynecological care by a specialist

§1002: health insurance consumer information

- Secretary to award grants to States for establishing, expanding or providing support for independent office of insurance consumer assistance/ombudsman programs
 - Provides \$30 million in funding

§1003: ensuring consumers get value for their dollars

- Secretary and states must annually review premium increases
- Provides \$250 million to states from 2010-2014 for reviewing/approving premium increases

§1004: ensuring that consumers get value for their dollars

- §1001 effective 6 months after enactment
- §1002 and 1003 effective upon date of enactment

§1005: Implementation funding

- Establishes Health Insurance Reform Implementation Fund
- Designates \$1 billion to the Secretary of Health and Human Services to finance the administrative costs of implementing health insurance reform

Subtitle B: Immediate action to make coverage more affordable and more available

§1101: immediate access to insurance for people with a preexisting condition

- Enacts temporary insurance program with financial assistance for uninsured with pre-existing condition
- Limits premium rates for newly insured
- Up to \$5 billion for this program, which terminates when Exchange is operational in 2014

§1102: reinsurance for early retirees

- Temporary reinsurance program for reimbursing participating employment-based plans (includes state and local government sponsored plans)
- Reimburses participating plans for 80% of cost of benefits in excess of \$15,000 and below \$90,000
- \$5 billion appropriated for fund

§1103: immediate information that allows consumers to identify affordable coverage options

- Establishes internet portal for easy access to affordable and comprehensive coverage options, including eligibility, availability, premium rates, cost sharing and percentage of total premium revenue spent on health care

§1104: administrative simplification

- Accelerates HHS adoption of uniform standards and operation rules for electronic transactions governed under HIPAA
- Requires health plans to certify compliance or face \$ penalties collected by Treasury Secretary

§1105: effective dates

- All sections in subtitle B effective upon enactment

Subtitle C: Quality health insurance coverage for all Americans

Part I – Health insurance market reforms

§1201: Amendment to the Public Health Service Act

- §2701: fair health insurance premiums
 - Individual/small group market premiums can only vary by family structure, geography, AV (actuarial value) of benefit, age (limited to ratio of 3:1) and tobacco use (limited to ratio of 5:1)
- §2702: guaranteed availability of coverage

- Each insurer must accept every employer and individual in the State that applies for coverage; permits annual/special open enrollment periods for those with qualifying lifetime events
- §2703: guaranteed renewability of coverage
 - Guaranteed regardless of health status, utilization of services, etc.
- §2704: prohibition of pre-existing condition exclusions or other discrimination based on health status
 - Cannot discriminate based on pre-existing condition or previous sicknesses
- §2705: prohibiting discrimination against individual participants and beneficiaries based on health status
 - No group health plan or individual/group insurer can set eligibility rules based on health status, medical condition, claims experience, receipt of care, medical history, genetic info, evidence of insurability (e.g. domestic violence, disability)
 - Employers can vary employee share of premiums by as much as 30% for employee participation in health promotion/disease prevention programs
- §2706: non-discrimination in health care
- §2707: comprehensive health insurance coverage
 - Small group/individual plan issuers to include coverage that incorporates defined essential benefits; provides specified AV
 - Compliance with limitations on allowable cost-sharing
- §2708: prohibition on excessive waiting periods
 - Prohibits waiting periods for group coverage that exceeds 90 days; no waiting periods apply to individual market
- §2709: coverage for individuals participating in approved clinical trials
 - Prohibits insurers from dropping coverage for individuals who choose to participate in clinical trials, including those that treat cancer or other life-threatening diseases

Part II – Other provisions

§1251: preservation of right to maintain existing coverage

- Any individual enrolled in any form of insurance is entitled to maintain coverage as it existed on date of enactment

§1252: rating reforms must apply uniformly to all health insurance issuers and group health plans

- Standards/requirements adopted by states must be applied uniformly to all plans in each relevant insurance market

§1253: annual report on self-insured plans

- Secretary of Labor to prepare annual report on self-insured group health plans

§1254: study of large group market

- Secretary of HHS to conduct study of fully-insured and self-insured group health plan markets

§1255: effective dates

- All provisions in this subtitle take effect on Jan 1, 2014
- Grandfathering takes effect on day of enactment and applies prohibition of pre-existing condition exclusion for children effective 6 months after enactment

Subtitle D: Available coverage for all Americans

Part I – Establishment of qualified health plans

§1301: qualified health plan defined

- Qualified health plans to be certified by Exchanges, provide essential health benefits package and be offered by licensed insurers that offer at least one qualified health plan at silver and gold levels

§1302: essential health benefits requirement

- Essential health benefits package defined as one that covers essential health benefits, limits cost-sharing and has a specified AV as follows
 - For individual and small group markets: Secretary to define essential benefits, which must be equal in scope to benefits of typical employer plan; requires one of the following levels of coverage under which the plan pays for the specified percentage of costs:
 - Bronze: 60% Silver: 70%
 - Gold: 80% Platinum: 90%
 - For all plans in market: prohibits out-of-pocket limits greater than HSA limits
 - For small group market: prohibits deductibles greater than \$2,000 for individuals and \$4,000 for families
- In individual market, catastrophic-only plan may be offered only to those under 30 or those who are exempt from individual responsibility requirement because affordability/hardship issues
 - Catastrophic-only plan must cover essential benefits and at least 3 primary care visits; also require cost-sharing up to HSA out-of-pocket limits

§1303: special rules

- States may prohibit abortion coverage in qualified health plans
- Ensures that plans may elect whether or not to cover abortion
- Federal and state laws regarding abortion not preempted

§1304: related definitions

- Small group market: market in which plan is offered by small employer (1-100 employees)
- Large group market: more than 100 employees
- Before 2016, small group market can be limited to 50 employees

Part II – Consumer choices and insurance competition through Health Benefit Exchanges

§1311: affordable choices of health benefit plans

- Secretary to award grants (available until 2015) to states for planning/establishment of American Health Benefit Exchanges; Exchanges must be established by 2014, which includes SHOP Exchange for small businesses
- Exchanges to certify and rate qualified health plans, inform individuals of eligibility for Medicaid/CHIP

§1312: consumer choice

- Allows qualified individuals to enroll in qualified health plan through the State's Exchange
- Requires insurers to pool the risk of all enrollees in all plans (except grandfathered plans) regardless of whether plans are offered through Exchange

§1313: financial integrity

- Exchange must keep accurate accounting of expenditures, submit annual reports to Secretary
- Cooperate with investigations and audits

Part III – State flexibility relating to Exchanges

§1321: state flexibility in operation and enforcement of Exchanges and related requirements

- Secretary to set standards for Exchanges, qualified health plans, reinsurance and risk adjustment

§1322: federal program to assist establishment and operation of nonprofit, member-run health insurance issuers

- Secretary to award loans for start-up costs and grants to meet solvency requirements until July 1, 2013 to member-run non-profits that will offer qualified health plans; loans must be repaid within 15 years
- Allows participants to form private purchasing council to enter into collective purchasing arrangements for items and services

- \$6 billion appropriated for CO-OP program; exempts participants from taxation

§1323: community health insurance option

- Struck by §10104
- Funding for territories increased to \$2 billion (Puerto Rico, Virgin Islands, Guam, American Samoa and Northern Marinas Islands)
 - caps on federal Medicaid funding increased
 - each territory may elect to operate Exchange

§1324: level playing field

- Requires CO-OP plans or multi-state plans to be subject to Federal/state laws that apply to private insurers

Part IV – State flexibility to establish alternate programs

§1331: state flexibility to establish basic health programs for low-income individuals not eligible for Medicaid

- States to contract with standard health plans for individuals ineligible for Medicaid and have income <200% FPL
- Legal immigrants <133% FPL and ineligible for Medicaid because of 5-year waiting period are eligible for basic health program

§1332: waiver for state innovation

- Beginning 2017, allows States to apply for waiver for up to 5 years of requirements relating to qualified health plans, Exchanges, cost-sharing reductions, tax credits, individual responsibility requirement and employee shared responsibility

§1333: provisions relating to offering of plans in more than one State

- Qualified health plans can be offered in all participating States but insurers would be subject to consumer protection laws of purchaser's State
- Insurers to be licensed in all participating States

§1334: multi-state plans

- Requires OPM to contract with health insurers to offer at least 2 multi-state qualified health plans (at least one non-profit) through Exchanges in each state

Part V – Reinsurance and risk adjustment

§1341: transitional reinsurance program for individual and small group markets in each State

- For 2014-16, requires States to establish non-profit reinsurance entity that collects payments from insurers market and makes payment to insurers in individual market that cover high-risk individuals

§1342: establishment of risk corridors for plans in individual and small group markets

- Establishes risk corridors for qualified health plans in 2014-16
 - If plan's cost (minus administrative costs) greater than 103% of total premiums, Secretary to make payments to defray excess cost
 - If plan's cost less than 97% of total premiums, plan makes payment to Secretary

§1343: risk adjustment

- States to assess charges on health plans with enrollees of lower-than-average risk

Subtitle E: Affordable coverage choices for all Americans

Part I – Premium tax credits and cost-sharing reductions

§1401: refundable tax credit providing premium assistance for coverage under a qualified health plan

- Internal Revenue Code to provide tax credits to assist with cost of health insurance premiums
- Improves health care financing for individuals with incomes up to 400% of the federal poverty level
- Restrains the growth in tax credits, starting in 2019, if premiums rise faster than the consumer price index
- Adjusts tax credits to make premiums more affordable as a percent of income as depicted in the following income tier:

Household Income (FPL Percent)	Initial Premium Percentage	Final Premium Percentage
≤133%	2.00%	2.00%
134% - 150%	3.00%	4.00%
151% - 200%	4.01%	6.30%
201% - 250%	6.31%	8.05%
251% - 300%	8.06%	9.50%
301% - 400%	9.50%	9.50%

§1402: reduced cost sharing for individuals enrolling in qualified health plans

- Standard out-of-pocket limits (\$5,950 for individuals, \$11,900 for families) reduced to 1/3 for those between 100-200% FPL, 1/2 for those between 200-300% FPL and 2/3 for those between 300-400% FPL
- Plan's share of total allowed cost of benefits increased to 90% for those between 100-150% FPL, 80% for those between 150-200% FPL

§1411: procedures for determining eligibility for Exchange participation, premium tax credits and reduced cost sharing, and individual responsibility exemptions

- Secretary to establish program to determine if individual applicant through Exchange or individual who is claiming a premium tax credit/reduced cost-sharing is a US citizen/national or alien lawfully present in US and meets income/coverage requirements

§1412: Advance determination and payment of premium tax credits and cost-sharing reductions.

- Sets the conditions for advanced payment of tax credits for premium assistance and cost-sharing reductions for individuals to be made during the open-enrollment period and based on household income. Advanced payments will also be allowed due to a significant change in income and eligibility status.
- No payments will be made for individuals not lawfully present.
- Revises the definition of income used for tax credit, subsidy eligibility and the individual responsibility requirement
 - Modified adjusted gross income
 - Income definition corresponds to both the current tax Form 1040 and income tax return filing thresholds

§1413: Streamlining of procedures for enrollment through an exchange and state Medicaid, CHIP, and health subsidy programs.

- The Secretary will establish a streamlined system to determine eligibility in any coverage assistance program available when applying for coverage through the exchange.
- Enrollment in the applicable assistance program will be automatic.
- The streamlined form may be filed a number of ways: online, in person, by mail, or by telephone.
- The state may establish its own form and may provide a supplemental form for eligibility determinations not based on income.

- Each state will have to develop for all state subsidized health programs a secure electronic interface allowing exchange of data. This system will be used to coordinate enrollment into eligible programs. The state is allowed to contract this work out.

§1414: Disclosures to carry out eligibility requirements for certain programs.

- Allows for the disclosure of limited taxpayer information to determine eligibility for certain programs in the Act.
- The data shall be limited to taxpayer identity, filing status, number of individuals for whom a deduction is allowed, modified gross income, other information for eligibility requirements, and the tax year for this information.

§1415: Premium tax credit and cost-sharing reduction payments disregarded for federal and federally assisted programs.

- Any tax credit or refund or any cost-sharing reduction payment provided by the Act shall not be counted as income for determining eligibility for any federal, state, or local program that is financed at least in part or whole by federal funds.

§1416: Study of geographic location in application of FPL.

- Directs the Secretary to study adjusting the federal poverty level throughout different geographic areas of the United States and its territories. If the study concludes that adjustments are necessary, a report will be due to Congress no later than January 1, 2013.

Part II – Small Business Tax Credit

§1421: Credit for employee health insurance expenses of small businesses.

Amends the Internal Revenue Code to add the following:

- §45R – Employee health insurance expenses of Small Employers.
 - 50% max credit for small businesses, 35% in tax-exempt small businesses from 2014 on;
 - 35% max credit for small businesses, 25% in tax-exempt small businesses 2010-2013.
 - The full credit is available for very small, low-income businesses with 10 or fewer employees and average annual wages of less than \$25,000.
 - A small business that provides health benefits for its employees can qualify for a sliding scale tax credit if there are fewer than 25 full time employees and average annual wages are less than or equal to \$50,000.
 - To qualify, the employer must contribute at least 50% of the employee's premium cost or 50% of an average premium for that state and area determined by the Secretary.
 - From 2014 onward, the applicable tax credits detailed above are available for the first two consecutive years of coverage that an employer offers.

Subtitle F – Shared Responsibility for Health Care

Part I: Individual Responsibility

§1501: Requirement to maintain minimum essential coverage.

- Congressional findings related to individual responsibility (a.k.a. individual mandate), amended by §10106. Amends subtitle D of the Internal Revenue Code of 1986 as follows:
 - §5000A – Requirement to maintain minimum essential coverage.
 - Individual requirement to maintain minimum essential benefits begins 2014.
 - Failure to maintain coverage results in a "Shared Responsibility Payment".
 - Shared responsibility payment is the applicable monthly payment amounts for the uninsured person or persons. It is capped by the national average premium cost of an approved bronze-level plan offered in the exchange that would cover the individual or family.

- APPLICABLE MONTHLY PAYMENT AMOUNTS. The applicable monthly payment amount is 1/12 the greater of either A. (Flat dollar amount) OR B. (Percentage of income).
- The flat dollar amount is the sum of applicable dollar amounts (\$95 in 2014, \$325 in 2015, and \$695, forward adjusted by a COLA beginning in 2016) for all adults age 18+ (amounts for dependent children are half).
- It is capped at 300% of the applicable dollar amount (\$285 in 2014, \$885 in 2015, and \$2,250 thereafter), for larger families.
- The percentage of income is 1.0% in 2014, 2% in 2015, and 2.5% from 2016 forward.
- The overall cap on the payments that a person or family would have to pay is the national average price of health plans at the bronze level that would cover that individual or family.
- Exceptions to the individual responsibility requirement are for those with religious objections, individuals not lawfully present, and incarcerated individuals.
- Exemptions from the penalty are for individuals who cannot afford coverage (hardship exemption for those monthly premiums would exceed 8% of annual income – subject to modification by the Secretary of HHS), those with incomes under 100% FPL, members of Indian tribes, those who went without insurance for not more than three months during the course of the year.

§1502: Reporting of Health Insurance Coverage

- Amends the Internal Revenue Code of 1986 by inserting:
- §6055: Reporting of Health Insurance Coverage
- Requires every person or business entity that provides coverage to individual report specified information about that coverage to the IRS.

Part II – Employer Responsibilities

§1511: Automatic enrollment for employees of large employers.

- Amends the Fair Labor Standards Act of 1938 by inserting:
 - §18A. Automatic enrollment for employees of large employers.
 - Requires employers with more than 200 full-time employees that offers enrollment in 1 or more health benefits plans to automatically enroll employees in one of the plans offered (subject to any waiting period authorized by law) with adequate notice and the opportunity for an employee to opt out of any coverage the employee was automatically enrolled in. This section does not supersede state law.

§1512: Employer requirement to inform employees of coverage options.

- Amends the Fair Labor Standards Act of 1938 by inserting:
 - §18B. Notice to Employees.
 - Beginning on March 1, 2013, employers are required to inform employees of the existence of the exchange. If the employer plan's share of the total allowed costs of benefits provided is less than 60%, the employee may be eligible for a premium tax credit and a cost sharing reduction. If the employee purchases a qualified plan through the exchange the employee will lose the employer contribution to any health benefits offered by the employer.

§1513: Shared Responsibility for Employers.

- Amends chapter 43 of the Internal Revenue Code of 1986 to add at the end:
 - §4980H. Shared Responsibility for Employers Regarding Health Coverage
 - Requires employers with more than 50 full time employees not offering health coverage to pay an assessment equal to the product of \$2,000 times the number of full-time employees if at least one employee obtains coverage through the exchange with a premium assistance tax credit or cost-sharing reduction.
 - Deducts the first 30 full time employees from the payment calculation

- Any large employer that offers benefits but has at least one FTE employee receiving a tax credit for premium assistance or cost-sharing reduction shall pay the lesser of \$3,000 for each employee receiving the aforementioned premium assistance OR \$2,000 for each full time employee total.
- The Secretary of Labor will conduct a study to determine whether employees' wages are reduced by reason of the assessments under section 4980H of the Internal Revenue Code of 1986. The Secretary shall report the results to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate.

