A SUMMARY OF PROVISIONS OF THE PPACA AND RELATED LEGISLATION THAT IMPACT STATE GOVERNMENT

VERSION 2.0

PREPARED FOR

LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS

SUBMITTED BY

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Provisions of the Patient Protection and Affordable Care Act (H.R. 3590)

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INTRODUCTION

This is Version 2.0 of *A Summary of Provisions of the PPACA and Related Legislation* outlining the provisions of selected Titles and sections of the Patient Protection and Affordable Care Act **(**PPACA**,** H.R. 3590) and the Health Care and Education Reconciliation Act of 2010 (HCERA, H.R. 4872).

The document provides brief summaries of the provisions that will most directly impact the Louisiana Department of Health and Hospitals (DHH) in the areas of Medicaid, CHIP, Public Health, the Health Care Workforce, and Program Integrity. Also included are summaries of the provisions relating to Health Insurance Exchanges, as the organizational responsibility for this requirement has not yet been established by the State of Louisiana. In addition, Version 2.0 has been updated to include provisions related to health insurance reform (which may impact the State as an employer) and Medicare.

Purpose

The purpose of the document is to identify and organize the provisions of this complex and wide-ranging federal legislation that fall within the purview of the State and DHH in particular. With the exceptions noted below, the *Summary* was compiled by reviewing every provision of the bill, as opposed to other reports that focus on only the most significant issues (e.g creation of health insurance Exchanges, Medicaid expansion) or that provide an overarching summary of PPACA. Other valuable references include the Covington and Burling Advisory Memorandums, Kaiser Family Foundation summaries (e.g. http://www.kff.org/healthreform/upload/8061.pdf), and the National Association of State Medicaid Director's side-by-side analysis, which can be found at http://www.nasmd.org/home/doc/draftHRsidebyside.pdf.

With the relevant provisions identified and organized, the Department can embark on the formidable task of identifying policy questions, critical issues, and potential grant opportunities; developing strategic implementation plans and timelines; and appointing Issues Committees to develop in-depth understandings of the federal requirements (or options) and prepare initial implementation work plans. In short, this *Summary* provides a "jumping-off point" for prioritizing the State's efforts to implement the PPACA.

Contents and Organization

The *Summary* includes an analysis of the Titles and selected sections that most directly affect DHH. For each provision of the legislation included in the *Summary*, there is a brief title, a summary, the PPACA citation, and, generally, the effective date of the provision.

The *Summary* is organized by the following focus areas:

- Health Insurance Reforms
- Health Insurance Exchanges
- Children's Health Insurance Program
- Medicaid
- Medicare
- Public Health
- Health Care Workforce
- Program Integrity Provisions

While these focus areas generally conform to the Titles of the PPACA, the *Summary* does not include an analysis of every Title. The following list of the PPACA Titles is annotated with a description of the areas in each Title that are included in the *Summary*:

Title I *Quality, Affordable Health Care for All Americans.* The entire Title is included; this Title makes various reforms to health insurance and details the requirements of Health Insurance Exchanges

Title II *Role of Public Programs.* The entire Title is included; this Title contains most of the provisions relating to the Children's Health Insurance Program and Medicaid

Title III *Improving the Quality and Efficiency of Health Care.* The entire Title is included; this Title includes Medicare provisions and federal initiatives related to quality and efficiency

Title IV *Prevention of Chronic Disease and Improving Public Health.* The entire Title is included except for the following sections:

Sec. 4103 – Medicare coverage of annual wellness visit providing a personalized prevention plan
Sec. 4104 – Removal of barriers to preventive services in Medicare
Sec. 4105 – Evidence-based coverage of preventive services in Medicare
Sec. 4205 – Nutrition labeling of standard menu items at chain restaurants
Sec. 4207 – Reasonable break time for nursing mothers
Sec. 4303 – CDC and employer-based wellness programs

Title V *Health Care Workforce.* The entire Title is included

Title VI *Transparency and Program Integrity.* Two of the eight Subtitles are included: "Medicare, Medicaid, and CHIP Program Integrity Provisions" and "Additional Medicaid Program Integrity Provisions" except for the following sections:

Sec. 6409 – Medicare self-referral disclosure protocol
Sec. 6410 – Adjustments to the Medicare durable medical equipment, prosthetics, orthotics, and supplies competitive acquisition program
Sec. 6601 – Prohibition on false statements and representations
Sec. 6602 – Clarifying definition
Sec. 6603 – Development of model uniform report form
Sec. 6604 – Applicability of State law to combat fraud and abuse
Sec. 6605 – Enabling the Department of Labor to issue administrative summary cease and desist orders and summary seizures orders against plans that are in financially hazardous condition
Sec. 6606 – MEWA plan registration with Department of Labor
Sec. 6607 – Permitting evidentiary privilege and confidential communications

Title VII *Improving Access to Innovative Medical Therapies.* Not included

Title VIII *Community Living Assistance Services and Supports (CLASS) Act.* Not included

Title IX *Revenue Provisions.* Not included

Title X *Strengthening Quality, Affordable Health Care for All Americans.* This Title is the "Manager's Amendment" adopted by the Senate and amending the first nine Titles; it is included consistent with the above descriptions of the other Titles

There are two indexes in the document that are hyperlinked to the relevant summary. The first index appears after the Table of Contents and is organized by area of focus by topic. This index is intended to provide a ready reference to the reader to quickly identify topics of interest.

The second index is at the end of the document and lists the provisions according to implementation date. This implementation date index is organized by area of focus, by topic, by year and by whether the provision is mandatory, optional, or no action required. An item categorized as not requiring action either does not impact DHH or is a provision that the State has little ability to influence (e.g. promulgation of a federal regulation).

It should be noted that the dates included in this second index reflect the implementation deadline of the provision and do not reflect the preparation time required for implementation. This second index was assembled to assist in prioritizing actions based on required implementation dates.

Integrated Legislation

For researchers there are essentially three pieces of legislation that constitute "federal health care reform": Titles I through IX of PPACA; Title X of PPACA – the Manager's Amendment; and HCERA, the trailing reconciliation bill. The Manager's Amendment and HCERA both amended various provisions of Titles I through IX of PPACA. This arrangement has created a situation that makes investigation of provisions very unwieldy.

To streamline the analysis of the legislation, a consolidated, integrated version of the PPACA has been compiled that maintained the page numbers of the enrolled PPACA. This "integrated" version of the legislation is a companion document to this *Summary* and is entitled *Integrated Provisions of the PPACA and HCERA.* Finally, since some HCERA provisions did not directly amend the PPACA, a copy of the enrolled version is also included.

For convenience, the individual summaries in the *Summary* have been hyperlinked to the relevant section in the *Integrated Provisions* and *Enrolled HCERA* documents.

Future Versions

It seems inevitable that the *Summary* will continue to evolve as it is used. As additional information becomes available, errors are discovered, or clarifications are necessary, a further

update will be undertaken. Also, if requested by DHH, the document can also be updated to include the Titles and Subtitles that were excluded from the *Summary* (because they have no apparent impact on DHH, i.e. Titles VII, VIII and IX).

Comments on the *Summary* are welcomed and should be directed to: spawlowski@burnshealthpolicy.com.

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INSURANCE REFORMS

Applicability

Grandfathered health plans. Permits individuals to retain their current private health insurance coverage and exempts health insurance plans in existence as of March 23, 2010 from some of the reforms included in PPACA [Sec. 1251, p. 43]

- For existing enrollees, allows existing plans to enroll family members under the regular terms of the plan and permits new employees to enroll in existing plan; also allows plans maintained pursuant to collective bargaining to continue as a grandfathered plan until the existing termination date of the collective bargaining agreement

Coverage and Premiums

Limits on premium variance. For plan years beginning on or after January 1, 2014, insurers (excluding grandfathered health plans) may only vary premiums based on whether the coverage is for an individual or family, rating area (approved by DHHS), age (between bands with a maximum variance of 3:1 to be determined by DHHS and the National Association of Insurance Commissioners), and tobacco use (with a maximum variance of 1.5:1) [Sec. 1201, p. 36]

Review of premium increases. Effective immediately, insurers must submit to DHHS and the State justification for "unreasonable increases" in insurance premiums prior to implementing the increase [Sec. 1003, p. 21]

- Appropriates $250 million for annual $1 million to $5 million grants to States to approve premium increases and make recommendations to Exchanges based on insurers' "excessive or unjustified" premium increases
- The appropriation is also available to create Medical Reimbursement Data Centers to develop and regularly update fee schedules and other database tools to reflect market rates for medical services and the geographic differences in rates, and make health care cost information readily available to the public through a website

Caps on non-clinical spending. Effective January 1, 2011, insurers must provide rebates to enrollees if less than 85% of premium revenue (80% in the small group and individual market) is spent on clinical services and health care quality activities (to be defined by DHHS and the National Association of Insurance Commissioners); beginning in 2014, the ratio will be based on an average over the previous three years [Sec. 1001, p. 12]

Availability and renewability of coverage. For plan years beginning on or after January 1, 2014, insurers (excluding grandfathered health plans) must accept every employer and individual in the State that applies for coverage and must renew coverage at the option of the employer or individual [Sec. 1201, p. 36]

Waiting periods. For plan years beginning on or after January 1, 2014, group health plans may not have waiting periods that exceed 90 days [Sec. 1201, p. 36]

[1] *All section references include amendments made by the Manager's Amendment and reconciliation bill (H.R. 4872)*

Provisions of the Patient Protection and Affordable Care Act (H.R. 3590)[1]

INSURANCE REFORMS (cont.)

Rescissions. For plan years beginning after September 2010 prohibits insurers from rescinding the coverage of an individual once enrolled except in cases of fraud [Sec. 1001, p. 12]

Lifetime and annual limits. For plan years beginning after September 2010 prohibits insurers from establishing lifetime limits on the dollar value of essential health benefits; until January 1, 2014 only permits annual limits to the extent determined by DHHS while after that date annual restrictions on essential health benefits are prohibited [Sec. 1001, p. 12]

Adult dependents. For plan years beginning after September 2010 requires insurers providing dependent coverage to continue coverage until an adult child's 26th birthday [Sec. 1001, p. 12]

- Makes conforming changes to the internal revenue code, e.g., allowing the deduction of medical expenses for children through the age of 26 [H.R. 4872, Section 1004(d), p. 7]

Coverage requirements. For plan years beginning on or after January 1, 2014 insurers in the individual or small group market (excluding grandfathered health plans) must offer at least enumerated essential health benefits; group health plans must limit annual deductibles to $2,000 for individuals and $4,000 for other coverage types (indexed for inflation beginning in 2015), but can be increased if the enrollee has a flexible spending arrangement, and total cost sharing (such as deductibles, copayments, and coinsurance, but excluding premiums) to $5,000 for individuals and $10,000 for families (indexed for inflation beginning in 2015); and any issuer offering bronze, silver, gold, or platinum coverage must offer a child-only plan at the same level [Sec. 1201, p. 36]

Coverage of preventive services. Effective within one year insurers (excluding grandfathered health plans) must provide coverage without cost-sharing for certain preventive services and immunizations [Sec. 1001, p. 12]

- With respect to breast cancer screening, the November 2009 recommendations of the United States Preventive Service Task Force will be ignored
- Authorizes DHHS to develop guidelines for value-based insurance design, which aims to remove barriers to encourage the use of high-value screenings, diagnostic tests, medications and procedures

Use of health status. For plan years beginning on or after January 1, 2014 prohibits insurers (excluding grandfathered health plans) from establishing rules for eligibility based on health status, medical condition, claims experience, receipt of health care, medical history, genetic information, disability, or other health-status factors determined by the DHHS [Sec. 1201, p. 36]

Preexisting conditions. For plan years beginning on or after January 1, 2014 insurers (excluding grandfathered group health plans) may not exclude individuals from coverage due to preexisting conditions and may not charge higher premiums for health-status related factors (provisions effective for individuals under 19 years of age in plan years beginning after September 23, 2010 [Sec. 1201, p. 36]

Temporary high-risk pools. Appropriates $5 billion for DHHS to establish by July 1, 2010, directly or through States or nonprofit entities, temporary (until January 1, 2014) high-risk health

insurance pools to provide coverage for individuals with preexisting conditions who have been without insurance for at least six months [Sec. 1101, p. 23]

- Premiums may vary by individual or family coverage, rating area, age (at a maximum ratio of 4:1) and tobacco use (at a maximum ratio of 1.5:1); pools must pay at least 65% of costs and limit annual out-of-pocket costs to $5,000 for an individual
- DHHS may stop taking applications to remain within available funding
- Supersedes State laws
- Establishes sanctions for employers that dump enrollees

Clinical trials. For plan years beginning on or after January 1, 2014 requires insurers (excluding grandfathered health plans) to permit individuals to participate in clinical trials for cancer or life-threatening conditions (if federally funded, conducted under an investigational new drug application with the FDA, or for investigational new drugs exempt from an application), if a health care professional says participation would be appropriate or the individual provides medical information of such, and cover routine patient costs associated with the trial [Sec. 1201, p. 36]

Consumer and Provider Protections and Responsibilities

Consumer rights. For plan years beginning after September 2010 enumerates several rights [Sec. 1001, p. 12]

- If an insurer permits designation of a primary care providers by enrollees, each enrollee may designate any participating primary care provider that is available to accept the enrollee
- If an insurer permits designation of a primary care providers by enrollees, each enrollee may designate for their child dependent a participating physician specializing in pediatrics as the child's primary care provider
- If a plan covers services in an emergency department, it must do so without prior authorization and may not implement greater restrictions or cost-sharing for non-participating providers than for participating providers
- Female enrollees must have direct access to obstetrics and gynecology without authorization or referral and insurers must treat the provision of OB/ GYN items and services as the authorization of a primary care provider