§1514: Reporting of Employer Health Insurance Coverage

- Amends the Internal Revenue Code of 1986 to add:
 - §6056. Large Employers Required to Report on Health Insurance Coverage
 - Requires large employers to report on health benefits offered or not offered.
 - Whether it offers to its full time employees and dependants the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan,
 - The length of any applicable waiting period,
 - The lowest cost option in each of the enrollment categories under the plan,
 - The employer's share of the total allowed costs of benefits provided under the plan,
 - The number and names of FTE employees receiving coverage.

§1515: Offering of Exchange-Participating Qualified Health Plans Through Cafeteria Plans.

- Amends the Internal Revenue Code of 1986 by adding a new paragraph to the end of section 125:
- §125 (f)(3): Certain Exchange-Participating Qualified Health Plans Not Qualified.
- Plans provided through the exchange will not qualify as a benefit under an employer-sponsored cafeteria plan, except for qualified employers (small employers and, after 2017, large employers in electing states) offering a choice of plans to their employees through the exchange.

§10108: Free choice vouchers

- Employers to offer coverage and make contribution to provide free choice vouchers to qualified employees for the purchase of qualified health plans through Exchange
- Must be equal to contribution that employer would have made to its own plan
- Employees qualify if required contribution under employer's plan is between 8 and 9.8% of their income

Subtitle G – Miscellaneous Provisions

§1551: Definitions

- Applies definitions to such terms as group health plan, medical care, and health insurance coverage contained in section 2791 of the Public Health Service Act to this title.

§1552: Transparency in Government

- HHS website will be published not later than 30 days after enactment listing all of the authorities provided to the Secretary under this act.

§1553: Prohibition against discrimination on assisted suicide

- Governments, providers or health plans that receive federal funding under this Act may not subject an individual or institutional health care entity to discrimination on the basis that the entity does not provide assisted suicide, or euthanasia.

§1554: Access to Therapies

- Prevents the HHS Secretary from promulgating certain regulations that:

- Creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care.
- Impedes timely access to health care services
- Interferes with communications regarding a full range of treatment options between the patient and the provider
- Restricts the ability of health care providers to provide full disclosure of all relevant information to patients making health care decisions
- Violates the principles of informed consent and the ethical standards of health care professionals.
- Limits the availability of health care treatment for the full duration of a patient's needs.

§1555: Freedom not to participate in Federal health insurance programs.

- No individual, company, or health insurer is required to participate in any federal health insurance program created or modified by this act.

§1556: Equity for certain eligible survivors

- Improves the Black Lung Benefits Act by striking the last sentence of §921(c)(4) of this act that limits claims made after the enactment of the Black Lung Benefits Act.

§1557: Nondiscrimination

- Protects individuals against discrimination related to participation in or denial of benefits for any health program or activity funded in part or whole by Federal financial assistance by any health plan under certain Acts (Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, section 504 of the Rehabilitation Act of 1973).

§1558: Protections for Employees

- Amends the Fair Labor Standards Act of 1938 by inserting:
- Sec 18C: Protections for employees
- Prevents employers from discrimination against employees with respect to compensation, terms, conditions, or other privileges of employment because the employee receives a premium tax credit or for other whistle-blower reasons.

§1559 Oversight

- The Inspector General of the Department of Health and Human Services shall have oversight authority with respect to the administration and implementation of this title as it relates to such Department.

§1560: Rules of Construction

- Nothing in this title shall be construed to modify, impair, or supersede the operation of any antitrust laws, Hawaii's Pre-paid Health Care Act, existing student health insurance plans, or existing federal requirements concerning the State agency responsible for determining eligibility for certain programs.

§1561: Health information technology enrollment standards and protocols

- Amends the Public Health Service Act by adding:
 - *Subtitle C – Other Provisions*
 - §3021: Health information technology enrollment standards and protocols.
 - Standards and protocols for HIT interoperability and security shall be developed within 180 days after enactment of this title. Standards and protocols shall allow for the following:
 - Electronic matching against existing Federal and State data
 - Simplification of stored eligibility information, digitization of documents, and systems verification of eligibility
 - Reuse of stored eligibility information to assist with retention of eligible individuals.

- Capability for individuals to apply, recertify and manage their eligibility information online including at home, at points of service, and other community-based locations.
- Ability to expand the enrollment system to integrate new programs, rules, and functionalities, to operate at increased volume, and to apply streamlined verification and eligibility processes to other federal and state programs.
- Notification of eligibility, recertification, and other needed communication regarding eligibility, which may include communication via email or to cell phones.
- Other functionalities necessary to provide eligibles with streamlined enrollment process.
- States may be required to incorporate these standards as a condition of receiving Federal health information technology funds.

§1562: GAO study regarding the rate of denial of coverage and enrollment by health insurance issuers and group health plans.

- Requires the GAO to study denial of coverage by health insurers and group health plans.

§1563: Conforming Amendments

- Technical and conforming amendments.

§1563: Sense of the Senate promoting fiscal responsibility.

- Shares CBO findings:
 - Reduction of federal deficit between 2010 and 2019.
 - Continued reductions of the deficit beyond 2019.
 - Extend the solvency of the Medicare HI Trust Fund
 - Increase the surplus in the Social Security Trust Fund, which should be reserved to strengthen the finances of Social Security.
 - Initial net savings generated by the Community Living Assistance Services and Supports (CLASS) program are necessary to ensure long-term solvency of that program. These savings should be reserved for the CLASS program.

§1563: Small business procurement

- Does not allow waiver of small business contracts under the Federal Acquisition Regulation of the Small Business Act.

§10109: development of standards for financial and administrative transactions

- Secretary to consult stakeholders and National Committee on Vital and Health Statistics and HIT Standards and Policy Committees to identify opportunities to create uniform standards for financial/administrative health care transactions

TITLE II – Role of Public Programs

Subtitle A – Improved Access to Medicaid

§2001: Medicaid coverage for the lowest income populations.

- Expands eligibility of Medicaid to childless adults and certain parents earning at or below 133% FPL.
- States have the option to cover those above 133% through a state plan amendment.
- Benefits provided are benchmark or benchmark-equivalent described in section 1937 of the Social Security Act.
- Prescription drug and mental health services are added to the minimum benefits package at actuarial value.
- Provides federal Medicaid matching payments for the costs of services to newly eligible individuals at the following rates:

- 100% in 2014, 2015, 2016
- 95% in 2017
- 94% in 2018
- 93% in 2019
- 90% in years after 2019
- Phases in additional federal support for covering nonpregnant childless adults for expansion states
 - In 2019, expansion states receive the same FMAP as other states for newly-eligible and previously-eligible nonpregnant childless adults
- Maintenance of effort: States are required to maintain eligibility standards until state exchange is fully operational. For children covered by Medicaid or CHIP, this MOE will extend until October 1, 2019. Exemptions from this MOE are for state coverage for optional non-pregnant, non-disabled, adult populations at income levels higher than 133% FPL if the state reports a budget deficit or projected budget deficit in the following state fiscal year.

§2002: Income eligibility for nonelderly determined using modified gross income.

- Amends the Social Security Act by adding:
 - (14) Income determined using modified gross income
 - With respect to the imposition of premiums and cost sharing (for Medicaid eligibility), a state shall use the modified gross income of an individual or household income. This will be the same measure used to determine eligibility in the state exchanges. No income or expense disregard will be applied by the state except for long-term services and support. Exempt groups would be evaluated on existing income counting rules and are:
 - Individuals who are eligible for medical assistance under the state plan or under a waiver of the plan
 - The elderly or Social Security Disability Insurance (SSDI) program beneficiaries
 - The medically needy
 - Enrollees in a Medicare Savings Program
 - The disabled.

§2003: Requirement to offer premium assistance for employer-sponsored insurance.

- Requires states to offer premium assistance and wrap-around benefits to all Medicaid beneficiaries who are offered employer-sponsored coverage.

§2004: Medicaid coverage for former foster care children.

- States are required to cover former foster children (who were foster children for more than 6 months) until age 25 in Medicaid coverage, if eligible starting in 2014.

§2005: Payments to territories.

- Spending caps to the US territories are increased by 30%. The applicable FMAP is increased by 5 percentage points up to 55%.

§2006: Special adjustment to FMAP determination for certain states recovering from a major disaster.

- Increases FMAP for states suffering a statewide disaster by half of the state's current FMAP for the first year and one-quarter for a second year.

§2007: Medicaid improvement fund rescission.

- Rescinds funds available in the Medicaid Improvement Fund beginning 2014 through 2018.

Subtitle B – Enhanced Support for the Children's Health Insurance Program

§2101: Additional Federal financial participation for CHIP.

- From October 1, 2013 - October 1, 2019, states will receive a 23-percentage point increase in federal funding for CHIP programs up to a cap of 100%.

- States are required to conform to a Maintenance of Effort, maintaining income eligibility levels until October 1, 2019.
- CHIP-eligible children who are unable to be included in the CHIP program due to enrollment caps will be provided tax credits for coverage through the exchange.
- Extends the current reauthorization period of CHIP to October 1, 2015.

§2102: Technical Corrections.

- Makes Technical corrections to the CHIPRA.

Subtitle C – Medicaid and CHIP Enrollment Simplification

§2201: Enrollment simplification and coordination with state health insurance exchanges.

- Amends the Social Security Act to add:
- Sec 1943: Enrollment simplification and coordination with state health insurance exchanges.
- Requires states to allow individuals to enroll through a website and coordinate seamless enrollment to state programs and the exchange.

§2202: Permitting hospitals to make presumptive eligibility determinations for all Medicaid eligible populations.

- Amends the Social Security Act by allowing hospitals the option to provide Medicaid services, based on preliminary information, during a period of presumptive eligibility to members of all Medicaid eligibility categories.

Subtitle D – Improvements to Medicaid services

§2301: Coverage for freestanding birth center services.

- Requires coverage of services provided by freestanding birth centers. This takes place upon enactment unless state legislation is required.

§2302: Concurrent Care for Children

- Allows children enrolled in Medicaid or CHIP to receive hospice care without waiving any rights of the child to be provided with treatment of a terminal illness.

§2303: State eligibility option for family planning services.

- Adds a new eligibility group to Medicaid consisting of 1) non-pregnant individuals with income up to the highest level applicable to pregnant women covered under Medicaid or CHIP and 2) individuals eligible under existing section 1115 waivers that provide family planning services and supplies.
- Benefits are limited to family planning and supplies and include diagnosis and treatment services that are provided in conjunction with a family planning service in a family planning setting.
- Medicaid payment rates to primary care physicians for furnishing primary care services to be no less than 100% of Medicare payment rates in 2013 and 2014
 - 100% federal funding for additional costs to States meeting this requirement

§2304: Clarification of definitions on medical assistance.

- Defines ‘medical assistance’ as both payment for services provided and the services themselves.

Subtitle E – New Options for States to Provide Long-Term Services and Supports

§2401: Community first choice option.

- Provides states the ability to establish home and community-based attendant services for individuals eligible for Medicaid whose income does not exceed 150% FPL or, if greater, the income level applicable for an individual determined to require institutional level of care.
- Delayed to October 1, 2011

§2402: Removal of barriers to providing home and community-based services.

- Removes barriers to HCBS by giving states the option to provide more types of HCBS through a state Medicaid plan amendment for individuals of higher need, instead of through a waiver.
- States have the ability to extend full Medicaid benefits to individuals receiving HCBS under a state plan amendment.

§2403: Money Follows the Person rebalancing demonstration.

- Extends the ‘Money Follows the Person Demonstration’ until October 1, 2016 and changes eligibility rules for individuals to participate by requiring residence in an inpatient facility for not less than 90 days.

§2404: Protection for recipients of home and community-based services against spousal impoverishment.

- Requires states to apply spousal impoverishment rules to those receiving HCBS for five years beginning January 1, 2014.

§2405: Funding to expand state aging and disability resource centers

- Appropriates to the Secretary of HHS \$10M for each fiscal year 2010 through 2014 to fund Aging and Disability Resource Center initiatives.

§2406: Sense of the senate regarding long-term care.

- Expresses the sense that the 111th Congress should act to reform long-term health care.

Subtitle F – Medicaid Prescription Drug Coverage

§2501: Prescription drug rebates.

- Increases the flat rebate for single-source and innovator multiple source prescription drugs from 15.1% to 23.1% except for clotting and outpatient drugs approved for pediatric applications, which increase to 17.1%. Basic drug rebates increase from 11% to 13%. Drug manufacturers must pay rebates for drugs dispensed to Medicaid subscribers.
- Narrows definition of new formulation of a drug to a line of extension of a single source or innovator multiple source drug that is an oral solid dosage form of the drug (for application of additional rebate purposes)

§2502: Elimination of exclusion of coverage of certain drugs.

- Removes the exclusion on Medicaid coverage of smoking cessation drugs, barbiturates, and benzodiazepines.

§2503: Providing adequate pharmacy reimbursement.

- Requires the Secretary to calculate the Federal upper reimbursement limit as no less than 175% of the weighted average of the most recently reported monthly average manufacturer prices for pharmaceutically and therapeutically equivalent multiple source drug products that are available for purchase by retail community pharmacists on a nationwide basis.

Subtitle G – Medicaid Disproportionate Share Hospital Payments

§2551: Disproportionate share hospital payments.

- A state’s DSH allotment is reduced once the state’s uninsured population is reduced by 45%. For states that spend up to 99.9% of their allotment, that reduction will be 50% unless the state is determined to be a low DSH state, at which point the reduction will be 25%. In states that spend more than 99.9% of their allotment, the reduction is 25%, or 17.5% in low DSH states. As the uninsured rate declines beyond the trigger point, the allotment will reduce accordingly to a level not to dip below 50% of that state’s allotment in FY2012.
- Aggregate reductions in DSH allotments for all States shall be equal to:
 - \$500 million for FY2014
 - \$600 million for FY2015 and 2016
 - \$1.8 billion for FY2017
 - \$5 billion for FY2018

- \$5.6 billion for FY2019
- \$4 billion for FY2020

Subtitle H – Improved Coordination for Dual Eligible Beneficiaries.

§2601: 5-Year period for demonstration projects.

- Medicaid waivers for coordinating care for dual eligibles are authorized for 5 years and may be extended at the request of the state to the Secretary for additional 5-year periods unless the Secretary determines that for the previous waiver period the conditions for the waiver have not been met or it would no longer be cost-effective and efficient, or consistent with the purposes of this title, to extend the waiver.

§2602: Providing federal coverage and payment coordination for dual eligible beneficiaries.

- The Secretary will establish a Federal Coordinated Health Care Office within CMS no later than March 1, 2010. The purpose of this is to coordinate care between Medicare and Medicaid and improve the coordination between Federal and State governments for dual eligibles to ensure these individuals have full access to the items and services provided.

Subtitle I – Improving the Quality of Medicaid for Patients and Providers

§2701: Adult health quality measures.

- The Secretary of HHS will identify and publish a recommended core set of adult health quality measures for Medicaid eligible adults similar to the child health quality measures in the CHIPRA of 2009. The secretary and states will report on the development of and improvements to care measures on an annual basis.

§2702: Payment adjustment for health care-acquired conditions.

- Medicaid will prohibit payment for services rendered due to a health care-acquired condition.

§2703: State option to provide health homes for enrollees with chronic conditions.

- Beginning January 1, 2011, a State, at its option as a State plan amendment, may provide for medical assistance under this title to eligible individuals with chronic conditions who select a designated provider, a team of health care professionals operating with such provider, or a health team and the individual's health home for purposes of providing the individual with health home services.

§10202: incentives for States to offer home and community based services as LTC alternative to nursing homes

- Creates financial incentives for States to shift Medicaid beneficiaries out of nursing homes and into home and community based services (HCBS)
- Provides FMAP increases to rebalance spending between nursing homes and HCBS

§2704: Demonstration project to evaluate integrated care around a hospitalization.

- Establishes a demonstration project in up to eight states to study the use of bundled payments for hospitals and physician services under Medicaid.

§2705: Medicaid global payment system demonstration project.

- In coordination with the Center for Medicare and Medicaid Innovation, the Global Payment System Demonstration Project will begin in up to five states under which a participating State shall adjust the payments made to an eligible safety net hospital system or network from a fee-for-service payment structure to a global capitated payment model.

§2706: Pediatric accountable care organization demonstration project.

- A demonstration project will be established to authorize a participating State to allow pediatric medical providers that meet specified requirements to be recognized as an accountable care organization for purposes of receiving incentive payments.
-

§2707: Medicaid emergency psychiatric demonstration project.

- The Secretary will establish a demonstration project under which an eligible State will provide payment under the State Medicaid plan to an institution for mental diseases that is not publicly owned or operated and that is subject to certain requirements in the Social Security Act for the provision of medical assistance available under such plan to individuals who are between 21-65 years of age, are eligible for Medicaid, and require such medical assistance to stabilize an emergency psychiatric condition.

Subtitle J – Improvements to the Medicaid and CHIP Payment and Access Commission (MACPAC).

§2801: MACPAC assessment of policies affecting all Medicaid beneficiaries.

- Clarifies topics to be reviewed by the MACPAC to include Federal Medicaid and CHIP regulations, additional reports of State-specific data, and an assessment of adult Medicaid services. This will also authorize \$11M in funding to the MACPAC for FY2010.

Subtitle K – Protections for American Indian and Alaska Natives

§10221: Indian health care improvement

- Authorizes appropriations for Indian Health Care Improvement Act to increase Indian health care workforce, new programs for innovative care delivery models, behavioral health care services, services for health promotion and disease prevention, Indian youth suicide prevention grant program etc

§2901: Special rules relating to Indians.

- Prohibits cost sharing for Indians with income at or below 300% FPL enrolled in coverage through a state exchange. Health programs operated by the Indian Health Service, Indian tribes, tribal organizations, and Urban Indian organizations will be defined as the payer of last resort. These agencies and organizations may serve as “Express Lane” agencies to determine Medicaid and CHIP eligibility.

Subtitle L – Maternal and Child Health Services

§10211: Definitions

§10212: Fund

- Pregnancy Assistance Fund for awarding competitive grants to States to assist pregnant/parenting teens/women

§10213: permissible use of funds

- States may use funds provided to make funding available to eligible institutions of higher learning
- Matching requirement: eligible institution of higher learning that receives funding through this provision to contribute non-federal funds equal to 25%

§10214: appropriations

- \$25 million for each fiscal year 2010-2019

§2951: Maternal, infant, and early childhood home visiting programs.

- Provides funding to states, tribes, and territories to develop and implement evidence-based Maternal, Infant, and Early Childhood Visitation models in order to reduce infant and maternal mortality by producing improvements in prenatal, maternal, and newborn health, child health and development, parenting skills, school readiness, juvenile delinquency, and family economic self-sufficiency.

§2952: Support, Education, and Research for Postpartum Depression.

- Provides support to women suffering from postpartum depression and helps to educate on these conditions.

§2953: Personal Responsibility Education.

- Provides funding for states to carry out personal responsibility education programs to educate adolescents on abstinence and contraception for prevention of pregnancy and sexually transmitted infections, including HIV/AIDS. Funding is also available for:
 - Innovative teen pregnancy prevention strategies and services to high-risk, vulnerable, and culturally underrepresented populations,
 - Allotments to Indian tribes and tribal organizations,
 - Research and evaluation, training, and technical assistance.

§2954: Restoration of funding for abstinence education

- Funds abstinence education \$50 million per year through FY2014.

§2955: Inclusion of information about the importance of having a health care power of attorney in transition planning for children aging out of foster care and independent living programs.

- Enables children aging out of the foster care system to have the opportunity to designate a medical power of attorney prior to emancipation from foster care.
- States must supply to children aging out of the foster care system information and the opportunity for the individual to designate another individual to make medical decisions on their behalf if they are unable to do so.

TITLE III: IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE

Subtitle A—Transforming the Health Care Delivery System

Part I: Linking Payment to Quality Outcomes Under the Medicare Program

§3001: Hospital Value-Based Purchasing Program (2013)

- Yearly incentive payments to hospitals for meeting performance standards or levels of performance improvement, measured over the fiscal year
 - Hospital must have no deficiencies that posed immediate threats to patient safety or health
 - Hospital must be able to be measured by a specified number of performance standards and for a minimum number of cases
 - Hospitals that are not able to participate may become part a three-year value-purchasing program demonstration under a waiver to test innovative methods of measuring and rewarding quality and efficient health care
- May exempt certain hospitals if they submit an annual report that shows how another state program achieves the same or better results in patient health outcomes and cost savings
- Measures must cover at least acute myocardial infarction, heart failure, pneumonia, specified surgeries, and healthcare-associated infections and include efficiency measures (such as Medicare spending per beneficiary) that are adjusted for age, sex, race, illness, previous experience with the measures (i.e., how hospitals typically have performed and improved upon them), and other factors
 - Measures must be included on the Hospital Compare website for at least one year prior to use and are subject to validation
 - Measures must be able to be assessed so as to determine an overall performance score
 - Measures will be related to those in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey
- Incentive payments will be made in the form of increased base operating DRG payments per discharge for the previous fiscal year, portioned according to the funding available from DRG payment reductions to all hospitals that year—regardless of whether or not they receive incentive payments

- For fiscal years 2013—1%, 2014—1.25%, 2015—1.5%, 2016—1.75%, 2017 and thereafter—2%
 - Hospitals may appeal the calculation
- Aggregate information on incentive payments and individual hospital performance data will be made publicly available in a user-friendly format (determined by stakeholder input) on the Hospital Compare website once hospitals are given the opportunity to review and submit corrections to this information
- Evaluation of program by 1) GAO for impact on quality of care, expenditures, and barriers hospitals face in meeting performance standards with final report due to Congress with recommendations July 1, 2017 and 2) HHS on ways to improve program and how to share savings with Medicare, if any, from value-based purchasing, with final report due to Congress by January 1, 2016
- Other: Secretary shall establish a value-based purchasing program demonstration under a waiver for a representative sample of inpatient critical access hospitals for three years
- Secretary will consult with small rural and urban hospitals on the application of this to them

§10335: Technical correction to hospital value-based purchasing (VBP) program

- VBP program to not include measures of hospital readmissions

§3002: Improvements to the Physician Quality Reporting System

- Starting in 2015, providers must satisfactorily submit data on quality or they will be paid in 2015 at 98.5% of their fee schedules and 98% thereafter
- Starting January 1, 2012, reporting will include measures on the meaningful use of electronic health records

§3003: Improvements to the Physician Feedback Program

- Using claims data, the Secretary will submit confidential reports to physicians on the resources used for and quality of their care as compared to other physicians
 - As of January 1, 2012, this will include “episode groupers” that combine separate but clinically related items and services into an episode of care for a patient
 - This data will be adjusted according to differences in patient socioeconomic status and demographics, ethnicity, health status, and geographic differences in payment rates
 - Episode grouper data and data analysis methods will be made available to the public

§3004: Quality Reporting for Long-Term Care Hospitals, Inpatient Rehabilitation Hospitals and Hospice Programs

- As of 2014, long-term care hospitals, inpatient rehabilitation hospitals and hospice programs that do not submit quality data will have a 2% reduction in their respective payment rates; these rate reductions will not be counted for calculations made the following year
- Actual measures must be endorsed by these hospitals and programs except when an appropriate area or topic has no endorsed measure and is therefore subject only to endorsement by a consensus organization
- This data will be made publicly available on the CMS website after these hospitals have had the opportunity to review and appeal the data

§3005: Quality Reporting for PPS-Exempt Cancer Hospitals

- As of 2014, cancer hospitals must submit quality data; no payment penalty is specified for unsatisfactory data
- Actual measures must be endorsed by these hospitals and programs except when an appropriate area or topic has no endorsed measure and is therefore subject only to endorsement by a consensus organization
- This data will be made publicly available on the CMS website after these hospitals have had the opportunity to review and appeal the data

§3006: Plans for a Value-Based Purchasing Program for Skilled Nursing Facilities and Home Health Agencies

- In consultation with stakeholders, the Secretary will develop a plan by October 1, 2011 to fund and implement a value-based purchasing program
- Under the plan, facilities and agencies will have payments adjusted according to meeting or improving upon measures of quality and efficiency
- Actual measures must be endorsed by these hospitals and programs except when an appropriate area or topic has no endorsed measure and is therefore subject only to endorsement by a consensus organization
- Measures will be made publicly available

§3007: Value-Based Payment Modifier Under the Physician Fee Schedule

- As of 2015, some physicians and physician groups will receive differential payments based measures of quality versus cost that promote systems-based care, adjusted for risk and geography and with consideration for the needs of physicians in rural and underserved areas; as of 2017, all physicians and physician groups will be included
- Payments are separate from geographic adjustment factors
- Performance data will be shared with physicians during the initial performance period of this reform

§3008: Payment Adjustment for Conditions Acquired in Hospitals

- Starting in 2015, payments will be at 99% for discharges with hospital acquired conditions for hospitals
 - Hospitals must be in the top quartile of hospitals as compared to the national average for hospital acquired conditions (after risk adjustment)
 - Secretary may exempt certain hospitals if they submit an annual report that shows how another state program achieves the same or better results in patient health outcomes and cost savings
- Prior to 2015, and each year thereafter, the Secretary will provide confidential reports hospitals about their performance
- Data will be made publicly available on the Hospital Compare website after hospitals have an opportunity to review and submit corrections for their information
- Conduct study on the potential effects of expanding this program to other facilities under Medicare, including different types of hospitals, clinics, etc. in terms of quality of care, patient safety, and spending

§10326: pilot testing pay-for-performance programs for certain Medicare providers

- Secretary of HHS to test value-based purchasing programs for certain facilities by no later than Jan 1, 2016

Part II: National Strategy to Improve Health Care Quality

§3011: National Strategy

- Transparent stakeholder-informed strategy to improve delivery of care, health outcomes and population health due to Congress January 1, 2011 (updated annually)
- Identify national priorities that: have the greatest potential for rapidly improving health outcomes, efficiency and patient-centeredness of care; address gaps in quality, efficiency, comparative effectiveness information, and health outcomes and data aggregation techniques; improve federal payment policies to emphasize quality and efficiency; enhance the use of health care data to improve quality, efficiency, transparency, and outcomes; address high-cost chronic disease; improve research and dissemination of best practices to improve patient safety and reduce errors, preventable admissions, readmissions, and health care-associated infections; and reduce health disparities
 - Includes: efforts to coordinate among agencies to minimize duplication of efforts and utilization of common quality measures; the establishment of agency-specific plans and annual benchmarks to meet national priorities; a reporting protocol; methods to align public and private payers for quality and patient safety efforts; the

- incorporation of quality improvement and measurement with health information technology efforts in the American Recovery and Reinvestment Act
 - Updated annually with a review of goals, gaps in strategy, progress, and obstacles
- By January 1, 2011, a health care quality internet website will be created through which to publicly share information on national priorities, agency-specific strategic plans, and other information

§3012: Interagency Working Group on Health Care Quality

- Working group to collaborate, cooperate, and consult between federal departments and agencies to develop strategies, goals, models, and timetables consistent with national priorities that align and avoid duplication of quality improvement efforts among agencies and the public and private sectors and streamline quality reporting and compliance requirements when possible
- Chaired by the Secretary, member of the group will include senior level representatives of federal agencies and departments with activities related to improving quality and safety, such as: DHS, CMS, NIH, CDC, FDA, HRSA, AHRQ, ONCHIT, SAMHSA, FTC, SSA, DOD, DOL, DOE, etc.
- Annually, starting December 31, 2010, group will report to Congress and publicly report progress and recommendations on the health care quality website

§3013: Quality Measure Development

- Definition: standards for measuring the performance and improvement of population health or of health plans and providers
- Allotment: \$75 million for each of fiscal years 2010 through 2014
- Secretary and directors of AHRQ and CMS will identify measures every three years that need improvement or fill gaps in line with national priorities
 - Information on measures determined to fill a gap will be available on the public website
- Grants and contracts will be awarded to eligible entities for quality measure development with priority for those that assess: health outcomes and functional status; care management and coordination across episodes of care and various providers, settings and plans; experience, quality and use of information given to and used by patients and caregivers; meaningful use of health information technology; safety, effectiveness, patient-centeredness, appropriateness, and timeliness of care; efficiency of care; equity of services and health disparities; patient experience and satisfaction; and the use of innovative quality improvement strategies
 - Eligible entities need: demonstrated expertise in developing quality measures including procedures that include the views of those whose performance will be assessed by the measures and those who will use the measures and collaborate with those who will be monitoring and reporting on such measures; and transparent policies on governance and conflicts of interest
 - Measures must be free of charge to all users

§3014: Quality Measurement

- Allotment: \$20 million from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund Multi-stakeholder groups will be convened to provide input on the selection of quality measures and national priorities for improvements in population health and care delivery with the first report on input to the Secretary no later than February 1, 2010 and annually thereafter
 - Excludes data sets used to establish payment rates
 - Open, transparent activities with voluntary participation by representatives of stakeholders interested in or affected by the use of a quality measure(s)
 - Secretary will consider input on measures and publish the rationale for the use of any measure not endorsed in the Federal Register
 - At least every three years beginning no later than March 1, 2012, measures will be assessed for their impact on quality, with measures maintained, improved or phased out

- Measures will be disseminated for use through workforce programs, training curricula, the national strategy, and other methods as determined

§3015: Data Collection; Public Reporting

- Collect and aggregate data on quality and resource use
- May award federal grants/contracts to match non-federal funds in a 5:1 ratio for data collection to eligible entities: a multi-stakeholder group that develops plans for consistent reporting of summary quality and cost information; a group capable of submitting summary data for a particular population or provider; or a federal Indian Health Service program or health program operated by an Indian tribe
- Must: promote the use of data to improve and coordinate care, including the ability to summarize and compare data across multiple sources; support the provision of timely, consistent quality and resource use information; make the data available to the public after providers review the data for inaccuracies on a website, with data available in a format designed with the help of and usable by multiple stakeholder—including having data that is sufficiently disaggregated and provider-specific when appropriate

Part III: Encouraging Development of New Patient Care Model

§3021: Establishment of Center for Medicare and Medicaid Innovation Within CMS

- As of January 1, 2011, test innovative payment and service delivery models to cut costs and improve quality informed by the input of federal agencies, clinical and analytical experts in medicine and health care management, and other stakeholders
- Funding: \$5 million for initial design, implementation and evaluation of models in FY2010; \$10 billion for activities FY2011-FY2019 and each subsequent decade with \$25 million allotted each fiscal year for continued design, implementation and evaluation
- Address populations with deficits in care leading to poor health outcomes or potentially avoidable expenditures
- Promote broad payment and practice reforms that can be regularly monitored and updated
 - Patient-centered medical homes for high-need patients and women's health needs
 - Salary-based reimbursement for primary care and other providers and suppliers
 - Coordinated care of those with multiple chronic conditions and using health information technology (e.g., disease registry, home health technology)
 - Particularly geriatrics with limited functional status and/or cognitive impairment and with an emphasis on providers moving to salary-based payment
 - Adjustments to physician payments/incentives for adherence to best practices for diagnostic imaging services and evidence-based cancer care guidelines
 - Medication therapy management
 - Community-based health teams for chronic care management
 - Payments to providers/suppliers for using patient decision support tools
 - Testing and evaluating integrating care for dual eligibles at the state level
 - Testing and evaluating all-payer payment reform at the state level
 - Post-acute care improvements and funding home health providers offering chronic care management using interdisciplinary teams
 - Collaborative of high-quality, low-cost health care institutions that develop, document, and disseminate best practices that they are using and help others employ these practices
 - Electronic monitoring through integrated health systems
- For efficiency, avoid physician or health professional referrals when a professional can legally provide a given service under existing state law
 - Comprehensive payments for Healthcare Innovation Zones (teaching hospital, physicians, and other clinical entities that together offer integrated, comprehensive health services and innovatively train future professionals)
- Models do not initially need to be budget neutral, but may be modified or terminated if they do not eventually improve quality without increasing spending and/or reduce spending without harming quality

- Evaluation results will be publicly available and may be used to expand the duration or scope of successful models, as well as reported to Congress at least once every two years starting in 2012 with results and recommendations for legislative action

§3022: Medicare Shared Savings Program

- Groups of providers and suppliers that manage and coordinate care for Medicare fee-for-service beneficiaries through an accountable care organization (ACO)
 - Professionals in group practice, networks of individual practices, partnerships or joint ventures with hospitals, employed by hospitals; including sufficient primary care physicians (at least 5,000/ACO)
 - Shared governance and legal structure to receive and distribute shared savings
- Accountable for quality, cost and overall care of beneficiary for at least three years
 - Evidence-based medicine and patient engagement
 - Reporting on quality and costs (e.g., clinical processes and outcomes, patient experience, utilization, transitions across healthcare settings)
 - Coordinated care and patient-centeredness
- ACOs meeting quality performance standards receive payments for shared savings
 - May incorporate requirements and incentive payments for use of health information technology, such as e-prescribing, EHR
 - Eligible if risk-adjusted Medicare expenditures per capita are a certain percentage below benchmarks estimated for each ACO; estimated using the most recent three years of expenditures for that ACO risk-adjusted and subject to a growth rate
 - Payments will equal a percentage of savings, with the remainder kept by Medicare
- Sanctions or termination of agreements for ACOs avoiding at-risk patients