Appeals process. For plan years beginning after September 2010, insurers must have an effective appeals process including an internal claims appeal process, which allows enrollees to review their file, present evidence, and maintain coverage during the appeal; insurers must also have an external review process meeting standards determined by DHHS [Sec. 1001, p. 12]

Individual responsibility and penalties. Beginning in 2014 establishes penalties for failure to meet minimum essential coverage in any month (except for gaps of up to three months), which must pay on annual tax returns [Sec. 1501(b), p. 126]; the penalty is the lesser of:

- The cost of national average premium for a bronze level plan OR the greater of:

  - $95 per person in 2014, $325 per person in 2015, and $695 per person in 2016 with cost-of-living adjustments in subsequent years (with a maximum multiplier of 3, e.g., if an individual and four dependents are not covered, the penalty is capped at three times the amounts noted above) OR
  - 1% of household income in 2014, 2% in 2015, and 2.5% in subsequent years
- Individuals are exempted if coverage would exceed 8% of household income in 2014 (increased in subsequent years by the excess of premium growth over income growth)

Premium assistance tax credits. Beginning in 2014 establishes tax credits for individuals with modified adjusted gross incomes between 100% and 400% of the federal poverty level (and legal aliens ineligible for Medicaid with income below 100% of the FPL) [Sec. 1401, p. 95]

- The credit amount is the lesser of the monthly premium in which the individual is enrolled, or the excess of premium for the applicable second lowest cost silver plan (excluding any coverage for benefits that are not essential health benefits) over a specified percentage (as outlined in the table below) of the individual's income

Income as a % of FPL	Premium percentage range (DHHS to set tiers within each range on a sliding scale)	
<133%	2.0%	2.0%
133-150%	3.0%	4.0%
150-200%	4.0%	6.3%
200-250%	6.3%	8.05%
250-300%	8.05%	9.5%
300-400%	9.5%	9.5%

- Beginning in 2015, the premium percentages will be adjusted by the excess of the rate of premium growth over the rate of income growth, and beginning in 2018 the premium percentages may be further increased by the excess of premium growth over the consumer price index to the extent necessary to ensure that tax credits and cost-sharing reductions do not exceed 0.504% of gross domestic product
- Individuals do not qualify if they are eligible for minimum essential coverage such as a government sponsored program or an employer-sponsored program that does not require an employee contribution in excess of 9.5% of income and in which the employer pays 60% of costs

INSURANCE REFORMS (cont.)

Reduced cost-sharing. Beginning in 2014 provides for reduced cost sharing for individuals enrolling in a silver level qualified health plan and with incomes between 100% and 400% of the federal poverty level wherein the federal government will make payments to insurers to reduce eligible individuals' cost sharing by the amounts in the table below (excluding costs associated with benefits that are not essential health benefits [Sec. 1402, p. 102]

Income as % of FPL	Reduction
100-200%	Two-thirds
200-300%	50%
300-400%	One-third

- Insurers must further reduce cost-sharing such that for individuals with incomes between 100-150% of the FPL the plan's share of costs is 94% of the total; for individuals between 150-200%, 87%; for individuals between 200-250%, 73%

Advance determinations for credits and reduced cost-sharing. DHHS will make advance determinations of eligibility for tax credits and reduced cost-sharing during the annual open enrollment period and Treasury will make advance payment to insurers [Sec. 1412, p. 113]

Tax credits and reduced cost-sharing and eligibility for other programs. Excludes tax credits and reduced cost-sharing from income when determining eligibility for federal programs and State and local programs funded at least in part with federal dollars [Sec. 1415, p.119]

Prohibition on discrimination against providers. For plan years beginning on or after January 1, 2014 prohibits insurers from discriminating with respect to participation under the plan against providers acting within the scope of their license/ certification, though they may vary reimbursement according to quality or performance measures [Sec. 1201, p. 36]

- Prohibits discrimination against health care entities on the basis that they do not assist suicide [Sec. 1553, p. 141]

Employer Impacts

Automatic enrollment for large employers. Requires employers with 200 employees that offer health benefit plans to automatically enroll new employees in a plan subject to any authorized waiting period, and offer employees the ability to opt-out [Sec. 1511, p. 134]

Free Choice Vouchers. Beginning in 2014, an employer offering minimum essential coverage and who pays a portion of the cost must provide a Free Choice Voucher to any employee with household income below 400 percent of the federal poverty level and whose required contribution would be between 8% and 9.8% of income; the Voucher is equal to the amount that the employer would pay for the employer-sponsored plan and is paid to the Exchange so that the employee can enroll in a qualified health plan, if the employer contribution exceeds the cost of the qualified health plan the excess is paid to the employee [Sec. 10108, p. 794]

- The amount paid to the qualified health plan is not counted as individual income and is treated as compensation for the purposes of employers' federal taxes

INSURANCE REFORMS (cont.)

Employer penalties. Beginning in 2014, if large employers (50-plus employees) do not offer full-time employees (30-plus hours per week) and their dependents minimum essential coverage and at least one employee is enrolled in a qualified health plan and receiving a premium tax credit or cost-sharing reduction, the employer is fined $166.67 per month multiplied by the total number of full-time employees reduced by 30; for large employers that offer minimum essential coverage but at least one employee is enrolled in a qualified health plan and receiving a premium tax credit or cost-sharing reduction, the employer is fined $250 per month multiplied by the number of full-time employees reduced by 30 and excluding employees receiving a Free Choice Voucher [Sec. 1513, p. 135]

- Penalty amounts will be adjusted each year by the average percentage premium growth
- The Department of Labor must conduct a study to determine whether these penalties result in reduced wages
- Prohibits employers from discharging or discriminating against employees because they receive a premium assistance tax credit or have provided information about a violation of health insurance laws [Sec. 1558, p. 143]

Discrimination in favor of highly compensated individuals. Requires that benefits provided for participants who are highly compensated individuals be provided for all other participants [Sec. 1001, p. 12]

Reinsurance for early retirees. Appropriates $5 billion for DHHS to establish by July 1, 2010 a temporary (until January 1, 2014) reinsurance program to provide reimbursement to participating employer-based plans for 80% of the costs of claims between $15,000 and $90,000 (with annual inflation adjustments) for early retirees (between 55-64 years of age) and their dependents [Sec. 1102, p. 25]

- To participate, employer-based plans must have programs and procedures to generate cost savings with respect to participants with chronic and high-cost conditions and provide documentation of the actual cost of medical claims
- DHHS may stop taking applications to remain within available funding

Small business tax credits. Effective in tax year 2010, establishes tax credits for small businesses with 25 or fewer employees and average incomes up to $50,000 (adjusted for cost-of-living in years after 2013) [Sec. 1421, p. 119]

- For entities with 10 or fewer employees and average salaries below $25,000, the credit is 35% of premium costs and 25% for nonprofits (increasing to 50% and 35%, respectively, in 2014 and subsequent years) with the credits phasing down up to 25 employees and $50,000 incomes

Cafeteria plans. Beginning in 2014 premiums for qualified health plans are not qualified benefits for cafeteria plan, except in the case of small employers that elect to make all its full-time employees eligible for one or more qualified plans offered in the small group market through an Exchange [Sec. 1515, p. 140]

Standards

Operating rules. Requires DHHS to establish business rules and guidelines for the electronic exchange of information related to administrative and financial transactions; DHHS is to solicit input from the National Committee on Vital and Health Statistics, the Health Information Technology (HIT) Policy Committee, and the HIT Standards Committee, and consider recommendations from a "qualified nonprofit entity" that focuses its mission on administrative simplification, uses a multi-stakeholder and consensus-based process, and is open and transparent [Sec. 1104, p. 28]

- DHHS is to adopt a single set of operating rules for each of health claims encounter information, health claims attachments, enrollment and disenrollment in a health plan, eligibility for a health plan, health care payment and remittance advice, health plan premium payments, first report of injury, health claim status, referral certification and authorization, and electronic funds transfers
- The standards are to enable eligibility determination and financial responsibility prior to or at the point of care, require minimal augmentation by paper, support a transparent claims and denial management system, and describe data elements in unambiguous terms
- Operating rules for eligibility for a health plan and health claims status are to be adopted by July 1, 2011 and effective by January 1, 2013; electronic funds transfers and health care payment remittance advice, adopted by July 1, 2012 and effective by January 1, 2014; health claims encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization, adopted by July 1, 2014 and effective by January 1, 2016
- Health plans must receive certification of compliance with the operating rules prior to the effective date or face fines of $1 per covered life per day (to a maximum $20 per covered life, or $40 per covered life if the plan knowingly provides inaccurate or incomplete data)
- DHHS must promulgate final rules to establish a unique health plan identifier by October 1, 2012; standards for electronic funds transfer by January 1, 2012; and standards for health claims attachments by January 1, 2014
- Requires DHHS to consider whether: the application process for enrollment of providers can be made electronic and standardized, operating rules should apply to the health care transactions of automobile insurance and worker's compensation, standardized forms could apply to various financial audits, could be greater transparency in methodologies to establish claim edits used by health plan, and whether health plans should be required to publish their timeliness of payment rules [Sec. 10109, p. 797]
- Requires DHHS to task the ICD-9-CM-Coordination and Maintenance Committee to convene by January 1, 2011 to receive input regarding the crosswalk between ICD-9 and ICD-10 on the CMS website and recommend appropriate revisions [Sec. 10109, p. 797]

Electronic funds transfers for Medicare. Effective January 1, 2014 Medicare will only make payment by electronic funds transfer or specified electronic remittance form [Sec. 1104(d), p. 36]

Information technology standards. Requires DHHS and Health Information Technology committees to develop within 180 days interoperable and secure standards and protocols that

facilitate enrollment in federal and state health and human services programs and authorizes grants for States to implement appropriate health information technology [Sec. 1561, p. 144]

Health promotion and disease prevention programs. For plan years beginning on or after January 1, 2014 programs of health promotion or disease prevention are permitted if they are not conditioned on health status factor and is available to all similarly situated individuals such as programs that reimburse of gym memberships, provide diagnostic testing (where the reward is based on participation and not outcomes), encourage preventive care, pay for smoking cessation (even if the individual does not quit), or reward attendance of period health education seminars [Sec. 1201, p. 36]

- If the program is based on health status factors, the reward may not exceed 30% of the cost of employee-only coverage (the federal government can increase this to 50%) and the program must be reasonably designed to promote health or prevent disease, permits an opportunity to qualify at least once per year, and is available to similarly situated individuals (including reasonable alternative standards for those for whom it is unreasonably difficult to qualify due to a medical condition)
- Grandfather existing health promotion and disease prevention programs
- Authorizes a 10-State demonstration in the individual market by July 1, 2014 (with possible expansion beginning July 1, 2017 if effective); the demonstration may not result in decreased coverage, increased federal costs due to tax credits, or cost-shifting, and may not be subterfuge for discrimination

Transparency

Consumer information. Within one year requires DHHS to work with the National Association of Insurance Commissioners to develop standard definitions of insurance related terms and a summary form for applicants and policy-holders regarding benefits, cost-sharing, limitations, etc. on a four page document with 12 point font written in easy-to-understand language that must be sent to applicants and enrollees by March 2012; enrollees must receive 60 days notice prior any modifications to the plan or coverage [Sec. 1001, p. 12]

- Insurers are also required to provide to DHHS and the State (and make available to the public) information regarding claims payment policies and practices, data on enrollment, rating practices, const-sharing, etc.

Grants for consumer information. Effective immediately, appropriates $30 million for expanding or establishing State offices of health insurance consumer assistance or health insurance ombudsman programs to assist with filing appeals, educate consumer, assist with enrollment, and resolve problems in obtaining health insurance or tax credits [Sec. 1002, p. 20]

Information regarding coverage options. By July 1, 2010, DHHS in consultation with the States must assist residents and small businesses identify affordable insurance (including through a website), through information about eligibility, premiums and cost sharing, and coverage offered by issuers, Medicaid, CHIP, coverage in the small group market, high-risk pools, tax credits, etc. [Sec. 1103, p. 28]

INSURANCE REFORMS (cont.)

Quality of care reporting. Within two years requires DHHS to establish reporting requirements for insurers regarding the extent to which they improve health outcomes through quality reporting, case management, care coordination, chronic disease management; implementation of activities to prevent hospital readmission; implementation of activities to improve patient safety and reduce medical errors; and implementation of wellness and health promotion activities (e.g. smoking cessation, weight management, physical fitness, heart disease prevention, diabetes prevention) [Sec. 1001, p. 12]

- Prohibits insurers from requiring patients to disclose gun ownership or increase rates/ withhold discounts for gun owners

Reporting of health insurance coverage. Beginning in 2014 providers of minimum essential coverage (Medicare, Medicaid, CHIP, employer-sponsored plans, and plans in the individual market) must submit reports to Treasury with the name, address, and TIN of enrollees; Treasury will notify tax filers not enrolled in minimum essential coverage and provide information on services available through Exchanges [Sec. 1502, p. 132]

- Beginning in 2014 large employers must report to Treasury whether they offer minimum essential coverage and the name, address, and TIN of each full-time employee that is enrolled [Sec. 1514, p. 138]

Notifications for employees. Beginning March 1, 2013 employers must provide all current and future employees written notice of information regarding the Exchange and potential eligibility for premium tax credits if the employer pays less than 60% of the employer's plan and the employees purchases a qualified health plan through the Exchange [Sec. 1512, p. 134]

Federal reports.