§3023: National Pilot Program on Payment Bundling

- Implemented as of January 1, 2013, a budget neutral, five-year pilot for Medicare beneficiaries enrolled in parts A and B (but not C or PACE); may be extended if successful—request due January 1, 2016
- Will pay entities for episodes of care for one of eight specified conditions when there is evidence for bundling: mix of chronic and acute conditions or of surgical and medical conditions; quality can be improved and costs cut (e.g., there is significant variation in readmission rates or costs for post-acute care); costs for post-acute care are high
 - Episode of care: three days prior to admission through 30 days following discharge
 - Payments made for services including care coordination, post-acute care, medication reconciliation, discharge planning, transitional care services, and other patient-centered activities
 - A participating entity to include: hospital, physician group, SNF, and home health agency
 - Entities may bid for bundled payments
 - Consultation with small rural hospitals including critical access hospitals about barriers to participation
- Quality of care measures: functional status; readmissions; rates of discharge; incidence of health care acquired infections; efficiency; patient-centeredness; patient perception of care
 - Reported yearly, preferably through EHR
 - Subject to an independent evaluation measuring improvements in quality, health outcomes, access, and cost containment with interim and final reports to Congress no later than two and three years from implementation, respectively

§3024: Independence at Home Demonstration Program

- Starting January 1, 2010, test payment incentives for physicians, physician assistants, and/or nurses experienced in directing home-based primary care teams to reduce preventable hospitalizations, readmissions, and emergency room visits and improve health outcomes, efficiency, cost, and satisfaction for up to 1,000 high-need beneficiaries
 - Home-based primary care: includes home visits and 24-7 availability and uses electronic health information systems, remote monitoring, and mobile diagnostic technology

- Serve at least 200 voluntary beneficiaries per year for a period of three years
- Focus on high-cost beneficiaries with at least two chronic conditions, two or more functional dependencies, and a hospital admission with acute or subacute rehabilitation services in the past year
- Includes spending targets estimated per capita for services without such a demonstration
- Incentive payments equal to a portion of the savings from expenditures (including the incentive payments themselves) below 5% of the spending target
- Funding: \$5 million for each FY2010-FY2015 from the federal Hospital Insurance Trust and Supplementary Medical Insurance Trust funds
- Monitored for quality measures, with termination for teams estimated to receive no incentive payment for the second of two consecutive years or for failing to meet quality standards during any year of the demonstration
- Independent evaluation and report on impact on coordination, expenditures, access, and quality

§3025: Hospital Readmissions Reduction Program

- For discharges as of October 2, 2012, payments reduced for excess readmissions for high-volume and/or high cost conditions
 - Base DRG x an adjustment factor equal to the greater of: floor adjustment factor or a portion of the aggregate payments for excess readmissions and discharges
 - Floor adjustment factor: FY2013—0.99; FY2014—0.98; FY2015 and thereafter—0.97
 - Aggregate payments: $1 - (\text{base DRG})(\# \text{ readmissions}) (\text{excess readmissions ratio} - 1)$
 - Excludes readmissions for conditions below a certain minimum or unrelated to discharge (e.g., planned readmissions or hospital transfers)
- Readmission rates data may be submitted to the Secretary by the hospitals themselves or the state or other entity
- Special rules for Medicare-dependent, small rural hospitals and sole community hospitals and exemptions for certain others if they submit an annual report that shows how another state program achieves the same or better results in patient health outcomes and cost savings
- No later than two years after implementation, programs to help hospitals with high rates of readmissions improve their rates will be available through patient safety organizations
- Readmission rates will be publicly available on the Hospital Compare website after hospitals have the opportunity to review data and submit corrections

§3026: Community-Based Care Transitions Program

- Funding for entities providing improved care transition services to high-risk Medicare beneficiaries with risk factors for readmission (e.g., cognitive impairment, depression, a history of readmission, and/or chronic disease) for a period of five years beginning January 1, 2011; may be expanded if successful
- Funding: \$500 million for FY2011-FY2015 from federal Hospital Insurance Trust and Supplementary Medical Insurance Trust funds
- Entities, e.g., certain hospitals, must have high readmission rates and a partnership with a community-based organization that can provide transition services and has sufficient stakeholder representation on its governing body
- Entities must apply to participate with proposals for at least one care transition intervention; priority given to entities run by the Administration on Aging and/or for medically underserved populations, small communities and rural areas
 - Intervention examples: initiating care transition no later than 24 hours before discharge; arranging timely post-discharge follow-up including information on symptoms that may indicate other health problems or health deterioration; assisting beneficiaries to ensure timely interactions between them and providers; providing self-management support and information; conducting comprehensive medication review and management

§10333: community-based collaborative care networks

- Provides grants to develop such networks

§3027 Extension of Gainsharing Demonstration

- Extended and given additional funding

Subtitle B—Improving Medicare for Patients and Providers

Part I: Ensuring beneficiary access to physician care and other services

§3101: Increase in the Physician Payment Update

- Update the single conversion factor to 0.5% for 2010 only

§3102: Extension of the Work Geographic Index Floor and Revisions to the Practice Expense Geographic Adjustment Under the Medicare Physician Fee Schedule

- In 2010, the employee wage and rent portions of the practice expense geographic index will be the greater of the current rate or $\frac{3}{4}$ of the difference between relative costs of wages and rents in different areas and the national average of wages and rents; in 2011, the portions shall be $\frac{1}{2}$
- Current methods for determining practice expense geographic adjustments will be reviewed for their ability to establish actual costs in different geographic areas and modified as necessary starting January 1, 2012; adjustments will be budget neutral

§3103: Extension of Exceptions Process for Medicare Therapy Caps

§3104: Extension of Payment for Technical Component of Certain Physician Pathology Services

§3105: Extension of Ambulance Add-Ons

§3106: Extension of Certain Payment Rules for Long-Term Care Hospital Services and of Moratorium on the Establishment of Certain Hospitals and Facilities

§3107: Extension of Physician Fee Schedule Mental Health Add-On

§3108: Permitting Physician Assistants to Order Post-Hospital Extended Care Services

- Adds physician assistants to the list of providers, including for examples clinical nurse specialists, to those who can order extended care services

§3109: Exemption of Certain Pharmacies from Accreditation Requirements

- May need to meet alternative accreditation requirements
- Pharmacies must certify and submit documents when requested to prove:
 - Less than 5% of their sales from items and services under Medicare
 - Has had a provider number for at least five years without any final adverse action in the past five years for supplying durable medical equipment, orthotics, and prosthetics

§3110: Part B Special Enrollment Period for Disabled TRICARE Beneficiaries

- Beneficiaries who elected not to enroll in during the initial enrollment period may do so in the year beginning the day after the last day of the initial enrollment period or within a year of when the individual is notified of enrollment
- Coverage begins on the first day of the month of enrollment or the first month after the end of the initial enrollment period

§3111: Payment for Bone Density Tests

- Payments reduced to: (0.7) (relative value for the service for 2006) (conversion factor for 2006) (geographic adjustment factor for 2010 and 2011)
- Study and report by the Institute of Medicine on impact of these payment reductions

§3112: Revision to the Medicare Improvement Fund

- Eliminates spending for 2014

§3113: Treatment of Certain Complex Diagnostic Laboratory Tests

- From July 1, 2011 to July 1, 2013, demonstration project giving separate payments for complex lab tests (e.g., analysis of gene protein expression, topographic genotyping, cancer chemotherapy sensitivity assay) for which no good alternatives exist
 - Payment directly to lab from the federal Supplemental Medical Insurance Trust Fund
 - Payments not to exceed \$100 million
- Report to Congress within two years of completion on impact on access, quality, health outcomes, costs with recommendations

§3114: Improved Access for Certified Nurse-Midwife Services

§10323: Medicare coverage for individuals exposed to environment health hazards

- Coverage provided to individuals exposed to environmental health hazards as a result of public health determination under Comprehensive Environmental Response, Compensation and Liability Act of 1980

§10329: Developing methodology to assess health plan value

10336: GAO study and report on Medicare beneficiary access to high-quality dialysis services

- Comptroller General to submit a study on impact on Medicare beneficiary access to high-quality dialysis services of end-stage renal disease prospective payment system to Congress within 1 year of enactment

Part II—Rural Protections

§3121: Extension of Outpatient Hold Harmless Provision

- Also permits sole community hospitals to be eligible for hold harmless

§3122: Extension of Medicare Reasonable Costs Payments for Certain Clinical Diagnostic Laboratory Tests Furnished to Hospital Patients in Certain Rural Areas

§3123: Extension of the Rural Community Hospital Demonstration Program

- One year extension of demonstration, including expanding the demonstration to include more hospitals (up to 30) in more states
- Voluntary for current hospitals participating

§3124: Extension of the Medicare-Dependent Hospital (MDH) Program

- Extension of payment methodology and target amount

§3125: Temporary Improvements to the Medicare Inpatient Hospital Payment Adjustment for Low-Volume Hospitals

- Increase on sliding scale from 25% for low-volume hospitals with up to 200 Medicare discharges to 0% for those with more than 1,500 per year

§3126: Improvements to the Demonstration Project on Community Health Integration Models in Certain Rural Counties

- Removes limit on number of eligible counties and adds physician services to project scope

§3127: MedPAC Study on Adequacy of Medicare Payments for Health Care Providers Serving in Rural Areas

- Includes analysis of adjustments to and adequacy of payments, access and quality of care
- Report to Congress no later than January 1, 2011 on impact with recommendations

§3128: Technical Correction Related to Critical Access Hospital Services

§3129: Extension of and Revisions to Medicare Rural Hospital Flexibility Program

- Includes adding in funding flexibility to assist with reforms under this bill, such as value-based purchasing programs, ACOs, and the pilot on payment bundling

§10324: protections for frontier states

- Beginning FY2011, establishes hospital wage index and geographic practice expense floors for hospitals/physicians in states in which at least 50% of counties in the state are frontier

Part III—Improving Patient Accuracy

§3131: Payment Adjustments for Home Health Care

- Adjusted to reflect changes in number of visits, mix of services, level of intensity of services, average cost of providing care, etc. for an episode of care
- Factors in differences by facility and geography
- Includes a four-year phase in starting in 2012
- MedPAC study on impacts on access, quality, number of home health agencies, and different types of agencies (rural, urban, for-profit, nonprofit) with report to Congress by January 1, 2015
- HHS study on costs and quality of care in efficient home health agencies, methods to revise PPS to better reflect actual costs and to estimate the validity and reliability of OASIS, impact of payment incentives and penalties, and ways to set payments based on costs of high-quality, efficient home health agencies and improve Medicare beneficiary access to care; report to Congress by March 1, 2011
 - Considerations: population density vs. access, variations in costs for dual eligibles, severity of illness, poverty status, absence of caregivers, language barriers, transportation and security costs, and the input of stakeholders including home health and Medicare beneficiary representatives, MedPAC, the Inspector General, and the Comptroller General

§3132: Hospice Reform

- After October 1, 2013, revise payments based on charges and payments, number of hospice care days and visits, length of visits and practitioner type providing visit, service types and costs, and revenues including charitable contributions
 - Subsequent rates subject to a yearly market basket percentage increase
- Aggregate expenditures will be the same as if no revisions had been made
- Consultation with hospice programs and MedPAC regarding data collection and payment revisions
- Adoption of hospice program eligibility recertification
 - As of January 1, 2011, face-to-face encounter between physician or nurse practitioner and patient to attest recertification before 180th day recertification(s)
 - If above a certain percentage of cases with hospice care longer than 180 days, these cases will be medically reviewed for recertification

§3133: Improvement to Medicare Disproportionate Share Hospital (DSH) Payments

- Starting FY2014, hospitals to receive 25% of what would otherwise be paid without reform plus additional payments to partly make up for this reduction based on changes in the number of uninsured under health care reform and the remaining amount of uncompensated care

§3134: Misvalued Codes Under the Physician Fee Schedule

- Identify, review and make adjustments to services that may be misvalued, which may include bundling codes
 - Review codes with fastest growth and substantial expense changes; codes for new technologies or services within a certain period; codes with low relative values particularly those used multiple times for a single treatment; multiple codes used for a single service; and codes that have not been reviewed

- Validate relative value units, including time, mental effort and professional judgment, technical skill and physical effort, and stress due to risk for services

§3135: Modification of Equipment Utilization Factor for Advancing Imaging Services

- Adjustment in practice expense that presumes higher utilization of imaging equipment
 - Vs. 50%: 65% for January 1, 2010 to January 1, 2013; 70% for January 1, 2013 to January 1, 2014; 75% thereafter
- Reduced payments for multiple imaging procedures
 - As of July 1, 2010, reduce the technical component even further from 25% (final rule 2005) to 50%
- By January 1, 2013, Chief CMS Actuary to analyze whether reductions 2010-2019 sum to more than \$3 billion

§3136: Revision of Payment for Power-Driven Wheelchairs

- Payments increased as of January 1, 2011

§3137: Hospital Wage Index Improvement

- Plan to Congress by December 31, 2011
- Plan, informed by stakeholders, including MedPAC recommendations from 2007 including a new hospital compensation index system
 - Calculates relative wages for each geographic area; minimizes wage index adjustments between and within metro and rural areas; minimizes index volatility due to policy; accounts for the effects on providers and the quality of care; and addresses occupational mix, staffing practices and ratios

§3138: Treatment of Certain Cancer Hospitals

- Adjustments to payments after determining if costs for cancer hospitals exceed those for others

§3139: Payment for Biosimilar Biological Products

§3140: Medicare Hospice Concurrent Care Demonstration Program

- Three-year, budget neutral demonstration at up to 15 hospice sites in both rural and urban areas
- Evaluated for impact on patient care, quality of life, and cost-effectiveness

§3141: Application of Budget Neutrality on a National Basis in the Calculation of the Medicare Hospital Wage Index Floor

- As of October 1, 2010

§3142: HHS Study on Urban Medicare-Dependent Hospitals

- Study on need for additional payments for urban, Medicare-dependent hospitals for inpatient services similar to those already paid out to Medicare-dependent rural hospitals
 - Hospitals not currently receiving any other additional payments or adjustments, such as for indirect medical education costs or DSH
 - Hospitals with more than 60% inpatient days or discharges during last two or here cost reporting periods were to Medicare beneficiaries

§3143: Protecting Home Health Benefits

- No reduction in guaranteed home health benefits

§10330: Modernizing computer and data systems of the Centers for Medicare and Medicaid Services to support improvements in care delivery

- Secretary of HHS to develop a plan and detailed budget to modernize computer/data systems of the Centers for Medicare and Medicaid Services

Subtitle C—Provisions Related to Part C

§3201: Medicare Advantage Payment

- Freeze Medicare Advantage payments in 2011
- Beginning in 2012, reduces MA benchmarks relative to current levels
 - Benchmarks vary from 95% of Medicare spending in high-cost areas to 115% in low-cost areas; increased by 5% in all areas for high-quality plans

§3202: Benefit Protection and Simplification

- Repealed in HR 4872

§3203: Application of Coding Intensity Adjustment During MA Payment Transition

- HHS to adjust MA risk scores for observed differences in coding patterns relative to traditional FFS

§3204: Simplification of Annual Beneficiary Election Periods

- Extra time for CMS, MA plans and prescription drug plans to process enrollment paperwork during annual enrollment periods
- Eliminates duplicative open enrollment period for MA plans
- Allows beneficiaries to disenroll from MA and return to traditional FFS program between Jan 1 and March 15 of each year

§3205: Extension for Specialized MA Plans for Special Needs Individuals

- Extends SNP program through 2013 and requires SNPs to be NCQA approved
- HHS to apply frailty payment adjustment to fully-integrated, dual-eligible SNPs that enroll frail populations
- HHS to transition beneficiaries enrolled in SNPs that don't meet statutory target definitions and requires dual-eligible SNPs to contract with State Medicaid programs beginning in 2013

§3206: Extension of Reasonable Cost Contracts

- Extends period of time for which cost plans may operate in areas that have other health plan options from beginning of 2010 to beginning of 2013

§3207: Technical Correction to MA Private Fee-for-Service Plans

- As of 2011, an extension of the 2009 employer group waiver-modification granted to plans that contract directly with HHS as a private fee-for-service MA plan
 - Allows plans to waive certain requirements involved in designing, offering, or enrolling individuals in Medicare plans offered by employers and unions

§3208: Making Senior Housing Facility Demonstration Permanent

- Demo plans that serve residents in continuing care retirement communities to operate under MA program

§3209: Authority to Deny Plan Bids

- Authorizes HHS Secretary to deny bids submitted by MA plans and prescription plans that propose to significantly increase beneficiary cost sharing or decrease benefits offered under the plan
- Begins 2011

§3210: Development of New Standards for Certain Medigap Plans

- HHS to request NAIC revisions to the standards for benefit packages classified as "C" and "F" so that these packages include nominal cost sharing that encourages the use of appropriate Part B physician services