- By March 2011 the Department of Labor must begin submitting annual reports regarding self-insurance plans [Sec. 1253, p. 44]
- By March 2011 DHHS must submit a study on fully insured and self-insured plan markets to compare characteristics and the extent to which the new insurance market is likely to cause adverse selection in the large group market or to encourage small and mid-size employers to self-insure [Sec. 1254, p. 44]
- Within one year requires GAO to study the denial of coverage for medical services among qualified health plans and other insurers [Sec.1562, p. 146]

Study on geographic variation in poverty level. Requires DHHS to study geographic variability in cost of living and determine feasibility of varying the federal poverty level according to geographic, and report finding to Congress by January 1, 2013 [Sec. 1416, p.119]

HEALTH INSURANCE EXCHANGES

Definitions

Qualified health plans. Meets the criteria for certification by each Exchange through with it is offered; provides all essential benefits; and is offered by an insurer that is licensed and in good standing in each applicable State, that offers at least one qualified health plan in the silver level and one in the gold level in each applicable Exchange, and that charges the same premium for each qualified health plan regardless of whether it is offered through the Exchange or directly from the issuer or through an agent [Sec. 1301, p. 44]

Essential health benefits. DHHS must ensure that the essential health benefits are equal to the scope of benefits provided under a "typical" employer plan, which will be informed by a survey of employer-sponsored coverage conducted by the Department of Labor [Sec. 1302(b), p. 45]

- Essential health benefits shall include, at a minimum: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, pediatric services including oral and vision care, and others determined by DHHS

Levels of coverage. Categories insurance plans offered through the exchange in terms of the extent to which benefits provided are actuarially equivalent to the full actuarial value of the essential health benefits [Sec. 1302(d), p. 49]

- Platinum: benefits provided that are equivalent to 90% of full actuarial value
- Gold: benefits provided that are equivalent to 80% of full actuarial value
- Silver: benefits provided that are equivalent to 70% of full actuarial value
- Bronze: benefits provided that are equivalent to 60% of full actuarial value

Large and small employers. Large employers are defined as having, on average, at least 101 employees in the preceding calendar year and at least one employee on the first day of the plan year and small employers are defined as those with fewer than 101 employees on average; beginning January 1, 2016, States may opt to define large employers as 51 or more employees on average [Sec. 1304(b), p. 54]

Construct of Exchanges

Establishment of Exchanges. By January 1, 2014 each State is to establish one or more American Health Benefit Exchanges ("Exchange") to facilitate the purchase of qualified health plans and assists qualified employers in the small group market [Sec. 1311(b), p. 55]

- States may elect to provide one Exchange for the individual and small group market or separate Exchanges for each
- Beginning in 2017, States may allow issuers of health insurance coverage in the large group market to offer qualified health plans through an Exchange [Sec. 1312(f), p. 65]

[1] *All section references include amendments made by the Manager's Amendment and reconciliation bill (H.R. 4872)*

HEALTH INSURANCE EXCHANGES (cont.)

Preservation of existing options outside the Exchange. Establishment of Exchanges shall not be construed to terminate, abridge, or limit the operation of any requirement under State law with respect to any policy or plan that is offered outside of an Exchange [Sec. 1312(d), p. 64]

- Institutions of higher education remain able to offer a student health insurance plan [Sec. 1560(c), p. 144]

Delegation of duties to administer Exchange. A State may permit an Exchange to enter into an agreement with an entity with demonstrated experience in the individual and small group health insurance markets and in benefits coverage that is not a health insurer or the State Medicaid agency to carry out one or more of the responsibilities of the Exchange [Sec. 1311(f), p. 61]

Subsidiary exchange option. A State may establish one or more subsidiary Exchanges if each Exchange serves a geographically distinct area of a minimum specified size [Sec. 1311(f), p. 61]

Regional or interstate exchange option. An Exchange may operate in more than one State if approved by each State and DHHS [Sec. 1311(f), p. 61]

Health care choice compacts. For the individual market, effective January 1, 2016, States may enter into health care choice compacts with an issuer that offers a qualified health plan in each of the States [Sec. 1333, p. 88]

- These compacts must be approved by the DHHS and the issuer must be licensed in the State where the qualified health plan will be offered and, with certain exceptions, is subject to all insurance regulations of the State in which the policy is written or issued rather than the State in which the consumer resides.
- A State may not enter into a compact unless the State enacts a law that specifically authorizes the State to enter into such agreements.

Multi-State Plans. Requires the federal Office of Personnel Management to enter into contracts with health insurance issuers to offer at least two multi-state qualified health plans through each Exchange in each State, with at least one being a not-for-profit, and at least one that does not offer abortion services [Sec. 1334, p. 90]

- A multi-state plan qualified health plan must offers a uniform benefit package in each State including essential benefits and consistent with other PPACA provisions for plans in the Exchanges regarding benefits, tax credits, and cost-sharing
- The plan must be offered in all regions and States that adopted adjusted community rating prior to enactment (reported by Kaiser as CO, CT, OR, NJ, MA, MD, ME, RI, WA, VT)

Grants/ loans to establish CO-OPs. To foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets, provides $6 billion for awarding, by July 1, 2013, start-up assistance and grants to assist in meeting any solvency requirements in States where the Consumer Operated and Oriented Plan (CO-OP) seeks to be licensed to issue qualified health plans. [Sec. 1322, p. 69]

- DHHS will require an advisory board consisting of 15 members appointed by the Comptroller General, and any person receiving a loan or grant under the CO–OP program must enter into an agreement with DHHS

HEALTH INSURANCE EXCHANGES (cont.)

- Any health insurance coverage offered by a private health insurance issuer shall not be subject to any federal or State law if a qualified health plan offered by a CO-OP is not subject to such law [Sec. 1324, p. 81]

Basic Health Program. In lieu of offering individuals with incomes between 133% and 200% of the federal poverty level and legal aliens with incomes up to 133% of the FPL coverage through an Exchange, States may enter into contracts to offer one or more standard health plans, that provide at least the essential health benefits, have a medical loss ratio of at least 85%, and charge premiums no greater than what the individual would pay in the second lowest cost silver plan [Sec. 1331, p. 81]

- Through the competitive process, States are to consider innovative features (such as care coordination and care management, incentives for preventive care use, and incentives for appropriate service utilization), managed care, and performance measures; States shall seek to coordinate the administration of, and provision of benefits under, its program with Medicaid, CHIP, and other State-administered health programs
- The federal government will transfer to the States an amount equal to 95% of the premium tax credits and cost sharing reductions for those individuals enrolled as if they had been enrolled in the Exchange

Catastrophic plans. Permits individual plans that provide no benefits until cost-sharing expenses have been reached may be offered to individuals under age 30, except that certain preventive health services and at least 3 primary care visits are covered prior to the cost-sharing limit [Sec. 1302(e), p. 50]

Child-only plans. Requires qualified health plans to offer a child-only plan (up to age 21) at each level (i.e. bronze, silver, gold, platinum) of coverage that it otherwise offers; [Sec. 1302(f), p. 50]

Stand-alone dental benefits. Exchanges shall allow an insurer to offer stand-alone dental benefits if they provide pediatric dental benefits [Sec. 1311(d), p. 58]

State opt-out for abortion coverage. A State may elect to prohibit abortion coverage in qualified health plans offered through an Exchange if the State enacts a law to provide for a prohibition; health plans are not required to provide abortion coverage, but when it is provided payment for abortion coverage must be payable under a separate check (this includes EFTs from employers) and the health plan must deposit this premium (a minimum of $1 per month) in a separate account [Sec. 1303, p. 53]

States may require additional benefits. States may require that qualified health plans (offered through the Exchange) provide benefits that are not essential health benefits, but must cover the cost of these additional benefits [Sec. 1311(d), p. 58]

W*aivers for innovation*. To encourage innovation beginning January 1, 2017, States may apply for a waiver of requirements relating to qualified health plans, essential benefits, cost sharing, and employer mandates [Sec. 1332, p. 85]

- DHHS must develop a process for coordinating and consolidating this State waiver

process and the existing waiver processes applicable to Medicare, Medicaid, and CHIP, and any other federal law relating to the provision of health care so that States may submit a single waiver application
- The State must enact a law authorizing the waiver request, which DHHS may grant if it provides coverage that is at least as comprehensive as the coverage through Exchanges, includes cost sharing protections against excessive out-of-pocket spending that are at least as affordable as coverage through the Exchange, is available to at least a comparable number of its residents as through Exchanges, and does not increase the federal deficit

Administration of Exchanges

Federal assistance to States. By March 2011, DHHS will make awards to States for the establishment of the Exchanges; grants may be renewed through December 31, 2014, but cannot be used for ongoing operations after January 1, 2015 [Sec. 1311(a), p. 55]

Mandatory functions. Includes several mandatory functions of Exchanges [Sec. 1311(d), p. 58]
- Implement procedures to certify, recertify, and decertify of health plans;
- Operation of a toll-free telephone hotline to respond to requests for assistance;
- Maintain an Internet website for prospective enrollees to compare information on plans;
- Assign a rating to each qualified health plan in accordance with the Secretary's criteria;
- Utilize a standardized format for presenting health benefits plan options in the Exchange;
- Inform individuals of eligibility requirements for the Medicaid, CHIP and any other applicable State or local public program and enroll such individuals if they are eligible;
- Establish and make available an electronic calculator to determine the actual cost of coverage after the application of any premium tax credit or cost-sharing reduction;
- Grant certifications for exemption from the individual responsibility penalty;
- Transfer required information to the Secretary of the Treasury;
- Provide to each employer the name of each employee who ceases coverage under a qualified health plan during a plan year (and the effective date of such cessation); and
- Establish the Navigator program

Federal approval of a State's Exchange. DHHS will determine on or before January 1, 2013 each State's readiness in developing their Exchange(s); if the State does not meet DHHS requirements, DHHS will establish and operate the Exchange within the State [Sec. 1321, p. 68]

Enrollment procedures. Each State shall develop for all applicable State health subsidy programs (Medicaid, CHIP, qualified health plans, and qualified basic health plans) a secure, electronic interface allowing an exchange of data (including information contained in the application forms) that allows a determination of eligibility for all programs based on a single application and, if an individual applying to an Exchange is found through screening to be eligible for Medicaid or CHIP, the individual is enrolled in that program [Sec. 1413, p. 115]
- Requires the DHHS to develop a single, streamlined form for all applicable State health subsidy programs that can be completed in-person, online, by telephone, or by mail, but permits a State to develop its own form

HEALTH INSURANCE EXCHANGES (cont.)

Enrollment through agents or brokers. DHHS will establish procedures by which a State may allow agents or brokers to enroll individuals and employers in qualified health plans in the Exchange and to assist individuals in applying for premium tax credits and cost-sharing reductions for plans sold through the Exchange [Sec. 1312(e), p. 65]

Navigators. An Exchange shall establish a program under which it awards grants, from operational funds and not federal funds received by the State to establish the Exchange, to entities that have existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be qualified to enroll in a qualified health plan [Sec. 1311(i), p. 62]

- An entity that serves as a navigator shall conduct public education activities; distribute information concerning enrollment in qualified health plans and the availability of premium tax credits and cost-sharing reductions; facilitate enrollment in qualified health plans; provide referrals for complaints and grievances, and provide culturally and linguistically appropriate information

Self-funding options. The State must ensure that the Exchange is self-sustaining beginning on January 1, 2015, including allowing the Exchange to charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding, to support its operations [Sec. 1311(d), p. 60]

Deductibles and cost-sharing. Limits annual deductibles for employer-sponsored small group products in the Exchange to $2,000 for individuals and $4,000 for other coverage types (indexed for inflation beginning in 2015), but can be increased if the enrollee has a flexible spending arrangement; annual limits on cost sharing (such as deductibles, copayments, and coinsurance, but excluding premiums) are limited to $5,000 for individuals and $10,000 for families (indexed for inflation beginning in 2015) [Sec. 1302(c), p. 48]

Data collection requirements. With respect to enrollee eligibility, the Exchange will be required to collect name, address, date of birth, and citizenship status; family income and family size (for potential tax credit); name, address, EIN of employer and full/part time status (for credits due to employer not providing credible coverage); and additional information as required by DHHS (to apply for an exemption from obtaining health insurance) [Sec. 1411, p.106]

- An Exchange must submit for verification the information provided by an applicant to DHHS, which will provide information to the Social Security Administration or Department of Homeland Security as needed
- Treasury may share taxpayer information for the purpose of determining eligibility for tax credits or reduced cost sharing, Medicaid, CHIP, or a basic health program [Sec. 1414, p.118]

Exchange reporting requirements. Each Exchange must provide information to DHHS and to the taxpayer regarding the level of coverage, the total premium paid before any tax credit, the amount of any advance tax credits, the name, address and TIN of the primary insured, and any information requiring a change in status [Sec. 1401(f), p. 101]

HEALTH INSURANCE EXCHANGES (cont.)