§1103: Savings from limits on Medicare Advantage plan administrative costs

- Requires that at least 85% of revenue from MA plans be spent on medical costs or activities that improve quality of care

Subtitle D—Medicare Part D Improvements for Prescription Drug Plans and MA-PD Plans

§3301: Drug manufacturers to provide 50% discount to Part D beneficiaries for brand-name drugs/biologics purchased during coverage gap beginning 2011

- Gradually provides 75 percent coverage for brand-name and generic drugs by 2020

§3302: Improvement in Determination of Medicare Part D Low-Income Benchmark Premium

- Removes MA rebates and quality bonus payments from calculation of low-income subsidy benchmark

§3303: Voluntary De Minimis Policy for Subsidy Eligible Individuals Under Prescription Drug Plans and MA-PD Plans

- Allows Part D plans that bid a nominal amount above the regional low-income subsidy (LIS) benchmark to absorb the cost of the difference between their bid and the LIS benchmark in order to remain a \$0 premium LIS plan

§3304: Special Rule for Widows and Widowers Regarding Eligibility for Low-Income Assistance

- Surviving spouse of LIS-eligible couple to delay LIS redetermination for one year after death of spouse

§3305: Improved Information for Subsidy Eligible Individuals Reassigned to Prescription Drug Plans and MA-PD Plans

- Requires HHS to transmit formulary and coverage determination information to subsidy-eligible beneficiaries who have been automatically reassigned to a new Part D low-income subsidy plan

§3306: Funding Outreach and Assistance for Low-Income Programs

- \$45 million to be used for outreach/education activities to State Health Insurance Programs, Administration on Aging, Aging Disability Resource Centers and National Benefits Outreach and Enrollment

§3307: Improving Formulary Requirements for Prescription Drug Plans and MA-PD Plans with Respect to Certain Categories or Classes of Drugs

- Codifies current 6 classes of clinical concern
- Removes criteria specified in §176 of MIPPA that HHS would have used to identify protected classes of drugs
- Secretary authorized to identify classes of clinical concern through rulemaking

§3308: Reducing Part D Premium Subsidy for High-Income Beneficiaries

- Reduces Part D premium subsidy for beneficiaries with incomes above Part B income thresholds

§3309: Elimination of Cost Sharing for Certain Dual Eligible Individuals

- Eliminates cost sharing for beneficiaries receiving care under a home and community-based waiver program who would otherwise require institutional care

§3310: Reducing Wasteful Dispensing of Outpatient Prescription Drugs in Long-Term Care Facilities Under Prescription Drug Plans and MA-PD Plans

- Part D plans to develop drug dispensing techniques to reduce prescription drug waste in LTC facilities

§3311: Improved Medicare Prescription Drug Plan and MD-PD Plan Complaint System

- Secretary to develop/maintain complaint system to handle complaints regarding MA and Part D plans or their sponsors

§3312: Uniform Exceptions and Appeals Process for Prescription Drug Plans and MA-PD Plans

- Part D plans to use single, uniform exceptions/appeals process

§3313: Office of the Inspector General Studies and Reports

- OIG to conduct study comparing prescription drug prices paid under Medicare Part D program to those paid under State Medicaid programs

§3314: Including Costs Incurred by AIDS Drug Assistance Programs and Indian Health Service in Providing Prescription Drugs Toward the Annual Out-of-Pocket Threshold Under Part D

- Drugs provided to beneficiaries by AIDS Drug Assistance Programs or Indian Health Service to count toward annual out-of-pocket threshold

§3315 Immediate Reduction in Coverage Gap in 2010

- Increases initial coverage limit in standard Part D benefit by \$500 for 2010
- \$250 rebate for all Part D enrollees who enter donut hole in 2010

§10328: improvement in Part D medication therapy management (MTM) programs

- Part D plans to include comprehensive review of medications (either in person or through telehealth technology) and written summary of review as part of MTM programs

Subtitle E—Ensuring Medicare Sustainability

§3401: Revision of Certain Market Basket Updates and Incorporation of Productivity Improvements into Market Basket Updates That Do Not Already Incorporate Such Improvements

- Incorporates productivity adjustment into market basket update for:
 - Inpatient hospitals, inpatient rehabilitation facilities, inpatient psychiatric hospitals and outpatient hospitals in 2012 and 2013
 - LTC hospitals in 2011, 2012 and 2013
 - Home health providers in 2013
 - Hospice providers in 2013 through 2019

§3402: Temporary Adjustment to the Calculation of Part B Premiums

- Freezes income thresholds at 2010 levels through 2019 for higher income beneficiaries who pay higher Part B premium rate

§3403: Establishment of an Independent Medicare Advisory Board

- Requires CMS's Chief Actuary to determine the per capita growth rate for Medicare each year following the second year of implementation
- Between the year of implementation (2014) and 2020, the Board will make yearly recommendations to reduce spending and improve quality of care in Medicare
- After 2020, the Board will only make binding recommendations every other year if growth in overall health spending exceeds growth in Medicare spending
- If the projection for the implementation year exceeds the target growth rate for the year, the Board must develop and submit a proposal with recommendations to reduce per capita spending to submit to Congress which should be implemented unless Congress enacts other legislation to slow the growth in spending
 - Recommendations should:
 - Result in a net reduction in total Medicare program spending
 - Reduce Medicare payments under parts C and D
 - Reduce payments to Medicare Advantage plans
 - Recommendations may not:
 - Ration care
 - Raise revenues or premiums
 - Increase beneficiary cost-sharing
 - Restrict benefits
 - Modify eligibility criteria
 - The Board should prioritize recommendations that extend Medicare solvency, and include those that:

- Improve health delivery and health outcomes (promoting integrated care, care coordination, prevention and wellness, quality and efficiency improvement)
- Protect access to evidence-based items and services
- Target reductions in program spending to sources of excess cost growth
- Consider how changes in payments to providers of services and suppliers effect beneficiaries

Subtitle F – Health Care Quality Improvements

§3501: Health Care Delivery System Research; Quality Improvement Technical Assistance

- Grants \$20M towards quality improvement and patient safety between 2010 and 2014
- Enables the Director of the Center for Quality Improvement and Patient Safety of the Agency for Healthcare Research and Quality (the Center) to identify, develop, evaluate, disseminate, and provide training in innovative quality improvement strategies
- Research should result in intended health outcomes, improved patient safety, reduced medical errors and improved workflow
- Technical assistance and implementation grants awarded to eligible institutions to train other institutions in quality improvement techniques or to implement models and practices identified by the Center

§3502: Establishing Community Health Teams to Support the Patient-Centered Medical Home

- Provides grants to establish community-based “health teams” designed to support primary care practices and the medical home
- Health teams must contract with primary care providers to:
 - Provide support services
 - Support patient-centered medical homes
 - Coordinate disease prevention and disease management
 - Serve as liaisons to community prevention and treatment programs
 - Develop and implement HIT
- Participating primary care providers must:
 - Provide care plans for patients
 - Provide access to health records
 - Meet regularly with care team to integrate care

§3503: Medication Management Services in Treatment of Chronic Diseases

- Provides grants to implement medication management services to treat individuals with chronic diseases aimed at improving quality of care and reducing the cost in treatment of such diseases
- Targeted individuals include those who:
 - Take four or more prescribed medications
 - Take any ‘high risk’ medications
 - Have two or more chronic diseases

§3504: Design and Implementation of Regionalized Systems for Emergency Care

- Allows the Assistant Secretary for Preparedness and Response to award at least four multiyear contracts or competitive grants to support pilot projects that design, implement, and evaluate innovative models of regionalized, comprehensive, and accountable emergency care and trauma systems for State, State partnership, Indian tribe or Indian tribe partnerships. Contracts or grants will be awarded to eligible entities who propose pilot projects aim to:
 - Develop a regional approach to emergency medical and trauma system access
 - Improve timeliness of patient transport
 - Allow for tracking of hospital resources
 - Create a data management system
- Requires that the HHS Secretary to support federal programs administered by NIH, AHRQ, HRSA, CDC, etc. that do research to improve the emergency care system looking at:

- Basic science of emergency care
- Model of service delivery and what contributes to better health outcomes
- Translation of research into practice
- Timely and efficient delivery of health services
- Requires that the HHS Secretary support federal programs administered by NIH, AHRQ, HRSA, CDC, etc. that do research to improve pediatric medical research including:
 - Examination of gaps and opportunities in research and strategy for the optimal organization and funding of research
 - Role as integrated component of overall health system
 - Planning, preparedness, coordination and funding
 - Training in professional education

§3505 Trauma Care Centers and Service Availability

- The Secretary will award grants to qualified public, nonprofit Indian Health Services, Indian tribal, and urban Indian trauma centers to:
 - Help defray uncompensated care costs
 - Further the mission of trauma centers (addressing costs and expenses, trauma education and outreach, coordination with local and regional trauma systems)
 - Provide emergency relief to ensure future sustainability of trauma services
- Minimum qualifications set for trauma centers:
 - Trauma centers must comply with guidelines set in §1213 (unless center is in a state with no trauma system)
 - Uncompensated care grants for trauma centers who meet at least one of the following criteria in one of the following categories:
 - Category A
 - 40% or more of visits in the emergency department were charity or self-pay patients
 - 50% or more of visits were Medicaid and charity and self-pay patients combined
 - Category B
 - 35% or more of visits in the emergency department were charity or self-pay patients
 - 50% or more of visits were Medicaid and charity and self-pay patients combined
 - Category C
 - 20% or more of visits in the emergency department were charity or self-pay patients
 - 30% or more of visits were Medicaid and charity and self-pay patients combined
 - Trauma centers in §1115 waiver states may qualify for uncompensated care grant if the center qualifies for funds under a Low Income Pool or Safety Net Care pool established through the waiver
 - Trauma centers must:
 - Be verified by the American College of Surgeons or designated by an equivalent state or local agency to qualify for funding
 - Prove they have a continued commitment to serve patients regardless of ability to pay
 - Have policies in place to assist patients who cannot pay for their treatment
- Awards for uncompensated care:
 - 100% of uncompensated care cost for category A trauma centers
 - Maximum of 75% uncompensated care cost for category B trauma centers
 - Maximum of 50% uncompensated care cost for category C trauma centers
- Core mission awards
 - 25% for Level III and Level IV trauma centers
 - 25% for large urban Level I and Level II trauma centers that:

- Have at least one graduate medical education fellowship in trauma or trauma related specialties for which annual uncompensated care costs exceed \$10M OR
 - At least 20% of emergency department visits are charity or self pay or Medicaid patients AND
 - Are not eligible for uncompensated care awards under §1241
- Emergency awards
 - Preference will be given to a trauma center that provides care in an area where care has decreased or will decrease if the center shuts down or lacks enough resources to care for the population
- Funding
 - Grants for three fiscal years unless waived by Secretary to give one extra year
 - \$2M maximum per year
 - 20% of funds should be used for uncompensated care, 20% for core mission awards and 10% for emergency awards
 - Of uncompensated care grants, 50% should be for category A, 35% for category B and 15% for category C
- \$100M per year from 2010-2015 in grants to states to promote universal access to trauma care services
 - Eligible entities must have:
 - Safety net public or nonprofit trauma centers
 - Hospitals in an underserved area

§3506: Program to Facilitate Shared Decision-Making

- Facilitates collaboration between patients and medical staff to ensure that informed patient preferences are considered in creating a medical plan beginning in 2010
- Establishes standards for “Patient Decision Aides” (educational tools) which allow patients to make well-informed decisions regarding their care
 - Gives 18 month contracts to eligible entity to certify patient decision aides
 - Requires that a broad range of experts and stakeholders convene to synthesize evidence and develop consensus based standards to evaluate decision aides
- Allows the Secretary to coordinate with heads of relevant agencies (such as NIH and CDC) to establish a program that awards grants or contracts to entities to develop, update, produce, test and disseminate decision aids
- Requirements for patient decision aides should:
 - Engage patients/caregivers/authorized representatives in informed decision making with their provider
 - Present timely, age-appropriate and educationally and culturally relevant evidence about risks and benefits of treatment options
 - Explain any lack of evidence to support one treatment over another
 - Address age-relevant information
- The Secretary will establish a Shared Decision-making Resource Center to manage development, implementation, training, technical assistance and evaluation of shared decision making efforts
- Provides grants to health care providers to develop, implement and assess certified shared decision-making techniques

§10331: Public reporting of performance information

- Secretary of HHS to develop “Physician Compare” website so Medicare beneficiaries can compare scientifically-sound measures of physician quality and patient experience measures

§3507: Presentation of Prescription Drug Benefit and Risk Information

- Allows the Secretary and the FDA to decide whether risks and benefits of prescription drugs should be advertised (for example, in the form of a drug facts box) in order to improve patient decision making
- Gives the Secretary one year to submit recommendations to Congress

- If the Secretary decides that labels would improve decision making, it should be implemented no later than 3 years after the submission of the report

§3508: Demonstration Program to Integrate Quality Improvement and Patient Safety Training into Clinical Education of Health Professionals

- Allows the Secretary to award grants to develop and implement academic curricula for health professionals that promote patient safety and quality improvement
- In order to be eligible, entities should:
 - Submit an application
 - Be from a health professional school
 - Collaborate with accrediting entity
 - Collect data regarding project effectiveness
 - Provide matching funds
- Starting two years after enactment, the Secretary will submit annual evaluations and recommendations to the Senate

§10332: availability of Medicare data for performance measurement

- Authorizes release and use of standardized extracts of Medicare claims data to measure the performance of providers/suppliers that protect patient privacy

§10325: revision to skilled nursing facility prospective payment system

- Delays implementation of certain skilled nursing facility ‘RUGs-IV’ payment system changes by one year (to Oct 1, 2011)

§3509: Improving Women’s Health

- Establishes an Office of Women’s Health which will aim to:
 - Establish goals within DHHS for disease prevention, health promotion, service delivery, research, and education
 - Provide advice to the Secretary regarding women’s health issues
 - Monitor DHHS activities regarding women’s health
 - Establish a Department of Health and Human Services Coordinating Committee on Women’s Health
 - Establish a National Women’s Health Information Center in order to:
 - Facilitate the exchange of health information
 - Facilitate access to information
 - Assist in analyzing issues and problems
 - Provide technical assistance
 - Coordinate health promotion with the private sector
 - Facilitate communication between the Office and grant recipients
- The Secretary may give grants to entities for evaluation and dissemination
- Also establishes Offices of Women’s Health within:
 - The Office of the Director of the Centers for Disease Control and Prevention
 - Director appointed by the Director of the Centers
 - The Office of the Director
 - Director appointed by the Director of Healthcare and Research Quality
 - The Office of the Administrator of the Health Resources and Services Administration
 - Director appointed by the Administrator of the Health Resources and Services Administration
- The directors of these offices shall:
 - Report to director’s appointer on level of activity
 - Establish goals for women’s health & coordinate with related offices
 - Identify projects to be conducted or supported
 - Consult with experts on the policy of the centers
 - Serve as a member of the DHHS Coordinating Committee on Women’s Health
- Establishes an Office of Women’s Health within the Office of the Commissioner
 - Director appointed by the Commissioner of Food and Drugs
 - Director shall:

- Report to the Commissioner on levels of activity
- Establish goals for women’s health including analysis of data by sex, if appropriate
- Provide information to women and providers regarding gender disparities
- Consult with relevant parties in regards to women’s health policies
- Estimate annual funding needs for clinical trials and analyses
- Serve as a member of the DHHS Coordinating Committee on Women’s Health
- Forbids the termination of any current Federal appointed position with responsibility over women’s health
- Forbids limiting the authority of the Secretary of Health and Human Services in terms of women’s health

§10334: minority health

- Codifies Office of Minority Health of Dept of HHS and a network of minority health offices within HHS

§3510: Patient Navigator Program

- Amends Section 340A of the Public Health Service Act
 - Limits grant periods to four years
 - Restricts grants to entities whose patient navigators meet core proficiencies
 - Extends \$3.5M of annual funding deadline from 2010 through 2015, if necessary

§3511: Authorization of Appropriations

- Authorizes appropriations of sums for Subtitle F

Subtitle G – Protecting and Improving Guaranteed Medicare Benefits

§3601: Protecting and Improving Guaranteed Medicare Benefits

- Guarantees no reduction of guaranteed benefits under title XVIII of the Social Security Act
- Ensures that savings generated for the Medicare program shall:
 - Extend the solvency of trust funds
 - Reduce premiums and other cost-sharing for beneficiaries
 - Improve/expand guaranteed benefits
 - Protect access to providers

§3602: No Cuts in Guaranteed Benefits

- Guarantees no reduction or elimination of benefits legally authorized to participants in Medicare Advantage plans