- Exchanges must annually submit to DHHS an accurate accounting of all activities, receipts, and expenditures [Sec. 1313, p. 66]

Health plan reporting requirements. Outlines reporting requirements for qualified health plans

- Health plans seeking certification as qualified health plans must submit information on claims payment policies, financial disclosures, data on enrollment and disenrollment, information on cost sharing and payments for out-of-network coverage, enrollee rights, other information required by DHHS; and a justification for any premium increase prior to implementation of the increase [Sec. 1311(e), p. 61]
- Health plans must report its activities related to guidelines that will be developed by the Secretary, which may include improving health outcomes, preventing hospital readmissions, reducing medical errors, reducing health disparities, and wellness and health promotion programs [Sec. 1311(g), p. 61]

Qualified health plan contractors. Beginning January 1, 2015, qualified health plans may only contract with hospitals with more than 50 beds if the hospitals that utilizes a patient safety evaluation system and a comprehensive program for hospital discharge, and only with other providers that implement health care quality improvement mechanisms to be determined by DHHS [Sec. 1311(h), p. 62]

Publishing Exchange administrative revenues and costs. An Exchange must publish the average costs of licensing, regulatory fees, and any other payments it requires; and its administrative costs; and monies lost to waste, fraud, and abuse, on an Internet website [Sec. 1311(d), p. 60]

Mental health parity. Qualified health plans in the Exchange must provide coverage for mental health issues in the same manner as health insurance issuers and group health plans are required [Sec. 1311(j), p. 63]

Payments to FQHCs. Qualified health plans must pay for services provided by federally qualified health centers at rates at least equal to the applicable Medicaid rates [Sec. 1302(g), p. 50]

Risk adjustment. For insurers in the individual or small group market, States must assess a charge on plans with lower-than-average actuarial risk to make payments to plans with higher-than-average actuarial risk. [Sec. 1343, p. 94]

Risk corridor program. For fiscal years 2014 through 2016, establishes a risk corridor program for qualified health plans in the individual or small group market [Sec. 1342, p. 93]

- DHHS pays 50% of the costs between 103% and 108% of a plan's target amount (premium revenues less administrative costs); for plans with costs in excess of 108% of their target amount DHHS pays 2.5% of the target amount and 80% of costs above 108%
- Plans that spend between 92% and 97% of their target amount must pay 50% of the difference between their costs and 97%; plans that spend below 92% of their target amount must pay 2.5% of the target amount and 80% of the difference between their costs and 92%

HEALTH INSURANCE EXCHANGES (cont.)

States required to contract with reinsurance entity. To stabilize premiums for the three-year period beginning January 1, 2014, States must contract with a non-profit entity for operation of a reinsurance program funded by payments (to be determined by the DHHS) required of health insurance issuers and third party administrators on behalf of group health plans; funds will be used to make payments to health insurance issuers that cover high risk individuals (50-100 high risk conditions will be defined by DHHS) in the individual market [Sec. 1341, p. 91]

- States must eliminate or modify any State high-risk pool to the extent necessary to carry out the reinsurance program

CHILDREN'S HEALTH INSURANCE PROGRAM (TITLE XXI)

Extension through 2015. Extends CHIP through fiscal year 2015, increases funding from $15.0 billion in fiscal year 2012 to $17.4 billion in fiscal year 2013, $19.1 billion in 2014, and $21.1 billion in 2015; all extends funding for outreach and enrollment through 2015 [Sec. 10203, p. 809]

Enhanced FMAP. Increases the CHIP FMAP by 23 percentage points (up to 100%) between October 1, 2015 and September 30, 2019 [Sec. 2101(a), p. 168]

Elimination of enrollment bonuses. Eliminates enrollment bonus payments after September 30, 2013 [Sec. 2101(c), p. 169]

Maintenance of CHIP eligibility. As a condition of continued receipt of Medicaid and CHIP funding, States may not implement eligibility standards, methodologies, or procedures for CHIP that are more restrictive than those in place upon passage of health care reform; Enrollment may be limited to federal financial participation [Sec. 2101(b), p. 168]

Public agency employees with targeted low-income children. Removes exclusion of children counted as "targeted low-income" whose parents are public agency employees if the agency's per-employee expenditures are at least equal to expenditures made in 1997 adjusted by medical inflation or the annual aggregate amount of cost-sharing imposed for coverage of the family would exceed 5% of their income [Sec. 10203, p. 812]

Assurance of coverage for low-income children. States must establish procedures to ensure that children ineligible for Medicaid and unable to enroll in CHIP due to shortfalls are enrolled through an Exchange in a qualified health plan certified by April 1, 2015 by DHHS as providing comparable benefits offered by CHIP; such children will be eligible for premium assistance and reduced cost sharing [Sec. 2101(b), p. 168]

Mandatory use of modified adjusted gross income. Effective January 1, 2014, requires that modified adjusted gross income be used to determine CHIP eligibility but States must ensure that converting to this standard does not result in the loss of eligibility [Sec. 2101(d) and (f), p. 169]

[1]*All section references include amendments made by the Manager's Amendment and reconciliation bill (H.R. 4872)*

MEDICAID (TITLE XIX)

Eligibility

Mandatory expansion to 138% of the federal poverty level. Medicaid expanded to 133% of the federal poverty level beginning January 1, 2014 (benefits must be benchmark or benchmark-equivalent) [Sec. 2001(a), p. 153]

- Requires that children ages 6 to 19 with incomes between 100% and 133% of the FPL formerly covered by CHIP be transitioned to Medicaid
- Every individual's calculated income is to be reduced by 5% so the effective limit is 138% [H.R. 4872 Sec. 1004(e), p. 8]
- States may opt to immediately begin expanding coverage up to 133% of the FPL and can phase-in by income; lower income must be served before higher incomes and a parent may not be enrolled unless their children already have health insurance
- Beginning January 1, 2014, States may expand coverage beyond 133%, and can phase-in by categorical group or income; lower income must be served before higher incomes and a parent may not be enrolled unless their children already have health insurance [Sec. 2001(e), p. 160]

Maintenance of Medicaid eligibility. To receive Medicaid funding, until the Secretary determines that an Exchange is fully operational States must maintain eligibility standards, methodologies, and procedures that are no more restrictive than as on the date of enactment of H.R. 3590 (due to the provisions of the American Recovery and Reinvestment Act, that effectively requires standards be no more restrictive than they were on July 1, 2008) [Sec. 2001(b), p. 157]

- A State with a budget deficit may reduce eligibility for non-pregnant, non-disabled adults with income above 133% of the federal poverty level
- Eligibility standards, methodologies, and procedures for children under the age of 19 must be maintained until October 1, 2019

Maintenance of Title XXI eligibility. As a condition of continued receipt of Medicaid and CHIP funding, States may not implement eligibility standards, methodologies, or procedures for CHIP that are more restrictive than as on the date of enactment of H.R. 3590 [Sec. 2101(b), p. 168]

- Enrollment may be limited to federal financial participation
- Maintenance of eligibility must be maintained until October 1, 2019

Mandatory coverage for former foster children. Effective January 1, 2014, States must provide Medicaid coverage to former foster children up to 26 years of age who aged out of the foster care system and received Medicaid coverage while in foster care [Sec. 2004, p. 165]

Optional family planning category. Permits States to establish an optional population with incomes up to the level for pregnant women who may receive family planning services and medical diagnosis and treatment services provided pursuant to a family planning service; presumptive eligibility for this group would be permissible [Sec. 2303, p. 175]

[1]*All section references include amendments made by the Manager's Amendment and reconciliation bill (H.R. 4872)*

Processes

Presumptive eligibility. Beginning January 1, 2014, expands the ability to use presumptive eligibility to all Medicaid populations (currently limited to pregnant women, children, and those with breast or cervical cancer) [Sec. 2202(a), p. 173]

- Allows hospitals to opt to become qualified entities to determine presumptive eligibility

Online enrollment. By January 1, 2014, States must permit individuals to apply for Medicaid or CHIP through a secure electronic interface and to consent to enrollment or reenrollment through electronic signature [Sec. 2201, p. 171]

- Individuals identified by an Exchange as eligible for Medicaid or CHIP must be able to enroll through the website without further determination by the State
- Website must link to any website of an Exchange, and provide comparisons of the benefits, premiums, and cost-sharing in the plans for which the applicant may be eligible
- Screening those found ineligible for Medicaid or CHIP for an Exchange or premium assistance and, if eligible, enrolling them without an additional application
- Services must be coordinated for individuals enrolled in both Medicaid or CHIP and a qualified health plan
- State must conduct outreach
- Provisions do not apply to home and community based services assessments

Mandatory use of modified adjusted gross income. Effective January 1, 2014, requires that modified adjusted gross income be used to determine eligibility, but States must ensure that converting to this standard does not result in the loss of eligibility [Sec. 2002(a), p. 161]

- No income disregards are permitted, except that each individual's modified adjusted gross income will be reduced by 5% for the purpose of determining income eligibility [H.R. 4872 Sec. 1004(e), p. 8]
- Asset tests are not permitted
- These provisions do not apply to individuals who are eligible due to receipt of other state or federal assistance, individuals receiving (or treated as if receiving) SSI, foster children, individuals at least 65 years old, the blind and disabled, pregnant women, those entitled to institutional care, Medicare cost-sharing individuals
- States that use the Express Lane option may continue to rely on Express Lane agencies' determinations (which use gross income or adjusted gross income shown by State income tax records or returns)
- New processes do not apply for those already undergoing the Medicare prescription drug subsidy determination
- New processes do not apply to long-term care eligibility determinations
- Grandfathers in those already enrolled on January 1, 2014 who would be disqualified due to the use of modified adjusted gross income, to the later of March 31, 2014 or their next regular redetermination
- Eligibility determinations are to continue to use point-in-time income
- Children who become ineligible due to the elimination of income disregards are treated as targeted low-income children and enrolled under the State child health plan [Sec. 2101(f), p. 169]

Coordination of dual eligibles. Creates a federal coordinated health care office within the Centers for Medicare and Medicaid Services to more effectively integrate Medicare and Medicaid services for dual-eligibles [Sec. 2602, p. 197]

- Goals are to provide dual-eligible individuals full access to benefits, simplifying access, improving quality, increasing their understanding and satisfaction, eliminating regulatory conflicts between Medicare and Medicaid, improving care continuity, eliminating cost-shifting, and improving providers quality
- Responsibilities are providing States with specialized Medicare Advantage plans for special needs individuals, supporting State efforts to align acute care and long-term care services, supporting coordination of contracting and oversight by the States and CMS, coordinating with the Medicare Payment Advisory Commission, and studying the provision of drug coverage for new full-benefit dual-eligibles

Quality measures for adults. Requires DHHS to establish quality measures for adults eligible for Medicaid [Sec. 2701, p. 199]

- DHHS must release for comment proposed measures by January 1, 2011, publish initial core set of measures by January 1, 2012, develop standardized reporting format by January 1, 2013, and begin reporting to Congress by January 1, 2014 and every three years thereafter
- States must report on the new health quality measures and State-specific information including external quality reviews of managed care organizations and benchmark plans
- Appropriates $60 million per year between 2010 and 2014 to carry out the requirements

MACPAC. Makes changes to Medicaid and CHIP Payment and Access Commission (MACPAC) [Sec. 2801, p. 210]

- Adds new topics for MACPAC to review, including eligibility policies, enrollment and retention processes, coverage policies, quality of care, and interactions with Medicare and Medicaid
- Requires States to cooperate with MACPAC as a condition of receipt of Medicaid and CHIP funding

1115 waivers. Requires DHHS to promulgate, within 180 days, regulations relating to section 1115 waivers relating to public comment; demonstration goals, costs, coverage, and compliance; submittal of periodic reports; and evaluations [Sec. 10201, p. 799]

Provisions relating to Indians. [Sec. 2901, p. 215]

- Makes Indian Health Services and Tribes and tribal organizations the payer of last resort
- Makes Indian Health Services and Tribes and tribal organizations express lane agencies

Administration of HCBS. DHHS must promulgate regulations related to the administration of home and community based services, including ensuring that States allocate resources in a manner that is responsive to consumers and supports individualized self-directed services; improved coordination among and regulation of providers such as coordination of eligibility determinations, development of quality systems, and assuring an adequate number of qualified direct care workers [Sec. 2402(a), p. 183]

Spousal impoverishment rules for HCBS. Between January 1, 2014 and December 31, 2018, States must apply protection against spousal impoverishment rules to individuals receiving home and community based services as if they were institutionalized [Sec. 2404, p. 187]

Funding

Enhanced FMAP for new eligibles. Enhanced federal funding for newly eligible individuals is provided beginning in calendar year 2014 [Sec. 2001(a), p. 154]

Calendar Year	FMAP for New Eligibles
2014-2016	100%
2017	95%
2018	94%
2019	93%
2020 and future years	90%

- Newly eligible individuals are those who were not eligible for State Medicaid coverage as of December 1, 2009 and eligible individuals on a waiver waiting list due to enrollment caps [Sec. 2001(a), p. 155]
- Beginning in January 2015, States must annually report the number of enrolled and newly enrolled Medicaid recipients as well as outreach and enrollment processes [Sec. 2001(d), p. 159]

Funding for expansion States. Beginning in 2014, provides for additional funding for "expansion" States for costs associated with non-traditional adults [Sec. 10201, p. 799]

- Create a "transition percentage" that gives expansion states a share of the enhanced FMAP that non-expansion states receive. The transition percentage is applied to the difference between the non-expansion states' FMAP and each individual expansion state's base FMAP and then added to the base FMAP. (not applicable to Louisiana)
- Provides for an additional 2.2% increase in Vermont's FMAP in 2014 and 2015

Special FMAP for States impacted by disasters. Provides a partial hold-harmless to FMAP declines in States recovering from a major disaster declared by the President in the preceding 7 fiscal years and every county or parish in the State required federal assistance (currently applies only to Louisiana and Hawaii) [Sec. 2006, p. 166]

- In the first applicable fiscal year, if the decline in the FMAP would be at least three percentage points, the State would retain one-half of the calculated percentage reduction in the FMAP
- In the second and succeeding fiscal years, if the decline in the FMAP would be at least three percentage points, the State would retain one-quarter of the calculated percentage reduction in the FMAP

MEDICAID (TITLE XIX) (cont.)