TITLE IV – PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH

Subtitle A – Modernizing Disease Prevention and Public Health Systems

§4001: National Prevention, Health Promotion and Public Health Council

- Allows the President to establish a “National Prevention, Health Promotion and Public Health Council” within the Department of Health and Human Services
 - The Surgeon General shall serve as the chairperson
 - The Council will be comprised of heads of appropriate Federal agencies
 - The purpose of the Council will be:
 - Provide Federal coordination of U.S. health and wellness
 - Develop a national prevention, promotion, and integrative strategy
 - Provide recommendations to the President and Congress regarding policy changes to address most pressing health prevention and promotion issues

- Consider and propose evidence-based models to promote individual and community health
 - Establish a process to gather public input
 - Submit national prevention and health promotion strategy reports
 - Carry out other activities determined appropriate by the President
- The President shall establish an d Advisory Group who will report to the Surgeon General
 - Maximum of 25 non-Federal members
 - Diverse group of licensed health professionals
 - Purpose is to develop policy and program recommendations to advise the Council including
 - Lifestyle-based chronic disease prevention and management
 - Integrative health care practices
 - Health Promotion
- The Chairperson and Council will develop a national prevention, health promotion and public health strategy no more than one year after the date of enactment which will:
 - Set specific goals and objectives for improving U.S. health through federally subsidized programs
 - Establish evaluation methods, including a timeline
 - Make recommendations to improve current Federal efforts
- Starting July 1, 2010 and annually thereafter, the Council shall submit a report to the President and relevant committees of Congress that:
 - Describes efforts on prevention, health promotion and public health
 - Describes national progress in meeting prevention, health promotion and public health goals
 - Contains a list of national priorities to address behavior modification and prevention measures for the five leading disease killers in the U.S.
 - Contains science-based initiatives to achieve goals of Healthy People 2010
 - Contains plans to consolidate Federal programs that promote health
 - Contains plans to assure Federal programs and non-DHHS programs are coordinated with science-based recommendations from CDC
- States that the Secretary and the Comptroller General should conduct periodic reviews and evaluation every five years, minimum

§4002: Prevention and Public Health Fund

- Establishes a Prevention and Public Health Fund administered through DHHS, Office of the Secretary to invest in prevention and help curb growing health care costs
- Funding:
 - \$500M in 2010
 - \$750M in 2011
 - \$1B in 2012
 - \$1.25B in 2013
 - \$1.5B in 2014
 - \$2B in 2015 and each year thereafter
- The Secretary shall transfer amounts to accounts within DHHS for programs that increase prevention and wellness
- The House and Senate appropriates committees maybe transfer funds to eligible activities

§4003: Clinical and Community Preventive Services

- Establishes an independent Preventive Services Task Force and a Community Preventive Services Task Force composed of individuals with appropriate expertise in order develop recommendations (Guide to Clinical Preventive Services) for the health care community on effective clinical preventive services
- The duties of the Task Forces include:
 - Develop new areas of interest and possible interventions
 - Review and update recommendations at least once every five years
 - Integrate with Federal health objectives
 - Disseminate recommendations

- Provide technical assistance when needed
 - Submit annual reports to Congress to identify gaps in research
- The Agency for Healthcare Research and Quality will provide ongoing administrative, research and technical support
- The Task Force will coordinate with each other and the Advisory Committee on Immunization Practices
- All members of the Preventive Services Task Force are not subject to political pressure

§4004: Education and Outreach Campaign Regarding Preventive Benefits

- The DHHS Secretary will plan a national prevention and promotion outreach and education campaign which includes dissemination of information that:
 - Describes importance of preventive services
 - Promotes use of preventive services
 - Encourages healthy behaviors
 - Explain preventive services covered under the Exchange plans
 - Describes additional care supported by Federal agencies
 - Includes general health information
- The Secretary shall consult with the Institute of Medicine on evidence-based scientific information for policies, programs, and evaluations
- The campaign should:
 - Be implemented no later than one year after enactment
 - Be designed to address lifestyle behaviors, five leading disease killers, and screening
 - Be carried out through competitive bidding for funding
 - May include multiple marketing mediums targeting specific age groups based on research
 - Not duplicate other efforts
 - May include humor and use of positive role models
 - Be evaluated every two years
- The Secretary will:
 - Establish a website, with the help of private sector experts, with science-based information for health care providers and consumers
 - Disseminate information through providers who participate in Federal programs, with the help of the CDC, that is consistent with national priorities
 - Develop and operate a Federal Internet website personalized prevention plan tool
 - Post most up-to-date scientific evidence for disease prevention for use by individuals
 - Allow individuals to calculate their disease risk based on individual measures
 - Establish an internet portal for accessing risk-assessment tools which will be maintained by private and academic entities
- \$500M maximum for campaigns and priority should be given to this funding over that through the CDC for similar goals
- Public awareness of preventive and obesity related services will be disseminated by:
 - The Secretary will provide guidance and information to States regarding obesity-related services for Medicaid beneficiaries
 - States will design public awareness campaigns
 - The Secretary will report to Congress starting January 1, 2011 and every three years thereafter until January 1, 2017

Subtitle B – Increasing Access to Clinical Preventive Services

§4101: School-Based Health Centers

- Provides grants to establish school-based health centers
- In order to be eligible for a grant, an entity should be:
 - A school-based health center or sponsoring one
 - Submit an application
- Those that serve large populations of children eligible for Medicaid, a waiver, or under the State child health plan will be given preference

- Grants are for facilities and may not be used to provide health services or for personnel*
- Appropriates \$50M for each fiscal year 2010 through 2013
- Definitions
 - Comprehensive primary health service should include:
 - Physical health
 - Mental health
 - Medically underserved children and adolescents
 - Residents of an area designated as medically underserved or has a shortage of health professionals
 - Shortages should be determined by:
 - Taking into account comments received from State and local officials
 - Including indicative health factors such as affordability, accessibility and availability
 - School-based health center (SBHC) is a health center that:
 - Does not perform abortion services
 - Provides comprehensive health services during school hours
 - Operates in accordance with established laws and standards, including parental consent
- To be eligible to receive a grant, the entity must:
 - Be a SBHC
 - Submit an application which contains:
 - Evidence that all criteria are met for entity to be a SBHC
 - Evidence of demand for the services
 - Assurance that services will be provided for children who have parental consent
 - Assurance that the SBHC is making effort to collaborate with other health care providers
 - Assurance that there will be on-site access during school hours and 24-hour on-call services, year-round
 - Assurance that the SBHC will be integrated into the academic environment and coordinate with other academic personnel
 - Assurance that the sponsoring facility takes responsibility for staffing the SBHC
 - Assurance that the SBHC will comply with laws concerning privacy and HIPAA laws
- Preference will be given to entities who serve communities of children with:
 - Barriers to primary and mental health care
 - High numbers of uninsured or high numbers of public program beneficiaries
 - Difficulties accessing health, mental health, and substance use disorder prevention services
- The Secretary may waive certain requirements, such a providing all comprehensive primary health services, for a period of time to be determined
- Funds may be used for:
 - Equipment
 - Training
 - Management and operation of programs
 - Staff salaries*
 - May not be used to provide abortions
 - Expanding and modernizing existing buildings
- Funds may not:
 - Overlap with another grant period
 - Be given to an entity in violation of a state law
- Eligible entities must provide 20% of the amount of the grant from non-Federal sources
 - Can be waived by the Secretary for those with serious hardship or other inabilities
 - Grants must supplement other Federal funds (not replace)
- The Secretary shall develop an evaluation plan
- Eligible entities should provide age-appropriate services

- No services may be performed without parental consent if the individual is a minor

§4102: Oral Healthcare Prevention Activities

- Establishes a five-year national, public education campaign focused on oral healthcare prevention and education through the Director for the Centers for Disease Control and Prevention
- The Secretary shall:
 - Ensure activities are targeted to specific vulnerable populations (children, pregnant women, the elderly, the disabled, ethnic and racial minority populations) and in a culturally and linguistically appropriate manner
 - Utilize science-based strategies to convey messages, including community water fluoridation and dental sealants
- The campaign will begin no more than two years after enactment, during which time the Secretary will plan the campaign
- Demonstration grants will be awarded to eligible entities who:
 - Will be a community-based provider of dental services
 - Submit an application
- Funds should be used to demonstrate effectiveness of research-based dental caries disease management activities
- Awards grants to 50 states and Indian territories

§4103: Medicare coverage of annual wellness visit providing a personalized prevention plan

- Annual wellness visit & personalized prevention plan services provided under Medicare without co-payments or deductibles
 - Includes comprehensive risk assessment, 5-10 year screening schedule, list of risk factors, education/advice/counseling, referral to community-based interventions

§4104: Removal of barriers to preventive services in Medicare

- Waives beneficiary coinsurance requirements for most preventive services
- Medicare to cover 100% of costs; beneficiaries do not pay coinsurance for preventive services

§4105: Evidence-based coverage of preventive services in Medicare

- Authorizes Secretary to modify coverage of any current covered preventive service in Medicare program as long as it is consistent with US Preventive Services Task Force (USPSTF) recommendations and not used for diagnosis/treatment

§4106: Improving access to preventive services for eligible adults in Medicaid

- Medicaid expanded to include:
 - Any clinical preventive services recommend with a grade A or B by USPSTF
 - Adult immunizations recommended by Advisory Committee on Immunization Practices (ACIP)
- States that cover these services without cost-sharing to receive increased FMAP of 1%

§4107: Coverage of comprehensive tobacco cessation services for pregnant women in Medicaid

- States required to provide Medicaid coverage for counseling/pharmacotherapy to pregnant women for tobacco cessation (diagnostic, therapy/counseling, prescription + nonprescription cessation agents approved by FDA)
- Prohibits cost-sharing

§4108: Incentives for prevention of chronic diseases in Medicaid

- Secretary to award grants to States to provide incentives for Medicaid beneficiaries to participate in programs providing incentives for healthy lifestyles
- Must have demonstrated success in helping individuals lower/control cholesterol and/or blood pressure, lose weight, quit smoking, prevent diabetes

Subtitle C – Creating healthier communities

§4201: Community transformation grants

- Authorizes Secretary to award competitive grants to promote individual/community health and prevent chronic disease
- 20% of Community Transformation Grants to be awarded to rural/frontier areas

§4202: Healthy aging, living well; evaluation of community-based prevention and wellness programs for Medicare beneficiaries

- To improve health status of pre-Medicare-eligibles by controlling chronic disease/reduce costs
- CDC to provide grants to States/large local health depts. To conduct pilot programs in 55-64 population to evaluate chronic disease risk factors, conduct evidence-based public health interventions, and ensure that individuals identified with chronic disease or at-risk for chronic disease receive clinical treatment to reduce risk

§4203: Removing barriers and improving access to wellness for individuals with disabilities

- Access Board to establish standards for accessibility of medical diagnostic equipment to individuals with disabilities

§10407: better diabetes care

- Secretary of HHS to develop national report card on diabetes; update every 2 years

§4204: Immunizations

- States to purchase adult vaccines under CDC contracts that provide 23-69% savings compared to private sector cost
- Grants for demo program to improve immunization coverage of children, adolescents and adults through evidence-based interventions
- Requires GAO study and report to Congress on vaccine coverage under Part D and impact on access to vaccines

§4205: Nutrition labeling of standard menu items at chain restaurants

- Compromise between Menu Education and Labeling (MEAL) Act (Harkin) and Labeling Education and Nutrition (LEAN) Act (Carper and Murkowski)
- Chain restaurant (>20 locations doing business under the same name) required to disclose calories on menu board and made available to customers upon request
 - Also includes total calories, fat calories, fat, saturated fat, cholesterol, sodium, total carbohydrates, complex carbohydrates, sugars, dietary fiber and protein

§10408: grants for small businesses to provide comprehensive workplace wellness programs

- \$200 million appropriated to give employees of small business access to comprehensive workplace wellness programs

§4206 Demonstration project concerning individualized wellness plan

- Pilot program to reduce risk factors for preventable conditions for at-risk populations who utilize community health centers

§4207 Reasonable break time for nursing mothers

- Amends Fair Labor Standard Act to require employers to provide break time/place for breastfeeding mothers to express milk
- Not applicable to employer with < 50 employees; no monetary damages

§10413: young women's breast health awareness and support of young women diagnosed with breast cancer

- Secretary of HHS to develop national education campaign for young women and health care professionals about breast health and risk factors

Subtitle D – Support for prevention and public health innovation

§4301: Research on optimizing the delivery of public health services

- Secretary to provide research funding for public health services and systems to examine:
 - Best practices relating to prevention, analyzing translation of interventions from academic institutions to clinics and communities, identifying effective strategies for delivering public health services in real world settings
- Annual report findings submitted to Congress

§4302: Understanding health disparities; data collection and analysis

- Any ongoing/new Federal health program must report/collect data by race, ethnicity, primary language and any other indicator of disparity
- Secretary to analyze data and monitor trends in health disparities

§4303: CDC and employer-based wellness programs

- CDC to study/evaluation best employer-based wellness practices
- Provide educational campaign and technical assistance to promote benefits of worksite health promotion

§4304: Epidemiology-laboratory capacity grants

- CDC to award grants to assist State, local and tribal public health agencies in improving surveillance for and responses to infectious diseases and other conditions of public health importance
- Grants used to strengthen epidemiologic capacity, enhance lab practices, improve information systems and develop outbreak control strategies

§4305: Advancing research and treatment for pain care management

- Authorizes Institute of Medicine Conference on Pain Care to evaluate adequacy of pain assessment, treatment and management
- Pain Consortium at NIH to enhance and coordinate clinical research on pain causes/treatments

§4306: Funding for childhood obesity demonstration project

- CHIP Reauthorization act of 2009 to improve quality of care under Medicaid and CHIP
- \$25 million for childhood obesity demonstration project; adjusts demo time period to FY2010-14

§10409: cures acceleration network

- Authorizes Cures Acceleration Network within NIH to award grants/contracts to develop cures and treatments of diseases

§10410: centers of excellence for depression

- Administrator of Substance Abuse and Mental Health Services Administration to award grants to centers of excellence in treatment of depressive disorders

§10411: programs relating to congenital heart disease

- Secretary of HHS to enhance/expand existing infrastructure to track epidemiology of congenital heart disease

§10412: automated defibrillation in Adam's Memory Act

- Amends/reauthorizes public access defibrillation programs in §312 of Public Health Service Act through 2014

Subtitle E – Miscellaneous Provisions

§4401: Sense of the Senate concerning CBO scoring

- Struck by §10405

§4402: Effectiveness of Federal health and wellness initiatives

- Secretary of HHS to evaluate effectiveness of existing Federal health and wellness initiatives

TITLE V – HEALTH CARE WORKFORCE

Subtitle A – Purpose and Definitions

§5001: Purpose

§5002: Definitions

Subtitle B – Innovations in the health care workforce

§5101: National health care workforce commission

- Establishes national commission to review health care workforce and projected workforce needs to provide comprehensive, unbiased information to Congress and Administration about how to align Federal health care workforce resources
- Added small business representation to Commission

§5102: State health care workforce development grants

- Grants created to enable State partnerships to complete comprehensive planning and to carry out activities leading to coherent and comprehensive health care workforce development strategies at State and local levels
- Support innovative approaches to increase skilled health care workers (e.g. career pathways for young people/adults)

§5103: Health care workforce assessment

- Codifies existing national center and establishes several regional centers for health workforce analysis to collect, analyze and report data related to Title VII of Public Health Service Act primary care workforce programs
- Centers to coordinate with State and local agencies to collect statistical information on labor/workforce

§5104: Interagency task force to assess and improve access to health care in the State of Alaska

- Temporary Task Force established to assess health care access and improve care delivery in AK

Subtitle C – Increasing the supply of the health care workforce

§5201: Federally supported student loan funds

- Eases loan qualification criteria for schools/students, shorten payback periods, decreases non-compliance provision to make primary care student loan program more attractive

§5202: Nursing student loan program

- Increases loan amounts from \$13,000 to \$17,000 per year through 2011; loans adjusted to provide cost-of-attendance increase for yearly loan rate and aggregate of loans
- Updates years for nursing schools to establish/maintain student loan funds

§5203: Health care workforce loan repayment programs

- Establishes loan repayment program for pediatric subspecialists and providers of mental and behavioral health services to children and adolescents who are/will be working in a Health Professional Shortage Area, Medically Underserved area or with Medically Underserved Population

- §5204: Public health workforce recruitment and retention program
- Loan repayment to public health students and workers in exchange for working at least 3 years at federal, state, local or tribal public health agency

- §5205: Allied health workforce recruitment and retention program
- Loan repayment to allied health professionals employed at health agencies or in settings providing health care to patients (including acute care facilities, ambulatory care facilities, residences and other settings located in Health Professional Shortage Areas, Medically Underserved Areas or serving Medically Underserved Populations)

- §5206: Grants for States and local programs
- Awards scholarships to mid-career public and allied health professionals employed in public and allied health positions at Federal, State, tribal or local level to receive additional training in public/allied health fields

- §5207: Funding for National Health Service Corps
- Increases/extends authorization or appropriates for National Health Service Corps scholarship and loan repayment for FY2010-15:
 - \$320,461,632 for FY2010
 - \$414,095,394 for FY2011
 - \$535,087,442 for FY2012
 - \$691,431,432 for FY2013
 - \$893,456,433 for FY2014
 - \$1,154,510,336 for FY2015

- §5208: Nurse-managed health clinics
- Strengthens safety-net by creating \$50 million grant program administered by HRSA to support nurse-managed health clinics

- §5209: Elimination of cap on the Commissioned Corps
- Allows Corps to expand to meet national public health needs by eliminating artificial cap on number of Commissioned Corps members

- §5210: Establishing a Ready Reserve Corps
- Ready Reserve Corps within Commissioned Corps for service in times of national emergency
 - Members may be called to active duty to respond to national emergencies and public health crises, and to fill critical public health positions left vacant by members of Regular Corps who have been called to duty elsewhere

Subtitle D – Enhancing health care workforce education and training

§5301: Training in family medicine, general internal medicine, general pediatrics and physician assistantship

- Grants to develop/operate training programs, financial assistance to trainees/faculty, enhance faculty development in primary care and physician assistant programs
 - Authorized to appropriate \$125,000,000 for FY2010 and such sums as may be necessary for FY2011-14
- Priority given to programs that educate students in team-based approaches to care (e.g. patient-centered medical home)
- Grants to establish maintain and improve academic units in primary care
 - \$750,000 authorized to be appropriated for each FY from 2010-14

§5302: Training opportunities for direct care workers

- Funding for 3 years to establish new training opportunities for direct care workers providing LTC services/supports

- §5303: Training in general, pediatric and public health dentistry
- Allows dental schools/education programs to use grants for pre-doctoral training, faculty development, dental faculty loan repayment and academic administrative units
- §10501: amendments to Title V
- (e) National diabetes prevention program: establishes diabetes prevention program at CDC
- §5304: Alternative dental health care provider demonstration project
- Authorizes Secretary to award grants to establish training programs for alternative dental health care providers to increase access in rural, tribal and underserved communities
- §5305: Geriatric education and training; career awards; comprehensive geriatric education
- Funding to geriatric education centers to:
 - Support training in geriatrics, chronic care management and LTC for faculty in health professions schools and family caregivers
 - Develop curricula and best practices in geriatrics
 - Expand geriatric career awards to advance practice nurses, clinical social workers, pharmacists and psychologists
 - Establish traineeships for individuals preparing for advanced education nursing degrees in geriatric nursing
 - No more than 24 grants of \$150,000 each
- §5306: Mental and behavioral health education and training grants
- Grants to schools for development, expansion or enhancement of training programs in social work, graduate psychology, professional training in child/adolescent mental health and pre-service or in-service training to paraprofessionals in child/adolescent mental health
 - For FY2010-13:
 - \$8,000,000 for training in social work
 - \$12,000,000 for training in graduate psychology, with no less than \$10,000,000 allocated for doctoral, postdoctoral and internship level training
 - \$10,000,000 for training in professional child and adolescent mental health
 - \$5,000,000 for training in paraprofessional child and adolescent work
- §5307: Cultural competency, prevention and public health and individuals with disabilities training
- Reauthorizes/expands programs to support development, evaluation and dissemination of model curricula for cultural competency, prevention and public health proficiency/aptitude for working with disabled
- §5308: Advanced nursing education grants
- Strengthens language for accredited Nurse Midwifery programs to receive advanced nurse education grants in Title VIII of Public Health Service Act
- §5309: Nurse education, practice and retention grants
- Grants to nursing schools to strengthen nurse education/training programs and to improve nurse retention
- §5310: Loan repayment and scholarship program
- Adds faculty at nursing schools as eligible individuals for loan repayment/scholarship programs
- §5311: Nurse faculty loan program
- Establishes Federally-funded student loan repayment program for nurses with outstanding debt who pursue careers in nurse education
 - Must teach at accredited school of nursing for at least 4 years within a 6 year period
- §5312: Authorization of appropriations for parts B through D of Title VIII
- \$338 million to fund Title VIII of Public Health Service Act nursing programs

§5313: Grants to promote the community health workforce

- Secretary to award grants to States, public health departments, clinics, hospitals, FQHC and other nonprofits to promote positive health behaviors/outcomes in medically underserved areas through use of community health workers
 - Community health workers offer interpretation/translation services, culturally appropriate health education/information, information counseling/guidance on health behaviors, advocate for individual/community health needs

§5314: Fellowship training in public health

- Secretary to address workforce shortage in State and local health departments in applied public health epidemiology, laboratory science and informatics

§5315: United States Public Health Sciences Track

- Directs Surgeon General to establish US Public Health Sciences Track (USPHST) to train physicians, dentists, nurses, physician assistants, mental and behavior health specialists, and public health professionals
- Emphasis on team-based service, public health, epidemiology and emergency preparedness/response
- Students receive tuition remission/stipend and accepted as Commission Corps officer in US Public Health Service with 2 year service commitment for each year of school covered

§10501: amendments to Title V

- (n)(1) National Health Service Corps improvements: increases loan repayment amount, allows for half-time service and allow for teaching to count for up to 20% of Corps service commitment

§5316: Rural physician training grants

- Grant program for medical schools to recruit/train medical students to practice medicine in underserved rural communities; 3 year grants for eligible entities (FQHC or nurse managed health clinic)
- Each grant recipient to receive no more than \$600,000/year

§5317: Demonstration grants for family nurse practitioner programs

- 12 month training program for careers as primary care providers in FQHCs and Nurse Managed Health Clinics (NMHCs)
- 3 year grants to FQHCs, 330A-1 NMHCs with capacity to train at least 3 practitioners
- Grants not to exceed \$600,000 per year for FY2011-2014

Subtitle E – Supporting the Existing Health Care Workforce

§5401: Centers of Excellence

- Reauthorized at 150% of 2005 appropriations for FY2010-2015
 - \$50 million per fiscal year, and sums as are necessary for subsequent years
 - Maintenance of effort requirement for existing activities

§5402: Health Care Professionals Training for Diversity

- Reauthorization for loan repayments and fellowships regarding faculty positions
 - Increases annual repayment from \$20,000 to \$30,000
 - Appropriates \$5 million for FY2010-2014
- Appropriates \$51 million for FY2010, and such sums as necessary 2011-2014 for scholarships to disadvantaged students
- Reauthorizes educational assistance in the health professions regarding individuals from a disadvantaged background
 - \$60 million in FY2010, sums as necessary 2011-2014

§5403: Interdisciplinary, Community-based linkages

- Amends section 751 of the Public Health Service Act as follows:

- §751: Area Health Education Centers
 - Infrastructure development award for healthcare workforce educational programs
 - Point of service maintenance and enhancement award for community-based innovations
 - Appropriates \$125 million annually for FY2010-2014
- Amends section 752 of the Public Health Service Act by striking this section and adding:
 - §752: Continuing Educational Support for Health Professionals Serving in Underserved Communities
 - Grants to enhance education and innovative support activities for primary care
 - Appropriates \$5 million annually for FY2010-2014

§5404: Workforce Diversity Grants

- Expands grants to associate degrees, bridge or degree completion programs, student scholarships or stipends for accelerated degree programs, pre-entry preparation, advanced education preparation, retention activities

§5405: Primary Care Extension Program

- §399W: Provides support to primary care providers to educate providers about preventive medicine, health promotion, chronic disease management, evidence-based medicine, mental health, and community-based health connectors
 - 6-year grants to establish state Program Hubs, with \$120 million appropriated annually for FY 2011-2012 and sums as necessary for 2013-2014

§10501: amendments to Title V

- (d) Loan repayment for faculty at schools that train physician assistants: includes faculty of PA schools as eligible for faculty loan repayment with in workforce diversity program

Subtitle F – Strengthening Primary Care and Other Workforce improvements

§5501: Expanding Access to Primary Care Services and General Surgery Services

- 10% Medicare bonus payment for primary care and general surgery services furnished 2011-2016 in shortage areas
 - Qualifying HCPCS services: 99201-99215, 99304-99340, 99341-99350

§5502: Medicare Federally Qualified Health Center Improvements

- Expansion of covered preventive services at centers
- Prospective payment system implementation
 - Data collection requirements for FQHCs prior to implementation
 - Payment of 103% of estimated expenditure upon system initiation, with future payments based on previous year expenditure

§5503: Distribution of Additional Residency Positions

- Allows HHS to redistribute unused residency slots to primary care training in shortage areas
- After July 1, 2011 for hospitals with unused slots for 3 consecutive cost reports, except in rural areas

§5504: Counting Resident Time in Non-provider Settings

- Effective July 1, 2010, any training time spent by resident in non-provider setting shall be counted towards Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME) funding

§5505: Rules for Counting Resident Time for Didactic and Scholarly Activities and Other Activities

- Counts conferences, seminars, vacation, sick or other leave towards IME costs
- Effective immediately

§5506: Preservation of Resident Cap Positions from Closed Hospitals

- Allows Secretary to redistribute residency slots in case of hospital closure within the last two years

§5507: Demonstration Projects to Address Health Professions Workforce Needs; Extension of Family-to-Family Health Information Centers

- §2008: Demonstration Projects to Address Health Professions Workforce Needs
 - Project to provide low-income individuals with opportunities for education, training, and career advancement to address health professions workforce needs
 - Appropriates \$80 million annually for FY2010-2014
 - Project to develop training and certification programs for personal or home care aides
 - Appropriates \$5 million annually for FY2010-2014

§5508: Increasing Teaching Capacity

- §749A: Teaching Health Centers Development Grants
 - Grant program to establish new or expanded primary care residency programs
 - \$25 million for FY2010, \$50 million for FY2011, \$50 million for 2012, and sums as necessary for each year thereafter
 - Subpart XI – Support of Graduate Medical Education in Qualified Teaching Health Centers
 - §340H: Program of Payments to Teaching Health Centers that Operate Graduate Medical Education Programs
 - Appropriates \$230 million for FY2011-2015 for expenses related to training primary care providers

§5509: Graduate Nurse Education Demonstration

- Appropriates \$50 million annually for FY2010-2015 in Medicare costs to 5 hospitals to increase graduate nurse education training (nurse practitioner, clinical nurse specialist, certified nurse anesthetist, nurse-midwife)

§10501: Amendments to Title V

- (l) Rural physician training grants: grants for medical schools to establish programs that recruit students from underserved rural areas who wish to practice in their hometowns
- (m)(l) Preventive medicine and public health training grant programs: amends/reauthorizes §768 of Public Health Service Act

Subtitle G – Improving Access to Health Care Services

§5601: Spending for Federally Qualified Health Centers (FQHCs)

- Additional appropriations of \$2.9 billion in 2010, \$3.8 billion in 2011, \$4.9 billion in 2012, \$6.4 billion in 2013, \$7.3 billion in 2014, \$8.3 billion in 2015, and increasing based on average costs

§5602: Negotiated Rulemaking for Development of Methodology and Criteria for Designating Medically Underserved Populations and Health Professions Shortage Areas

- Directs Secretary to establish rulemaking process with advisement from stakeholders, with target publication date of July 1, 2010

§5603: Reauthorization of the Wakefield Emergency Medical Services for Children Program

- Reauthorizes grant awards to states and medical schools to support expansion of emergency medical services for children's trauma care
- Appropriates \$25 million in FY2010, increasing annually to \$30 million in 2014

§5604: Co-Locating Primary and Specialty Care in Community-Based Mental Health Settings

- §520K: Awards for Co-locating Primary and Specialty Care in Community-based Mental Health Settings

- Appropriates \$50 million for FY 2010, and sums as necessary for 2011-2014 for grants to qualifying projects

§10502: Infrastructure to expand access to care

- Provides funding to HHS for construction or debt service on hospital construction costs for new health facility

§10503: Community Health Centers and National Health Service Corps Fund

- Establishes titular fund that will create expanded and sustained national investment in community health centers under §330 of Public Health Service Act and National Health Service Corps

§5605: Key National Indicators

- Establishes a Commission on Key National Indicators to conduct comprehensive oversight of a newly established key national indicators system
- Establishment of national indicator system
- GAO study and report on previous best practices for a indicator system
- Appropriates \$10 million for FY2010 and \$7.5 million annually for FY2011-2018

§10504: demonstration project to provide access to affordable care

- Secretary of HHS to establish 3-year demo project in States to provide comprehensive health care services to uninsured at reduced fees

Subtitle H – General Provisions

§5701: Reports

- Secretary shall submit report on activities in this Section to appropriate Committees of Congress

TITLE VI – TRANSPARENCY AND PROGRAM INTEGRITY

Subtitle A – Physician Ownership and Other Transparency

§6001: Limitation on Medicare Exception to the Prohibition on Certain Physician Referrals for Hospitals

- Prohibits physician-owned hospitals that don't have provider agreement and prohibits physicians from self-referring patients to hospitals in which they own
- Before December 31, 2010 from participating in Medicare
- New requirements for participating hospitals address conflict of interest, bona fide investments, patient safety, and expansion limitations

§6002: Transparency Reports and Reporting of Physician Ownership or Investment Interests

- Beginning March 31, 2013, requires any manufacturer (drug, device, biological, medical supply) that provides a payment or other transfer of value to a physician/practice/group/hospital to submit notification to HHS, or be subject to a fine up to \$10,000
- Requires Secretary to establish reporting procedure by October 1, 2011

§6003: Disclosure Requirements for In-office Ancillary Services Exception to the Prohibition on Physician Self-Referral for Certain Imaging Services

- Requires a referring physician to inform the patient in writing that the individual may obtain the service outside the physician's group
- Effective January 1, 2010

§6004: Prescription Drug Sample Transparency

- Part A of title IX of the Social Security Act as amended by section 2002 of this Act is amended by adding:

- §1128H: Reporting of Information Relating to Drug Samples
 - Requires drug manufacturers and distributors to report information regarding drug samples beginning April 1, 2012

§6005: Pharmacy Benefit Managers Transparency Requirements

- Part A of title IX of the Social Security Act is amended by adding after section 1150, the following section:
 - §1150A: Pharmacy Benefit Managers Transparency Requirement
 - Requires Pharmacy Benefit managers (PBM) that contract with health plans under Medicare to provide information on percentage of prescriptions provided through retail pharmacies and mail order, percentage for which a generic was available and dispensed, pharmacy type, and aggregate amounts of rebates, discounts, concessions that were negotiated

§10609: labeling changes

- Modifies requirements applicable to labeling of generic drugs

Subtitle B – Nursing Home Transparency and Improvement

Part I – Improving Transparency of Information

§6101: Requires Disclosure of Ownership and Additional Disclosable Parties information

- Requires Medicare Skilled Nursing Facilities (SNF) and Medicaid Nursing Facilities (NF) to make available information on governing board identity, employees, organizational structure of additional parties with effective date determined by Secretary

§6102: Accountability Requirements for Skilled Nursing Facilities and Nursing Facilities

- §1128I: Accountability Requirements for Facilities
 - Within 36 months of enactment, requires facilities to have in operation a compliance and ethics program effective in preventing and detecting criminal, civil, and administrative violations

§6103: Nursing Home Compare Medicare Website

- Requires Secretary to add information to website including facility staffing data, links to State websites with information regarding survey and certification programs, standardized complaint form use, and the number of adjudicated instances of criminal violations by facility or employees
- Effective one year after enactment

§6104: Reporting on Expenditures

- Requires Secretary to modify cost reports to include expenditures on wages and benefits of staff, separating RNs, licensed professional nurses, certified nursing assistants, and other medical and therapy staff
- Effective 2 years after date of enactment

§6105: Standardized Complaint Form

- Requires Secretary to develop a standardized complaint form for use by residents, and requires states to establish complaint resolution process
- Effective one year after enactment

§6106: Ensuring Staffing Accountability

- Requires Secretary to develop program for facilities to report staffing and contracting information based on payroll data no later than 2 years after enactment

§6107: GAO Study and Report on Five-star Quality Rating System

- Study will include analysis of the systems implementation and improvements no later than two years after enactment

Part II – Targeting Enforcement

§6111 Civil Money Penalties

- Provides Secretary with authority to reduce civil monetary penalties (CMP) for facilities that self-report and promptly correct deficiencies within 10 days of imposition
- Effective one year after enactment

§6112: National Independent Monitor Demonstration Project

- Instructs HHS to develop, test, and implement an independent monitor program to oversee interstate and large intrastate chains of skilled nursing facilities within one year of enactment

§6113: Notification of Facility Closure

- Requires administrator of facility preparing to close to notify residents, the State, and the Secretary in writing at least 60 days before closure or be subject to penalty
- Requires preparation of plan for safe transfer of residents
- Effective 1 year after enactment

§6114: National Demonstration Projects on Culture Change and Use of Information Technology in Nursing Homes

- One project to develop best practices in nursing facilities involved in culture change movement
- One project to develop best practices in use of information technology to improve resident care
- Implementation no later than one year after enactment, with appropriations as necessary