DSH cuts. Beginning in fiscal year 2014, reduces disproportionate share hospital (DSH) payments [Sec. 2551, p. 194]

- Reductions of $500 million in fiscal year 2014, $600 million in 2015 and 2016, $1.8 billion in 2017, $5.0 billion in 2018, $5.6 billion in 2019, and $4.0 billion in 2020
- Secretary to determine methodology – the largest reductions to be allocated to States with the lowest percentage of uninsured individuals and those that do not target their DSH allotments to hospitals with high volumes of Medicaid patient or with high levels of uncompensated care; smaller allocations for low DSH States (less than 3% of their total Medicaid revenue is from DSH)
- Methodology to consider the extent to which DSH was included in budget neutrality calculations for a coverage expansion under a section 1115 waiver prior to July 1, 2009

Special DSH rules for Hawaii. Includes various limits to reductions to Hawaii's DSH reductions [Sec. 10201(e), p. 802]

- Specifies that Hawaii will receive $7.5 million in DSH for the second, third, and fourth quarter of fiscal year 2012
- Requires DHHS to deem Hawaii to be a low DSH State when implementing reductions
- Prohibits DHHS from limiting the total payments made to hospitals in Hawaii under the QUEST 1115 waiver

Special DSH rules for Tennessee. Includes special provision for Tennessee, by providing $47.2 million in fiscal year 2012 and $53.1 million in fiscal year 2013 for "…a State that has a DSH allotment of $0 for the 2d, 3rd, and 4th quarters…" [H.R. 4872, Section 1203, p. 67]

Prescription drug rebates. Effective January 1, 2010, increases the required minimum manufacturer's rebate to State Medicaid programs for single source drugs and innovator multiple source drugs from 15.1% to 23.1%; except for clotting factors and drugs approved exclusively for pediatric indications, which increases to 17.1% [Sec. 2501, p. 188]

- For other drugs (i.e. generics), the minimum rebate is increased to 13.0% from 11.0%
- The federal government retains the entire savings to Medicaid associated with the increased rebates (for the underlying 15.1%, the States and federal government share in the savings according to the FMAP)
- Requires that Medicaid managed care organizations receive the same drug manufacturer's rebates

Reduction of upper payment limit for pharmacy reimbursement. Effective October 1, 2010, the upper payment limit for pharmacy reimbursement is established at no less than 175% of the weighted average of reported average manufacturer prices rather than 250% [Sec. 2503, p. 192]

Primary care physician reimbursement. Requires that services delivered by a primary care physician (family medicine, general internal medicine, and pediatric medicine) be reimbursed at 100% of Medicare rates in 2013 and 2014; 100% federal funding for the increased rate compared to the rate in effect in the State plan as of July 1, 2009 [H.R. 4872 Sec. 1202, p. 24]

MEDICAID (TITLE XIX) (cont.)

Prohibition on shifting costs to political subdivisions. Conditions States' receipt of enhanced Medicaid funding on not increasing political subdivisions' percentage of Medicaid costs (if applicable) compared to their December 31, 2009 contributions, but permits voluntary contributions [Sec. 10201, p. 799]

Elimination of funding for health care acquired conditions. Effective July 1, 2011, eliminates Medicaid payments for health care acquired conditions (those that could have reasonably been prevented through the application of evidence-based guidelines) [Sec. 2702, p. 200]

Community First Choice Option. Effective October 1, 2011 States may establish a State plan amendment through a new Section 1915(k) option to provide a Community First Choice Option [Sec. 2401, p. 179]

- To provide a person-centered and self-directed system of attendant supports to individuals with income up to 150% of the federal poverty level or the amount applicable for those requiring an institutional level of care
- Program must be developed with a Development and Implementation Council that includes consumers and must be statewide
- Services include those to assist in accomplishing activities of daily living and instrumental activities of daily living and may include transition costs for individuals transitioning out of an institution
- Services may be delivered via an agency-provider model or alternative model (e.g. vouchers, direct cash payments, or use of a fiscal agent)
- States receive an extra 6 percentage points to their FMAP for these services, but must maintain current spending levels under their State plan and any waivers

Money Follows the Person extension. Extends Money Follows the Person rebalancing demonstration through 2016 [Sec. 2403, p. 186]

- Reduces the length of time that an individual has resided in an inpatient facility from 6 months to 90 days

Funding for ADRCs. For each of fiscal years 2010 through 2014, appropriates $10 million for Aging and Disability Resource Centers [Sec. 2405, p. 187]

Long term care rebalancing. Creates a $3 billion State Balancing Incentive Payments Program between October 1, 2011 and September 30, 2015 for States that expend more than 50% of their long-term care funding on institutional services [Sec. 10202, p. 805]

- States that spend more than 75% of their long term care funding on institutional services must establish a target of less than 75% by October 1, 2015 and receive a 5% increase in their FMAP for non-institutional based long term care services; States that spend more than 50% of their long term care funding on institutional services must establish a target of less than 50% by October 1, 2015 and receive a 2% FMAP increase
- States must maintain eligibility standards as in effect on December 31, 2010 and implement a single entry point system, conflict-free case management services, and core standardized assessment instruments

Grants for Prevention of Chronic Diseases. Beginning January 1, 2011, appropriates $100 million over a five year period for grants for programs that help clients cease tobacco use, reduce their weight, lower their cholesterol or blood pressure, and avoid diabetes [Sec. 4108, p. 443]

Medicaid Improvement Fund. Rescinds the Medicaid Improvement Fund [Sec. 2007, p. 167]

Indian hospitals and ambulatory care clinics. Eliminates the January 1, 2010 sunset of Medicare Part B payments to hospitals or ambulatory care clinics operated by the Indian Health Service or by an Indian tribe or tribal organization [Sec. 2902, p. 215]

Benefits

Minimum benchmark benefits. Benchmark benefits must include prescription drugs and mental health services at actuarial value [Sec. 2001(c), p. 158]

Family planning services in benchmark coverage. Effective immediately, family planning services and supplies must be covered in any benchmark coverage for individuals of child-bearing age [Sec. 2303(c), p. 178]

Mandatory Medicaid coverage of freestanding birth centers. Mandates Medicaid coverage of freestanding birth centers, effective immediately unless State legislation is required (must then be implemented by the first day of the first calendar quarter after the close of the first regular legislative session that begins after the Act) [Sec. 2301(a), p. 174]

Hospice services for children. Effective immediately, a child may opt to continue to receive hospice services without losing Medicaid or CHIP coverage for treatment for the condition for which a diagnosis of terminal illness has been made [Sec. 2302(d), p. 175]

Smoking cessation drugs, barbiturates, and benzodiazepines. Effective January 1, 2014, requires coverage of smoking cessation drugs, barbiturates, and benzodiazepines [Sec. 2502, p. 192]

Tobacco cessation benefits for pregnant women. Effective October 2010, requires coverage of tobacco cessation counseling and pharmacotherapy (including non-prescription treatment) for pregnant women and prohibits copayments for these services [Sec. 4107, p. 442]

Premium assistance for employer-sponsored insurance. Effective January 1, 2014 eliminates age restriction on State-provided premium assistance for Medicaid-eligible individuals receiving employer-sponsored insurance (previously only available to individuals under the age of 19 and their families) [Sec. 2003, p. 164]

Preventive Services. Beginning January 1, 2013 adds certain clinical preventive services and vaccines for adults as allowable services and provides a 1 percentage point increase in the FMAP for these services in States that offer them without copayments [Sec. 4106, p. 441]

Home and Community Based Services through a 1915(i) State Plan Amendment

Expansion of HCBS Income Eligibility. Effective October 1, 2010, permits States to provide home and community based services through a 1915(i) State plan amendment to individuals with incomes up to 300% of the federal benefit rate [Sec. 2402(b), p. 184]

- Services may differ in type, amount, duration, or scope from those offered to individuals who satisfy the needs-based criteria

State plan amendments for HCBS targeting populations. Effective October 1, 2010, permits States to provide home and community based services to specific, targeted populations through a 1915(i) amendment and to differ the type, amount, duration, or scope of services among each specific population [Sec. 2402(b), p. 184]

- These services may be phased in over five years, but after that time, all eligible individuals must be enrolled

Eliminate ability to disenroll waiver participants due to caseload. Effective October 1, 2010, removes States' ability to disenroll individuals receiving home and community based services under a 1915(i) amendment due to eligibility criteria changes made in response to greater than anticipated enrollment [Sec. 2402(e), p. 186]

Changes to waivers of provisions. Effective October 1, 2010, eliminates option of waiving statewideness for 1915(i) amendments for home and community based services and adds option of waiving comparability [Sec. 2402(f), p. 186]

Elimination of States' ability to limit scope of services in State plan amendments for HCBS. Effective October 1, 2010, removes ability of States to limit scope of services in 1915(i) amendments for home and community based services [Sec. 2402(c), p. 185]

Optional category to provide full Medicaid benefits for individuals receiving HCBS. Effective October 1, 2010, establishes optional eligibility category to provide full Medicaid benefits to individuals receiving home and community based services under a 1915(i) amendment [Sec. 2402(d), p. 185]

State Plan Options and Demonstration Waivers

Bundled payments for integrated care around a hospitalization. Provides for a demonstration project in up to 8 States for the period of January 1, 2012 and December 31, 2016 for bundled payments for the provision of integrated care around a hospitalization for Medicaid beneficiaries [Sec. 2704, p. 205]

- States would receive funding at their regular FMAP
- States selected to participate specify the one or more episodes of care to be addressed and the services to be included in the bundled payment
- Participating hospitals must have robust discharge planning programs to ensure clients requiring post-acute care have appropriate access to post-acute care settings

Emergency psychiatric demonstration project. Establishes the emergency psychiatric demonstration project under which a State makes payments to a non-publicly owned institution for mental disease for medical assistance to individuals between 21 and 65 years old who require medical assistance to stabilize an emergency medical condition [Sec. 2707, p. 208]

- Projects will be conducted for three consecutive years
- $75 million is appropriated beginning in fiscal year 2011 and is available through December 31, 2015; payments are made to States at their FMAP
- A participating State must establish a mechanism for how it will ensure that participating institutions determine whether or not an individual has been stabilized; the mechanism must commence before the third day

Health home option. Beginning January 1, 2011, States may utilize a State plan amendment to provide health home services for eligible individuals with chronic condition [Sec. 2703, p. 201]

- Eligible individuals have 2 chronic conditions (mental health condition, substance use disorder, asthma, diabetes, heart disease, or obesity), one chronic condition and risk of another, or a serious and persistent mental health condition
- Home health providers may be a physician, clinical practice or clinical group practice, rural clinic, community health center, community mental health service, home health agency, or other entity specified by the State
- Services may include comprehensive care management, care coordination and health promotion, comprehensive transitional care, patient and family support, referral to community services, use of health information technology to link services
- $25 million is set aside for State planning grants at the regular FMAP; a special 90% FMAP is available for the first eight quarters of services
- Payments may be tiered based on client severity and capabilities of the provider; payment is not limited to a per member per month system
- Amendment must include requirement for hospitals to establish processes for referring eligible individuals, program must coordinate with substance abuse and mental health service agencies

Global capitated model for safety net hospital systems. Authorizes, but does not fund, a demonstration project in up to 5 States for the period of fiscal year 2010 through fiscal year 2012 to adjust payments for an eligible safety net hospital system or network (as defined by DHHS) from a fee-for-service structure to a global capitated model [Sec. 2705, p. 206]

- Budget neutrality requirements under a section 1115 waiver do not apply during the testing period

Pediatric accountable care organization. Authorizes, but does not fund, a pediatric accountable care organization demonstration project for the period of January 1, 2012 and December 31, 2016 [Sec. 2706, p. 207]

- A participating State and DHHS will establish quality guidelines and minimal level of savings; an accountable care organization that meets performance guidelines and achieves savings greater than the minimum will receive an incentive payment (determined by DHHS)
- An accountable care organization must agree to participate for at least three years

MEDICAID (TITLE XIX) (cont.)

Extension of duration of waivers serving dual eligibles. Allows 1915 or 1115 waivers that serve dual-eligible individuals (even if non-dual eligible individuals may be enrolled) to be conducted for five years [Sec. 2601, p. 196]

MEDICARE AND FEDERAL INITIATIVES

Federal Initiatives and Strategic Planning

Independent Medicare Advisory Board. Establishes the Medicare Advisory Board comprised of 3 ex-officio members (DHHS Secretary and the Administrators of the Centers for Medicare and Medicaid Services and the Health Resources and Services Administration) and 15 members chosen by the President serving six-year terms including physicians and other health professionals, experts in pharmo-economics or prescription drug benefit programs, employers, third-party payers, researchers, representatives of consumers and the elderly; providers may not comprise a majority of the committee [Sec. 3403, p. 371]

- If Medicare estimates that per capita spending growth for Medicare Parts A, B, and D for two years out ("implementation year") calculated as the five-year average with the implementation year as the fifth year exceeds the target growth, which before 2018 is the increase in CPI and the increase in the medical care expenditure category of CPI (after 2018, it is the increase in nominal gross domestic product per capita plus 1%), the Board must make a proposal to reduce per capita spending growth and implement the plan unless Congress takes action
- Beginning in 2014, a plan (if applicable) must be submitted to Congress and the President by January 15 with the legislative proposal to implement the recommendations
- The proposal must achieve the savings target which is 0.5% in 2015, 1% in 2016, 1.25% in 2017, and 1.5% in succeed years; not ration care, raise revenues, raise premiums, restrict benefits, or modify eligibility; not reduce rates for services already scheduled to receive a reduction in inflationary payment updates in excess of a reduction due to productivity; may reduce subsidy payments related to administrative expenses and performance bonuses for Medicare Advantage and prescription drug plans; and may only make recommendations related to Medicare
- House and Senate majority leaders must introduce the legislative proposal and various limits are set on Congress' ability to make changes, debate, and time limits
- Unless Congress passes a law to supersede DHHS is to implement the proposal by August 15 with rate changes occurring the next regular adjustment timeframe and any recommendation that is not related to payments following the regular regulatory process timeframe
- For implementation year 2020 and succeeding years, Congress may enact a joint resolution to repeal the Board with a three-fifths vote by August 15, 2017
- The proposal is not implemented if a proposal was required in the previous year and the projected per capita rate of growth in national health care expenditures exceeds that of Medicare; this provision may not be applied in consecutive years
- Beginning July 1, 2014 the Board must produce annual public reports regarding nationwide health care costs, patient access, utilization, and quality of care; and beginning January 1, 2015 must produce biennial reports regarding slowing growth in non-federal health care
- $15 million is appropriated for the Board in fiscal year 2012 with the appropriation increasing by each year
- A 10-member Consumer Advisory Council is established comprised of representatives chosen by the Comptroller General to advise the Board

[1]*All section references include amendments made by the Manager's Amendment and reconciliation bill (H.R. 4872)*

- By July 1, 2015, the Government Accountability Office is to study changes resulting from the Board and the effect on access, affordability, impact on other public or private payers, and quality

Center for Medicare and Medicaid Innovation. Creates CMI within the Centers for Medicare and Medicaid Services to test innovative payment and service delivery models and to reduce expenditures while maintaining or improving quality in two phases: Phase I is the testing of models and does not have to be budget neutral while Phase II (expansion) cannot increase costs; $10 billion is appropriated for fiscal years 2011 through 2019 and each subsequent decade and beginning in 2012 CMI must submit annual reports to Congress [Sec. 3021, p. 271]

Federal working group on health care quality. The President is to convene an Interagency Working Group on Health Care Quality chaired by the DHHS Secretary to achieve collaboration and cooperation between federal agencies, avoid duplication of effort, and assess alignment of quality efforts in the public and private sectors; the group is to submit a report to Congress by December 31, 2010 and annually thereafter [Sec. 3012, p. 262]

Assessing health plan value. By September 2011 requires DHHS in consultation with stakeholders to develop a methodology to measure health plan value, including cost, qualify, efficiency, and actuarial value [Sec. 10329, p. 847]

Offices of Women's Health. Establishes Offices of Women's Health in the DHHS Office of the Secretary, Centers for Disease Control and Prevention, Agency for Healthcare Research and Quality, Health Resources and Services Administration, and Food and Drug Administration; authorizes funding for fiscal years 2010 through 2014 [Sec. 3509, p. 413]

Offices of Minority Health. Establishes Offices of Women's Health in the DHHS Office of the Secretary, Centers for Disease Control and Prevention, Agency for Healthcare Research and Quality, Health Resources and Services Administration, and Food and Drug Administration, the Centers for Medicare and Medicaid Services, and the Substance Abuse and Mental Health Services Administration [Sec. 10334, p. 853]

National strategy for quality improvement. Requires DHHS to establish by January 1, 2011 a national strategy to improve the delivery of health care services, patient health outcomes, and population health; the strategy must be updated annually and available online [Sec. 3011, p. 260]

Episode groupers. Requires DHHS to develop by January 1, 2012 episode groupers that combine separate but clinically related items and services into an episode of care for the purpose of comparing physicians and service utilization [Sec. 3003, p. 248]

Quality measure development. Appropriates $75 million for each of fiscal years 2010 through 2014 for grants and contracts to develop quality measures and identify at least triennially existing measures that require improvement and gaps in which no quality measures exist; outcome measures for acute and chronic diseases are to be developed within 2 years and for primary and preventive care within 3 years [Sec. 3013, p. 263]

Quality measurement. Requires that the existing consensus-based entity convene multi-stakeholder groups (voluntary collaborative of organizations) to provide input on the selection of quality and efficiency measures and national priorities, and submit annual reports beginning February 1, 2012; $20 million is made available for each of fiscal years 2010 through 2014 [Sec. 3014, p. 266]

Public reporting of performance information. Requires DHHS to establish a strategic framework to collect, aggregate, and publicly report through a website data on quality and resource use measures; funding is authorized but not appropriated for fiscal years 2010 through 2014 and DHHS may contract for this work, but the awardee must provide a 1:5 match [Sec. 3015, p. 269]

Data to evaluate provider performance. Instructs DHHS to make claims data available to qualified entities to evaluate the performance of providers [Sec. 10332, p. 850]

Physician Compare website. By January 1, 2011 requires DHHS to develop the Physician Compare website to make available by January 1, 2013 information regarding patient health outcomes, efficiency, safety, effectiveness, timeliness, and other criteria [Sec. 10331, p. 848]

- By January 1, 2019 requires DHHS to establish a demonstration program to provide financial incentives for beneficiaries who receive services from high quality physicians

Prescription drug information. By March 2011, DHHS is to report on whether adding quantitative data regarding benefits and risks in a standardized format to prescription drug advertising would improve decision-making by clinicians and patients [Sec. 3507, p. 412]

CMS data systems. By 2011 requires DHHS to develop and post a plan to modernize the Centers for Medicare and Medicaid Services' computer and data system [Sec. 10330, p. 847]

Report on dialysis services. By March 2011 requires the Government Accountability Office to submit a report regarding Medicare beneficiaries' access to high-quality dialysis services and specified oral drugs [Sec. 10336, p. 856]

Elimination of Funds.

- Eliminates the $22.9 billion appropriated for 2014 for the Medicare Improvement Fund [Sec. 3112, p. 303]
- Eliminates Medicare Advantage Regional Plan Stabilization Fund [Sec. 10327(c), p. 846]

Rates, Rate Methodologies, and Service Requirements

Changes to market basket updates. Makes changes to the market basket updates of a number of services [Sec. 3401, p. 362]

- For outpatient hospitals, inpatient hospitals, and inpatient rehabilitation facilities, the update is reduced by 0.25% in fiscal years 2010 and 2011, 0.1% in 2012 and 2013, 0.3% in 2014, 0.2% in 2015 and 2016, and 0.75% in 2017 through 2019; also beginning in 2012 reduces the update by a productivity adjustment equal to the 10-year moving

average of change in the annual economy-wide private nonfarm business multi-factor productivity

- Implements in 2010 a prospective rate system for psychiatric hospitals with the same reduction in annual updates as specified for inpatient hospitals; also beginning in 2014 if psychiatric hospitals do not report on quality measures to be determined by October 1, 2012 their rate will be reduced by 2%
- For long-term care hospitals, the update is reduced by 0.25% in fiscal years 2010, 0.5% in 2011, 0.1% in 2012 and 2013, 0.3% in 2014, 0.2% in 2015 and 2016, and 0.75% in 2017 through 2019; also beginning in 2012 reduces the update by a productivity adjustment equal to the 10-year moving average of change in the annual economy-wide private nonfarm business multi-factor productivity
- Beginning in 2012 reduces skilled nursing facility and dialysis rate updates by a productivity adjustment equal to the 10-year moving average of change in the annual economy-wide private nonfarm business multi-factor productivity
- For home health agencies, the update is reduced by 1% in fiscal years 2011 through 2013; also beginning in 2015 reduces the update by a productivity adjustment equal to the 10-year moving average of change in the annual economy-wide private nonfarm business multi-factor productivity
- Beginning in 2013 reduces hospice care rate updates by a productivity adjustment equal to the 10-year moving average of change in the annual economy-wide private nonfarm business multi-factor productivity; also reduced rate update s by 0.3% in fiscal years 2013 through 2019 unless the total percentage of non-elderly insurance population changes by a certain amount
- Beginning in 2011 reduces ambulance services and ambulatory surgical centers rate updates by a productivity adjustment equal to the 10-year moving average of change in the annual economy-wide private nonfarm business multi-factor productivity
- Beginning in 2011 reduces laboratory services rate updates by a productivity adjustment equal to the 10-year moving average of change in the annual economy-wide private nonfarm business multi-factor productivity; and makes another 1.75% reduction in fiscal years 2011 through 2015 except that the reduction is not implemented if existing scheduled changes would result in a cut to the update
- Beginning in 2011 reduces durable medical equipment, prosthetic devices, orthotics, prosthetics, and certain other items rate updates by the difference between CPI and a productivity adjustment equal to the 10-year moving average of change in the annual economy-wide private nonfarm business multi-factor productivity

Value-based purchasing program for hospitals. Beginning in fiscal year 2013 reduces hospitals base operating diagnosis-related group Medicare payment amounts by 1% (and growing by .25% each year until reaching 2% in fiscal year 2017 and succeeding years) and uses the funds to establish a program to provide incentive payments based on measures covering at least acute myocardial infarction, heart failure, pneumonia, surgeries, and health care associated infections, and beginning in fiscal year 2014 efficiency measures including Medicare spending per beneficiary [Sec. 3001, p. 235]

- By March 2012, establishes a budget-neutral Medicare demonstration program for hospitals excluded from the hospital value-based purchasing program due to insufficient

cases or measures to test innovative methods of measuring and rewarding quality and efficient health care
- By March 2012, establishes a budget-neutral Medicare demonstration program for inpatient critical access hospitals to test innovative methods of measuring and rewarding quality and efficient health care

Value-based purchasing program for other providers. Requires DHHS to develop a plan to implement a Medicare value-based purchasing program for ambulatory surgical centers and report the plan by January 1, 2011; plans for value-based purchasing for skilled nursing facilities and home health agencies must be reported by October 1, 2011 [Sec. 3006, p. 254]

Value-based purchasing pilot. Requires DHHS to establish by January 1, 2016 a value-based purchasing pilot for psychiatric hospitals, long-term care hospitals, rehabilitation hospitals, cancer hospitals, and hospices; the program cannot increase expenditures [Sec. 10326, p. 843]

Value-based payment modifier for physicians. Requires DHHS to establish a budget-neutral Medicare value-based payment modifier beginning in 2015 for specific physicians to be determined by DHHS and all physicians in 2017 based on measures of the quality of care to be determined by DHHS that eliminate the effect of geographic adjustments and take into account risk factors [Sec. 3007, p. 255]

Physician quality reporting system. For physicians, physician assistants, nurse practitioners, therapists, and other professionals, extends existing Medicare incentive payments for quality reporting to 2014 but reduces the incentive from 2% in 2010 to 1% in 2011 and 0.5% in 2012-2014; beginning in 2015 a 1.5% penalty is established for non-reporting, which grows to 2% in 2016 and succeeding years [Sec. 3002, p.245]
- For fiscal years 2011 through 2014, provides an additional 0.5% for such professionals participating in a maintenance of certification program and meeting other requirements [Sec. 10327, p. 844]

Mental health add-on for physicians. Extends for one year, through 2010, a 5% adjustment in the Medicare physician fee schedule for psychiatric therapeutic procedures [Sec. 3107, p. 300]

Geographic factors for physician Medicare fees. Extends for one year, through 2010, the floor for the geographic index for physician work effort for those areas where the cost would be below the national average by setting the index for these areas at the national average; for the practice expense (employee wages and rent) geographic index in 2010 and 2011 reduces the factor by one-half but holds physicians harmless from any loss and requires DHHS to analyze current methods and data to make appropriate adjustments in 2012 [Sec. 3102, p. 298]

Misvalued codes in the physician fee schedule. Requires DHHS to periodically review potentially misvalued codes (those with the greatest growth, new technologies, multiple codes often billed in conjunction with a single services, not reviewed since implementation of RBRVS, etc.) and adjust relative values as appropriate and to establish a process to validate relative value units; also eliminates the Practicing Physicians Advisory Council [Sec. 3134, p. 316]

MEDICARE AND FEDERAL INITIATIVES (cont.)

Hospital wage index. Extends through September 30, 2010 the hold harmless on hospital wage index reclassifications and for fiscal year 2010 for hospitals that qualify for wage index reclassification DHHS will only include such wage data if it results in a higher rate and will pay hospitals for any difference associated with the reclassification already accrued in fiscal year 2010 [Sec. 3137, p. 320]

- By December 31, 2011 DHHS must submit a plan to reform the hospital wage index system and the index used in fiscal year 2009 is restored until such report is submitted

Hospital wage index floor on a national basis. Beginning October 1, 2010 for achieving budget neutrality for hospital wage index floors requires DHHS to use a national, rather than State-specific, adjustment to the area wage index [Sec. 3141, p. 323]

Urban Medicare-dependent hospitals. By January 1, 2011 DHHS must submit a report on the need for additional payment for inpatient care at urban Medicare-dependent hospitals [Sec. 3142, p. 323]

Hospital acquired conditions. To reduce hospital acquired conditions, beginning in fiscal year 2015 hospitals in the top quartile of hospital acquired conditions will receive a 1% reduction in Medicare payments for discharges; hospitals may be exempted if the State submits an annual report regarding any similar program that achieves the same outcomes [Sec. 3008, p. 258]

- By January 1, 2012, DHHS must submit a report regarding the feasibility of applying the healthcare acquired condition policy to other providers (e.g. inpatient rehabilitation facilities, long-term care hospitals, skilled nursing facilities, health clinics, etc.)