Part III – Improving Staff Training

§6121: Dementia and Abuse Prevention Training

- Requires facilities to include dementia management and abuse prevention training as part of pre-employment initial training
- Effective one year after enactment

§6201: Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-term Care Facilities and Providers

- Requires the Secretary to establish a nationwide program based on the background check pilot program in Medicare Modernization Act, with appropriations as necessary

Subtitle D – Patient-Centered Outcomes Research

§6301: Patient-Centered Outcomes Research

- Establishment of a non-profit organization, the Patient-Centered Outcomes Research Institute outside of government to disseminate, train, and build data capacity for comparative effectiveness research
- Governed by public-private sector appointed Board, with appropriations of \$10 million in FY 2010, \$50 million in 2011, \$150 million in 2012 and increasing thereafter based on revenue relating to fees on health plans
- Prohibits findings to be construed as mandates on practice guidelines or coverage decisions

§6302: Federal Coordinating Council for Comparative Effectiveness Research

- Sunsets the council upon enactment

Subtitle E – Medicare, Medicaid, and CHIP Program Integrity Provisions

§6401: Provider Screening and Other Enrollment Requirements under Medicare, Medicaid and CHIP

- Requires Secretary to establish screening procedures, where all providers and suppliers would be subject to licensure checks at the minimum, with additional measures based on risk: fingerprinting, criminal background checks, multi-state database inquiries, and site visits

- Provider and suppliers enrolling or re-enrolling in Medicare, Medicaid, and CHIP required to disclose current/previous affiliations with provider and suppliers that have uncollected debt, have had payments suspended, have been excluded from participating in public programs, or have had billing privileges revoked
 - Secretary authorized to deny enrollment if affiliation poses undue risk
- Requires providers and suppliers to establish a compliance program developed by the Secretary
- 90 day period of enhanced oversight for initial claims of DME suppliers beginning January 1, 2011

§6402: Enhanced Medicare and Medicaid Program Integrity Provisions

- CMS shall include claims and payment data from Medicare (Parts A,B,C,D), Medicaid, CHIP, VA/DOD programs, SSA, and HIS in the integrated data repository (IDR)
- Requires Secretary to enter into data-sharing agreements with Social Security Commissioner, VA and DOD Secretaries, Director of HIS to help identify waste, fraud, and abuse, and allows HHS and Attorney General to have access to data for law enforcement purposes
- Requires overpayments to be reported and returned within 60 days of payment identification or by due date of cost report, whichever is later
- Requires all public program providers to include their national provider identifier on enrollment applications
- Withholds federal matching payments to states that do not report enrollee encounter data to the state's Medicaid Managed Information System (MMIS)
- Expands Civil Monetary Penalties (CMP) to individuals who knowingly make false statements, omissions, misrepresentations under federal health programs
- Allows Secretary to issue subpoenas and require witness testimony in fraud cases
- Requires Secretary to take into account the volume of billing for Durable Medical Equipment (DME) when determining the size of a surety bond.
- Authorizes suspension of payments to provider or supplier under fraud investigation
- Increases Health Care Fraud and Abuse Control (HCFAC) to \$250 million for FY2011-2020
- Requires Medicare and Medicaid integrity Program contractors to provide performance statistics including recovered overpayments, fraud referrals, and return on investment

§6403: Elimination of Duplication Between the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank

- Eliminates HIPDB and transfers collection to NPDB one year after enactment

§6404: Maximum Period for Submission of Medicare Claims Reduced to not more than 12 Months

- Reduces from three years to one year, effective January 1, 2010

§6405: Physicians Who Order Items or Services Required to be Medicare Enrolled Physicians or Eligible Professionals

- Required for Durable Medical Equipment or home health services, with additional services authorized by the Secretary
- Clarifies that only physicians may order home health services under Part A and B
- Effective July 1, 2010

§6406: Requirement for Physicians to Provide Documentation on Referrals to Programs at High Risk of Waste and Abuse

- Grants Secretary the authority and extends the HHS permissive exclusion authority to disenroll physicians and suppliers that fail to maintain and provide access to written orders or requests for DME payment, certification for home health services, or other referrals
- Effective January 1, 2010

§6407: Face-to-Face Encounter with Patients Required Before Physicians May Certify Eligibility for Home Health Services or Durable Medical Equipment Under Medicare

- Authorizes Secretary to apply requirement to other items and services if doing so would reduce fraud, waste, and abuse

- Effective January 1, 2010

§6408: Enhanced Penalties

- Imposes penalty for false statements for up to \$50,000 or delaying inspection up to \$15,000 per day of failure for unverified Medicare Advantage or Part D enrollment, plan transfer for the purpose of earning commission, marketing requirement compliance, contracting with an entity that commits a violation
- Effective January 1, 2010

§6409: Medicare Self-Referral Disclosure Protocol

- Requires Secretary to establish protocol to enable providers and suppliers to disclose actual and potential violation of physician self-referral law within 6 months of enactment

§6410: Adjustments to the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Acquisition Program

- Expands the number of bidding areas from 79 to 100 of the largest metropolitan statistical areas (MSA), and to use competitively bid prices in all areas by 2016

§6411: Expansion of the Recovery Audit Contractor (RAC) Program

- Requires states to establish contracts with one or more RACs to identify underpayments and overpayments, and to recoup overpayments made under state Medicaid plans and state waivers
- Expand RAC to Part C and D

§6501: Termination of Provider Participation Under Medicaid if Terminated Under Medicare or Other State Plan

- Requires states to terminate individuals and entities from their Medicaid programs in they were terminated from Medicare or another state's Medicaid program

§6502: Medicaid Exclusion from Participation Relating to Certain Ownership, Control, and Management Affiliations

- Excludes individuals and entities that have failed to repay overpayments, are suspended, excluded or terminated from participation in any Medicaid program, or are affiliated with other excluded entities

§6503: Billing Agents, Clearinghouses, or Other Alternate Payees Required to Register Under Medicaid

- For any alternate payees submitting claims on behalf of providers, in a manner specified by the Secretary

§6504: Requirement to Report Expanded Set of Data Elements Under MMIS to Detect Fraud and Abuse

- Requires states and Medicaid managed care entities to submit data elements as determined necessary by the Secretary for program integrity, oversight, and administration
- Effective January 1, 2010

§6505: Prohibition on Payments to Institutions or Entities Located Outside of the United States

- For Medicaid state plan or waiver

§6506: Overpayments

- Extend state repayment due date from 60 days to one year when amount is in ongoing judicial or administrative determination, and 30 days after judgment for fraud overpayments, effective immediately

§6507: Mandatory State Use of National Correct Coding Initiative

- Requires states to make their Medicaid Management Information System compatible with Medicare's national correct coding initiative (NCCI)

§6508 General Effective Date

- Unless otherwise noted, this subtitle takes effect January 1, 2011 with acceptable delay if state legislation required

Subtitle G – Additional program integrity provisions

§6601: prohibition on false statements and representations

- Multiple employer welfare arrangement (MEWA) employees/agents subject to criminal penalties if they provide false statements in marketing materials

§10606: health care fraud enforcement

- Enhances sentencing guidelines, changes intent requirement for fraud under anti-kickback statute, increases subpoena authority relating to health care fraud

§6602: Clarifying definitions

§6603: Development of model uniform report form

- Model uniform reporting form to be developed for consistent reporting of suspected cases of fraud and abuse

§6604: Applicability of State law to combat fraud and abuse

- Dept of Labor to adopt regulatory standards to prevent fraudulent MEWAs who claim that State law enforcement is preempted by Federal law

§10607: State demonstration programs to evaluate alternatives to current medical tort litigation

- Grants to States to test alternatives to civil tort litigation

§6605: Enabling the Department of Labor to issue administrative summary cease and desist orders and summary seizures orders against plans in financially hazardous condition

- Dept of Labor can issue “cease and desist” orders to temporarily shut down operations of plans conducting fraudulent activities until hearings can be completed; can also seize a plan’s assets if plan is in a financially hazardous condition

§6606: MEWA plan registration with Dept of Labor

- MEWA required to file Federal registration forms and subject to government verification

§6607: permitting evidentiary privilege and confidential communication

- Dept of Labor to allow confidential communication among public officials relating to fraud/abuse investigations

§10608: extension of medical malpractice coverage to free clinics

- Extended to free clinics

Subtitle H – Elder Justice Act

§6701: Short title of subtitle – Elder Justice Act of 2009

§6702: Definitions

§6703: Elder justice

- Secretary of HHS to award grants and provide greater protection to those seeking care in LTC facilities
- Owners, operators and employees of these facilities required to report suspected crimes

Subtitle I – Sense of the Senate regarding medical malpractice

§6801: Sense of the senate regarding medical malpractice

- States should be encouraged to develop/test alternative models to existing civil litigation system

Title VII: Improving access to innovative medical therapies

Subtitle A – Biologics price competition and innovation

§7001: Short title – Biologics Price Competition and Innovation Act of 2009

§7002: Approval pathway for biosimilar biological products

- Establishes process to license biological product shown to be biosimilar to or interchangeable with a licensed biological product
- Prohibits approval of application as either biosimilar or interchangeable until 12 years from the date the reference product is first approved
- Includes patent infringement provisions (e.g. exchange of information, good faith negotiations, etc)

§7003: Savings

- Secretary of Treasury to determine amount of savings for each fiscal year as a result of the enactment of this subtitle
- Savings to be used for deficit reduction

Subtitle B – More affordable medicines for children and underserved communities

§7101: Expanded participation in 340B program

- Extends 340B discounts to inpatient drugs
- Extends participation to certain children's hospitals, cancer hospitals, critical access and sole community hospitals

§7102: improvements to 340B program integrity

- Establishes new auditing, reporting and compliance requirements for Secretary, pharmaceutical manufacturers and 340B covered entities

7103: GAO study to make recommendations on improving the 340B program

- To be done within 18 months

Title VIII – Community living assistance services and supports

§8002: Establishment of national voluntary insurance program for purchasing community living assistance services and support (CLASS program)

- Establishes CLASS program for the purchase of community living assistance services and support by individuals with functional limitations
- Allows 5-year vesting period for eligibility of benefits
- No taxpayer funds to be used to pay benefits under this provision

Title IX – Revenue provisions

Subtitle A – Revenue offset provisions

§9001: Excise tax on higher cost employer-sponsored health coverage

- Levies 40% excise tax on insurance companies/plan administrators for any health coverage plan above the \$10,200/single coverage and \$27,500/family coverage threshold
 - Tax would apply to amount of premium in excess of threshold

- Tax would apply to self-insured plans and those in group market, but not in individual market
- Threshold does not include stand-alone dental and vision coverage
- Threshold would be indexed at CPI-U plus one percentage point in year 2019 and CPI-U in years thereafter
- Tax applies to self-insured plans and plans sold in the group market, but not to plans sold in the individual market (except for coverage eligible for the deduction for self-employed individuals)
- Effective after Dec 31, 2017
- Additional threshold of \$1,650/singles and \$3,450/families available for retired individuals ≥55 years old, and for plans that cover employees engaged in high risk professions

§9002: Inclusion of cost of employer-sponsored health coverage on W-2

- Employers to disclose benefit value for each employee's insurance coverage on the employee's W-2

§9003: Distributions for medicine qualified only if for prescribed drug or insulin

- Conforms definition of qualified medical expenses for HSAs, FSAs and HRAs to definition used for medical expense itemized deductions

§9004: Increase in additional tax on distributions from HSAs and Archer MSAs not used for qualified medical expenses

- Additional tax for HS withdrawals before age 65 that are used for purposes other than qualified medical expenses increased from 10 to 20%
- Increased from 15 to 20% for Archer MSA withdrawals

§9005: limitation on health flexible spending arrangements under cafeteria plans

- FSA contributions limited to \$2,500/year

§9006: expansion of information reporting requirements

- Business that pay >\$600 to corporate/non-corporate providers of property and services to file information report with each provider and IRS

§9007: additional requirements for charitable hospitals

- New requirements for nonprofit hospitals, including periodic community needs assessment
- Changes limitation on amount that can be charged by charitable hospital for emergency/medically necessary care from "lowest amount charged" to individuals who have insurance to "the amount generally billed"

§9008: imposition of annual fee on branded prescription pharmaceutical manufacturers and importers

- Effective after December 31, 2010, the fee on pharmaceutical manufacturers will be changed to the following:
 - \$2.5 billion in 2011
 - \$2.8 billion in years 2012-2013
 - \$3.0 billion in 2014-2016
 - \$4.0 billion in 2017
 - \$4.1 billion in 2018
 - \$2.8 billion in year 2019 and after
- Non-deductible; allocated across industry according to market share; not applied to companies with sales of branded pharmaceuticals of \$5 million or less
 - §9009: imposition of annual fee on medical device manufacturers and importers
 - Annual fee of \$2 billion on medical device manufacturing sector
 - Non-deductible; allocated across industry according to market share; not applied to companies with sales of medical devices in US of \$5 million or less

§9010: Imposition of annual fee on health insurance providers

- The applicable amount of the fee on health insurance providers is changed to the following:

- \$8.0 billion in 2014
- \$11.3 billion in years 2015-2016
- \$13.9 billion in 2017
- \$14.3 billion in 2018
- For years after 2018, the amount of the annual fee is the amount for the preceding year increased by the rate of premium growth for the preceding calendar year
- Modifies the exemption from the fee to include non-profits which receive more than 80 percent of their gross revenues from government programs that target low-income, elderly, or disabled populations
- 50 percent of net premiums written by entities who are exempt from federal income tax under Internal Revenue Code sections 501(c)(3), (4), (26), and (29) are included in determination of an entity's market share
- Provision is delayed for three years and becomes effective after December 31, 2013
 - Non-deductible; allocated across industry according to market share; not applied to companies whose net premiums written are \$25 million or less

§9011: Study and report of effect on veteran health care

- Secretary of US Dept of VA to review and report to Congress on the effect that fees assessed on pharmaceutical and medical device manufacturers and health insurance providers have on cost of medical care provided to veterans

§9012: Eliminate deduction for expenses allocable to Medicare Part D

- Eliminates deduction for subsidy for employers who maintain prescription drug plans for Part D eligible retirees
- Effective after Dec 31, 2012

§9013: modification of itemized deduction for medical expenses

- AGI threshold for claiming itemized deduction for medical expenses increases from 7.5 to 10%
- Individuals 65 and older able to claim this deduction at 7.5% of AGI through 2016

§9014: limitation on excessive remuneration paid by certain health insurance providers

- Limits deductibility of executive compensation under §162(m) for insurance providers if at least 25% of insurance provider's gross premium income from health business is derived from health insurance plans that meet minimum essential coverage requirements
- Deduction limited to \$500,000 per taxable year; applies to all officers, employers, directors and other workers/service providers performing services for or on behalf of covered health insurance provider

§9015: Additional hospital insurance tax on high-income taxpayers

- Modifies HI tax rate for single taxpayers with incomes >\$200,000 or couples filing jointly with incomes >\$250,000 from 0.5 to 0.9%
- Balances the tax treatment of earned and unearned income under the Medicare contribution for taxpayers with income above \$200,000 for singles (\$250,000 for married couples filing jointly)
- Imposes a 3.8 percent tax on income from interest, dividends, annuities, royalties and rents that are not derived in the ordinary course of trade or business,
- Excludes active S corporation or partnership income
- Only income in excess of the thresholds is subject to the tax
- Effective for taxable years after December 31, 2012

§9016: Special deduction for Blue Cross Blue Shield (BCBS)

- Non-profit BCBS organizations must have MLR \geq 85% in order to take advantage of special tax benefits provided under IRC §833 (including deduction for 25% of claims/expenses, 100% deduction for unearned premium reserves)

§9017: Excise tax on indoor tanning services

- 10% tax on indoor tanning services using an electronic product with one or more UV lamps
- Effective on or after July 1, 2010

Subtitle B – Other provisions

§9021: Exclusion of health benefits provided by Indian tribal governments

§9022: Establishment of simple cafeteria plans for small businesses

- Establishes Simple Cafeteria Plans that ease participation restrictions so that small business can provide tax-free benefits to their employers
 - Self-employed individuals included as qualified employees

§9023: Qualifying therapeutic discovery project credit

- 2 year temporary tax credit subject to cap of \$1 billion to encourage investments in new therapies to prevent, diagnose and treat acute/chronic diseases

§9024: Health professionals State repayment tax relief

- Excludes gross income payments made under any State loan repayment or loan forgiveness program intended to provide increased availability of health care services in underserved or health professional shortage areas

§9025: Expansion of adoption tax credit and adoption assistance programs

- Increases adopted tax credit and adoption assistance exclusion (\$12,170 for 2009) by \$1,000 and makes credit refundable
- Extended through 2011

Title X – Strengthening quality, affordable health care for all Americans

This title amends the previous titles; the amendments were applied throughout the document.