Hospital readmissions reduction program. Beginning in fiscal year 2013 for hospitals with excess readmissions (compared to an expected level) for specified conditions, Medicare diagnosis-related group payments to hospitals will be reduced by 1% in 2013, 2% in 2014, and 3% in succeeding years [Sec. 3025, p. 290]

- By March 2012, DHHS is to establish a program to assist hospitals with a high rate of risk adjusted readmission to improve their readmission rate

Disproportionate Share Hospital payments. Beginning in fiscal year 2014, changes the DSH formula to account for the reduction in the number of uninsured individuals by applying the existing formula to 25% of total funding and adjusting the remaining funds by: one less the percent change in the number of uninsured individuals in 2013 to the comparison year and an additional 0.1% reduction (0.2% in succeeding years), and the proportion of uncompensated care furnished by the hospital compared to the total amount [Sec. 3133, p. 314]

Long-term care hospitals. Extends for two years, through 2012: a delay in implementing a policy restricting the proportion of patients that can be admitted from a co-located or host hospital, and a moratorium on the establishment of new long-term care hospitals or beds [Sec. 3106, p. 300]

Cancer hospitals. Beginning January 1, 2011 DHHS will adjust Medicare rates for cancer hospitals if costs for ambulatory patient classification at such hospitals exceeds the costs at other hospitals [Sec. 3138, p. 321]

MEDICARE AND FEDERAL INITIATIVES (cont.)

Cancer hospital quality reporting. Beginning in fiscal year 2014 requires that cancer hospitals exempt from the prospective payment system report on quality measures to be determined by DHHS [Sec. 3005, p. 253]

Facility quality reporting. Beginning in 2014 requires long-term care hospitals, inpatient rehabilitation hospitals, and hospices to report on quality measures to be determined by DHHS or their Medicare rate updates will be reduced by 2% [Sec. 3004, p. 250]

Delay in changes to skilled nursing facility payment methodology. Delays for one year to October 1, 2011 implementation of Version 4 of the Resource Utilization Group (RUG-IV) for skilled nursing facilities other than the change specific to therapy furnished on a concurrent basis and changes to the lookback period to ensure only services furnished after admission to a skilled nursing facility are used as factors in determining case mix classification [Sec. 10325, p. 842]

Independent laboratory services. Extends for one year, through 2010, Medicare's special treatment of independent laboratory services [Sec. 3104, p. 299]

Bone density test payment. Provides for a special Medicare payment rate in 2010 and 2011 for bone mass scans and requires DHHS and the Institute of Medicine to study the impact of payment reductions in 2007-2009 on beneficiary access [Sec. 3111, p. 303]

Equipment utilization factor for advanced imaging services. Makes a number of changes projected to save Medicare $3 billion: beginning in 2011, the expensive diagnostic imaging equipment utilization rate will decrease from the scheduled 90% (which has not been implemented) to 75% which will have the effect of increasing the rate compared to what it would otherwise be, beginning in 2011 exempts expensive DIE fee schedules from budget neutrality calculation in the periodic review and adjustment in relative values, and increases the reduction from 25% to 50% in payments for the technical component portion of single-session imaging to consecutive body parts [Sec. 3135, p. 318]

Pharmacy accreditation. Delays for one year, through 2010, the requirement that pharmacies receive specified accreditation, and wholly exempts pharmacies that have had an issued provider number for at least five years and for which durable medical equipment, prosthetics, orthotics, and certain other items are less than 5% of total pharmacy sales [Sec. 3109, p. 300]

Ambulance add-ons. Extends Medicare add-ons for one year, through 2010: a temporary rate increase for ground ambulances, a special increase for rural air ambulances, and a special increase for ground ambulances in rural areas [Sec. 3105, p. 299]

Power-driven wheelchairs. Effective January 1, 2011 changes the payment schedule for power-driven wheelchairs to 15% of the total in each of the first three months and 6% in succeeding months (from the current 10% and 7.5%) and eliminates the ability for the beneficiary to lump-sum purchase a power-driven wheelchair allowing this option only for complex, rehabilitation power-driven wheelchairs [Sec. 3136, p. 319]

Nurse mid-wife services. Beginning January 1, 2011 increases the cap on nurse mid-wife services to 100% of the physician charge for the same services (current cap is 65%) [Sec. 3114, p. 305]

Home health care payments. Beginning in 2014, DHHS will: adjust home health care Medicare prospective payment rates to reflect changes in the number of visits in an episode, mix of services, level of intensity, etc., reduce rates by 5%, reduce the cap on outliers to 2.5% of total expenditures, and institute a cap on agencies wherein no more than 10% of their revenue can be from outlier payments [Sec. 3131, p. 309]

- Reestablishes an increase in payments for home health in rural areas for April 1, 2010 to January 1, 2016 but reduces the add-on to 3% from the former 5%
- Requires DHHS to submit a report by March 1, 2014 related to home health payments and, based on the report, DHHS may implement a four-year demonstration project with $500 million of funding
- States that nothing in PPACA "shall result in the reduction of guaranteed home health benefits" under Medicare [Sec. 3143, p. 324]

Hospice. Requires DHHS to begin collecting data by January 1, 2011 to revise Medicare payments for hospice care by October 1, 2013 in a budget-neutral manner [Sec. 3102, p. 312]

- Requires that a hospice physician or nurse practitioner have a face-to-face encounter with the patient prior to each recertification of eligibility
- For facilities where a certain percentage (to be determined) of case have been in hospice for more than 180 days, cases must be medically reviewed

Physician assistants ordering extended care. Beginning January 1, 2011 allows physician assistants to order inpatient psychiatric hospital services, post-hospital extended care services, home health services, and inpatient hospital dental services [Sec. 3108, p. 300]

Therapy caps exceptions extension. Extends through 2010 the process for requesting an exception to Medicare caps on physical therapy and occupational therapy [Sec. 3103, p. 299]

Biosimilar biological products. Effective in the second calendar quarter after enactment of federal legislation providing for a biosimilar pathway, sets Medicare payment for biosimilar biological products at the average sales price plus 6% of the amount of the referenced biologic product [Sec. 3139, p 321]

Demonstrations and Other Programs

Medicare shared saving program. By January 1, 2012 requires DHHS to establish a shared savings program under Medicare Part A and B with accountable care organizations (e.g. doctors in group practice arrangements, networks of ACO professionals, partnerships between hospitals and ACO professionals, hospitals employing ACO professionals) that must be for at least three years and have at least 5,000 Medicare beneficiaries; DHHS will set spending benchmarks and if the ACO spends less they get a percentage of the savings, and programs may use a partial capitation model or other payment model [Sec. 3022, p. 277]

Independence at home demonstration program. By January 1, 2012 requires DHHS to establish an independence at home demonstration limited to 10,000 Medicare beneficiaries with two or more chronic diseases, a non-elective hospital admission within the past 12 months, receipt of rehabilitation services within the past 12 months, and two or more functional dependencies, to test a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams; DHHS will set target spending levels and providers can get a portion of savings if spending is within 5% less than the target [Sec. 3024, p. 286]

National pilot program on payment bundling. By January 1, 2013 requires DHHS to establish a five-year Medicare pilot program on payment bundling in which DHHS will select 10 conditions and make bundled payments for integrated care including services such as care coordination, medication reconciliation, discharge planning, and transitional care services, during an episode of care (three days prior to hospital admission, the hospital stay, and 30 days after discharge) with participating providers such as a hospital, physician group, skilled nursing facility, and home health agency; the program is not to result in increased expenditures [Sec. 3023, p. 281]

- Establishes a separate pilot for continuing care hospitals

Community-based care transitions program. For the five year period beginning January 1, 2011 makes available $500 million for community-based organizations that provide care transition services or a hospital with a high readmission rate partnering with such organization to furnish improved care transition services to high risk Medicare beneficiaries with one or more chronic conditions and not enrolled in a Medicare Advantage program [Sec. 3026, p. 295]

Community-based collaborative care network. Authorizes appropriations for fiscal years 2011 through 2015 for community-based collaborative care networks, which include a hospital and all federally qualified health centers with a joint governance structure to provide comprehensive coordinated and integrated health care to low-income individuals; funds may be used to help individuals access services, to provide case management, outreach, transportation, direct patient care services, and to expand capacity [Sec. 10333, p. 852]

Complex diagnostic laboratory test demonstration. Beginning July 1, 2011 establishes a two-year, $100 million demonstration project to make separate payments directly to laboratories (rather than to the hospital) for covered complex diagnostic laboratory tests for hospitalized individuals [Sec. 3113, p. 304]

Gainsharing demonstration extension. Extends to September 30, 2011 gainsharing programs (authorized by the Deficit Reduction Act to test and evaluate methodologies and arrangements between hospitals and physicians) in effect as of October 1, 2008 and appropriates an additional $1.6 million [Sec. 3027, p. 297]

Special Part B enrollment period for disabled TRICARE beneficiaries. Provides for a special enrollment period for disabled veterans who elected not to enroll during their initial enrollment period, giving them 12 more months to enroll after their initial period and exempts these enrollees from the 10% premium increase that is generally applicable for enrollment after the initial period [Sec. 3110, p. 302]

MEDICARE AND FEDERAL INITIATIVES (cont.)

Health care delivery system research. Authorizes appropriations of $20 million for each of fiscal years 2010 through 2014 for the Center for Quality Improvement and Patient Safety of the Agency for Healthcare Research and Quality to identify, develop, evaluate, disseminate, and provide training in best practices in the delivery of health care; and establishes a grant programs with a 1:5 matching requirement for entities (providers, associations, etc.) to provide technical assistance, and implementation awards to hospitals, providers, or consortiums of providers [Sec. 3501, p. 389]

Community health teams. Establishes a grant program to make awards to States or State-designated entities for the creation of community-based interdisciplinary, interprofessional teams that must have a plan for long-term financial sustainability within three years to work with primary care providers to provide support services; support patient-centered medical homes; work with local PCPs to coordinate disease prevention and chronic disease management; work with local entities to develop interdisciplinary, interprofessional care plans; involve providers, patients, and caregivers in program oversight; and provide 24-hour coverage during transitions in care setting [Sec. 3502, p. 395]

Medication management services. Establishes a grant program for eligible entities to implement medication management services provided by licensed pharmacists as a collaborative multidisciplinary approach to the treatment of chronic disease, and provide services including: perform assessments, formulate medication treatment plans, monitoring, documenting, training, and education to targeted individuals on four or more medications, high risk medications, two chronic diseases, or high risk of medication related problems [Sec. 3503, p. 398]

Regionalized systems for emergency care. Appropriates $24 million for fiscal years 2010 through 2014 for contracts with a State (or multiple States) partnering with one or more local governments with a priority for medically underserved areas for four or more pilot projects to design, implement, and evaluate innovative models of regionalized comprehensive and accountable emergency care and trauma systems; requires a 1:3 match, which may be cash or in-kind [Sec. 3504, p. 400]

- Authorizes appropriations for DHHS to support other federal programs' emergency medical research

Trauma care centers. Appropriates $100 million in fiscal year 2009 and authorizes appropriations through 2015 to establish three programs for public, nonprofit, and other trauma centers: Half of the appropriated funds are to defray substantial uncompensated care with awards ranging from 50% to 100% of uncompensated costs, depending on the percent of visits that were charity or self-pay (minimum 20%), 35% of the funding is for core mission awards to address costs such as personnel and fixed costs, 15% of the funds are for emergency awards to ensure continued and future availability of trauma services; a center may not receive more than $2 million in a year [Sec. 3505, p. 404]

- Also appropriates $100 million for each of fiscal years 2010 through 2015 to provide funding to States to make grants to public, nonprofits trauma centers or a hospital in an underserved area seeking to establish new trauma services; 40% of the funding is reserved for safety net public, nonprofit trauma centers

Shared decision-making. Authorizes appropriations to develop patient discussion aids, which are educational tools to assist in understanding treatment option, deciding on the appropriate provider, etc. [Sec. 3506, p. 409]

Clinical education demonstration projects. Creates a program to award grants with a 1:5 match to professional schools for demonstration projects to develop and implement academic curricula that integrates quality improvement and patient safety [Sec. 3508, p. 412]

Patient Navigator program. Extends the patient navigator program through fiscal year 2015, increases the requirements for navigators by adding minimum core proficiencies to be defined by the grantee, and authorizes appropriations through fiscal year 2015 [Sec. 3510, p. 419]

Income threshold for Part B premiums. For 2011 through 2019 freezes the income threshold for income-related Part B premiums at 2010 levels ($85,000 for an individual) [Sec. 3402, p. 370]

Special funding for Montana. Provides for deemed Medicare coverage for individuals exposed to environmental health hazards (only one area in Montana meets the criteria, establishes a program for early detection funded with $23 million for fiscal years 2010 through 2014 and $20 million for each five-year period thereafter, and creates a pilot program to develop flexible benefits and innovative reimbursement methodologies [Sec. 10323, p. 836]

Programs for Rural Areas

Rural hospital outpatient hold harmless provision. Extends for one year, through 2010, the outpatient hold harmless provision for hospital in rural areas with less than 100 beds; also extends the hold harmless provision to sole community hospitals even with more than 100 beds [Sec. 3121, p. 305]

Hold harmless for frontier States. For frontier States provides a hold harmless in the area wage index for hospitals, the area wage adjustment factor for hospital outpatient services, and the expense index for physicians such that the indexes may not be below 1.00 and exempts these adjustments from budget neutrality [Sec. 10324, p. 841]

Clinical diagnostic laboratory tests in rural areas. Reinstates for one year, beginning July 1, 2010, a requirement mandating reimbursement of 100% of reasonable costs of outpatient clinical diagnostic laboratory tests for rural hospitals with fewer than 50 beds [Sec. 3122, p. 305]

Rural community hospital demonstration program. Extends for five years the rural community hospital demonstration program to furnish covered inpatient hospital services, reimbursed at the reasonable cost of such services, to Medicare beneficiaries and expands the program from 15 States to 20 and to 30 hospitals [Sec. 3123, p. 305]

Medicare-dependent hospital program. Extends for one year, to October 1, 2012, provide special reimbursement for Medicare-dependent small rural hospitals; and permits hospitals to decline reclassification from Medicare-dependent small rural hospitals [Sec. 3124, p. 306]

Inpatient hospital payment for low-volume hospitals. In fiscal years 2011 and 2012 expands this Medicare program for low-volume hospitals by increasing the number of allowable discharges to qualify from800 to 1,600 and decreasing the required distance between hospitals from 25 miles to 15 miles [Sec. 3125, p. 307]

Community health integration models. Eases limitation in this Medicare program for rural hospitals by eliminating the requirement that entities provide services in no more than 6 counties, eliminating the requirement that critical access hospitals located in the service county provide rural health clinic services; also adds physician services to those services that receive at least reasonable rates [Sec. 3126, p. 307]

Adequacy of Medicare payment in rural areas. Requires the Medicare Payment Advisory Commission to study the adequacy of payments for items and services in rural areas [Sec. 3127, p. 308]

Rural hospital flexibility program. Authorizes appropriations for this Medicare program in fiscal years 2011 and 2012 and allows funds to be used to implement various PPACA provisions [Sec. 3129, p. 308]

Hospice concurrent care demonstration. Establishes a three-year budget-neutral demonstration program with 15 hospices programs to provide both hospice and "regular" Medicare benefits to improve patient care, quality of life, and cost-effectiveness [Sec. 3140, p. 322]

Medicare Advantage Plans

Beneficiary election period. Beginning in 2011 allows individuals during the first 45 days of every year to disenroll from Medicare Advantage plans and go to fee-for-service but not other MA plans; and beginning in 2012 the annual enrollment period is changed from November 15 through December 31 to October 15 through December 7 [Sec. 3204, p. 338]

Beneficiary costs. Beginning January 1, 2011 cost-sharing in Medicare Advantage plans for chemotherapy, renal dialysis, skilled nursing care, and other services to be determined cannot exceed cost-sharing for the same services under traditional Medicare and when there is no cost-sharing in traditional Medicare the cost-sharing under MA must be part of overall actuarially equivalent cost-sharing; and beginning in 2012 the formula for MA beneficiary rebates is based on quality rating with plans with higher ratings receiving greater rebates [Sec. 3202, p. 336]

- Requires that MA plans use supplementary premiums and performance bonuses be used to provide supplemental care, pay prescription drug premiums, or pay Part B premiums

Modified benchmarks. Beginning in 2012 establishes a new standard for Medicare Advantage plan area-specific non-drug monthly benchmarks (the maximum amount that Medicare will pay), which excludes indirect medical education costs and applies a lower percentage to the base payment amount for an area in those areas with higher spending based on establishment of spending quartiles; if an area changes quartile in a year, the change in the percentage is phased in over two years [H.R. 4872 Sec.1102, p. 12]

- If the revised formula results in a change of $30 to $50 per beneficiary per month, it is phased in over four years; if the change is more than $50, it is phased in over 6 years

Plans for special needs individuals. Extends to January 1, 2014 Medicare Advantage plans for special needs individuals (e.g. institutionalized, dually eligible, severe or disabling chronic condition) and makes various changes to the plans [Sec. 3205, p. 339]

- Allows the use of PACE payment rules (e.g. accounting for comparative frailty of the population)
- Beginning in 2011, DHHS is to use a risk score that reflect that reflects the known underlying risk profile of similar individuals rather than the default risk score for new enrollees in MA plans not for special needs individuals
- Extends for two years, through 2012, the ability of MA plans for special needs individuals and serving dual eligibles but without a contract with Medicaid to continue to operate but not expand
- Requires that individuals enrolled in an MA plan for special needs individuals but no longer meeting the criteria be transitioned to a regular MA plan or fee-for-service by January 1, 2013 except that DHHS may grant a limited exception for former dual eligibles who are no longer eligible for Medicaid
- For 2012 and subsequent years, requires MA plans for special needs individuals to be approved by the National Committee on Quality Assurance

Reasonable cost contracts. Extends for three years, through 2012, DHHS' ability to enter into reasonable cost contracts with HMOs and other eligible organizations without meeting requirements regarding the lack of alternative Medicare Advantage plans [Sec. 3206, p. 341]

Private fee-for-service plans. Beginning in 2011 requires DHHS to apply the 2008 service area extension waiver policy to employer-sponsored Medicare Advantage fee-for-service plans in the same manner it is applied to coordinated care plans [Sec. 3207, p. 341]

Senior housing facility demonstration. Allows senior housing facility demonstration programs in existence on December 31, 2009 to become permanent; such programs limit the service area to a senior housing facility, provide primary care onsite, and provide transportation [Sec. 3208, p. 341]

Authority to deny plan bids. Beginning January 1, 2011 allows DHHS to reject any or all Medicare Advantage plan bids or prescription drug plan bids that propose significant cost-sharing increase or benefit decreases [Sec. 3209, p. 342]

Medigap benefit package standards. Requires DHHS to request that the National Association of Insurance Commissioners review and revised the standards for Medicare Supplemental Health Insurance Policies ("Medigap") to be implemented as of January 1, 2015 [Sec. 3210, p. 342]

Prescription Drug Plans

Formulary requirements. Beginning January 1, 2011 DHHS is to establish the formulary of covered Part D drugs of clinical concern that prescription drug plans must cover, until that time plans must cover anticonvulsants, antidepressants, antineoplastics, antipsychotics, antiretrovirals, and immunosuppressants [Sec. 3307, p. 353]

Coverage gap discount program. Requires DHHS to create a model agreement for a Medicare coverage gap discount program for prescription drugs to be established by January 1, 2011 wherein manufacturers, as a condition of participating in Medicare, must provide 50% discounts available at points of sale for individuals in the coverage gap (wherein individuals are responsible for all costs between $2,250 to $3,600 (since adjusted for inflation); referred to as the "doughnut hole") unless DHHS determines the drug is essential for beneficiaries' health or, for 2011 only, there were extenuating circumstances still to be defined; for the purpose of calculating the gap, beneficiaries receive credit for the negotiated (non-discounted) price as if they had paid out-of-pocket [Sec. 3301, p. 343]

Low-income benchmark premium. Beginning January 1, 2011 excludes any reduction in premium amounts attributable to rebates or bonus payment from the low-income subsidy benchmark premium for Medicare Advantage prescription drug plan [Sec. 3302, p. 350]

Including certain costs in coverage gap. Beginning January 1, 2011 adds drug costs paid by a State Pharmaceutical Assistance Program, Indian Health Services, or the AIDS Drug Assistance Program to the calculation of beneficiaries' costs related to the coverage gap as if they were paid out-of-pocket [Sec. 3314, p. 360]

Coverage gap rebate. Provides a $250 rebate to any individual who reaches the coverage gap [H.R. 4872 Sec. 1101(a), p. 8]

Voluntary waiving of de minimis premiums. Beginning January 1, 2011 allows prescription drug plans to waive monthly premiums, if de minimis, for subsidy-eligible individuals (income less than 150% of the federal poverty level and meets resource standard); DHHS may auto-enroll individuals in plans that have waived de minimis premiums [Sec. 3303, p. 351]

Information for subsidy-eligible individuals. Beginning no later than January 1, 2011 if DHHS reassigns a subsidy-eligible individual to a new prescription drug plan, DHHS must provide the beneficiary with information on the formulary differences between the plan and the consumer's appeal rights [Sec. 3305, p. 352]

MEDICARE AND FEDERAL INITIATIVES (cont.)

Low-income assistance for widows and widowers. Beginning January 1, 2011 for subsidy-eligible individuals whose spouse dies, their eligibility is automatically extended by one year beyond the normal determination/ redetermination date [Sec. 3304, p. 351]

Outreach and assistance for low-income programs. For fiscal years 2010 through 2012 makes available: $15 million for fiscal years 2010 through 2012 for State Health Insurance Assistance Programs; $15 million for Area Agencies on Aging to provide outreach to Medicare beneficiaries, $10 million for Aging and Disability Resource Centers for outreach regarding Part D benefits; $5 million for the National Center for Benefits and Outreach Enrollment to maintain web-based decision support tools and provide outreach, clearinghouse, and technical assistance services [Sec. 3306, p. 352]

Dual eligibles cost sharing. By January 1, 2012 extends the exemption from prescription drug cost-sharing to dual eligibles who would be institutionalized but are not due to receipt of services through a Section 1115, 1915(b), or 1915(c) waiver, or a 1915(i) state plan amendment [Sec. 3309, p. 357]

High-income beneficiaries subsidy reduction. Creates new monthly Part D premiums for higher-income individuals ($80,000 per year for an individual, as adjusted by inflation since 2007) by reducing federal subsidies [Sec. 3308, p. 354]

Long-term care facility dispensing. For plan years beginning after January 1, 2012 requires prescription drug plans to utilize uniform dispensing techniques to be defined for individuals in long-term care facilities to reduce waste associated with 30-day fills [Sec. 3310, p. 357]

Medication therapy management. By March 2013, prescription drug plans must offer medication therapy management to beneficiaries with multiple chronic diseases and are taking multiple drugs and auto-enroll such individuals (and allow the ability to opt-out) to increase adherence to prescription medications including annual comprehensive medication review and follow-up intervention as warranted; for at-risk individuals who are not enrolled, prescription drug plans must have a process to assess at least quarterly medication use [Sec. 10328, p. 846]

Complaint system. Requires DHHS to develop and maintain a complaint system for prescription drug plans and establish a model electronic complaint form [Sec. 3311, p. 357]

Exceptions and appeals process. By January 1, 2012 requires prescription drug plans to use a single, uniform exception and appeals process and provide instant access through a toll-free number and website [Sec. 3312, p. 358]

Inspector General reports. Beginning July 1, 2011 the DHHS Inspector General is to submit an annual report regarding the extent to which prescription drug plan formularies cover drugs commonly used by dual eligibles; and to submit a report by October 1, 2011 that compares prices between PDPs, Medicare Advantage PDPs, and Medicaid for the 200 most frequently dispensed covered Part D drugs [Sec. 3313, p. 359]

PUBLIC HEALTH

New federal public health councils and task forces.

- National Prevention, Health Promotion and Public Health Council [Sec. 4001, p. 420]
- Community Preventive Services Task Force [Sec. 4003, p. 423]

Standards for accessible medical diagnostic equipment. By 2012 requires federal agencies to establish standards for accessible medical diagnostic equipment in medical settings [Sec. 4203, p. 452]

Preventive benefits education and outreach campaign. Establishes an education and outreach campaign regarding preventive benefits [Sec. 4004, p. 426]

- Subordinates existing Centers for Disease Control and Prevention grants to the States for similar purposes to this new program
- Requires States to design public awareness campaigns to educate Medicaid enrollees regarding available preventive and obesity-related services

Young women's breast health. Creates a federal public education campaign and health care professional education campaign, outlines research activities, and provides grants to organizations that support young women diagnosed with breast cancer [Sec. 10413, p. 872]

Research on postpartum depression and mental health. Requires DHHS to provide research and education related to postpartum depression, and conduct a longitudinal study of relative mental health consequences for women resolving a pregnancy in various ways [Sec. 2952, p. 226]

Grants for services for postpartum conditions. Establishes grant program for State and other entities to provide education and services to women with or at risk of postpartum depression, and funds the program at $3 million in fiscal year 2010 and authorizes funding in 2011 and 2012 [Sec. 2952, p. 226]

Health care power of attorney for children aging out of foster care. By October 1, 2010 requires States to include information about health care power of attorney as part of transition planning for children who will age out of foster care. [Sec. 2955, p. 234]

Data collection requirements. Effective in 2012, all federally supported health programs must collect and report client information, including race, ethnicity, language, and disability status [Sec. 4302, p. 460]

Needs assessment for early childhood home visitation program. To continue to receive Maternal and Child Health Services block grant funds requires States within 6 months to conduct an assessment of at-risk communities (e.g. concentration of infant mortality, poverty, crime, unemployment, etc.), existing early childhood home visitation programs, and the State's capacity to provide substance abuse treatment and counseling services [Sec. 2951, p. 216]

Grants for early childhood home visitation programs. Creates grants for States to operate early childhood home visitation programs using proven service delivery models in existence for at

[1]*All section references include amendments made by the Manager's Amendment and reconciliation bill (H.R. 4872)*

least three years or promising new approaches (limited to 25% of grant funding) [Sec. 2951, p. 216]

- Programs must include quantifiable measures and three and five year benchmarks for maternal and newborn health, prevention of child maltreatment, school readiness, crime and domestic violence, economic self-sufficiency, and community coordination, and must demonstrate improvement within three years
- Priority for high-risk populations, including those residing in communities of need; low-income families; pregnant women under 21 years of age; families with a history of child abuse, substance abuse, or tobacco use; families with children with low school achievement; children with developmental delays or disabilities; families that have served in the Armed Forces
- Appropriates $100 million in fiscal year 2010, $250 million in 2011, $350 million in 2012, and $400 million in 2013 and 2014; States must supplement, not supplant, existing funding, but if States do not apply nonprofit organizations may apply for the State's share beginning in 2012
- Funding is set-aside for Tribes

Catalyst to Better Diabetes Care Act. Among other requirements of the Centers for Disease Control and Prevention, the agency is tasked with working with States to encourage improvement in vital statistics data such as capturing information regarding diabetes and other chronic conditions on death certificates, as well as set standards for diabetes medical education for medical professionals [Sec. 10407, p. 858]

National diabetes prevention program. Effective in 2010, authorizes, but does not fund, a Centers for Disease Control and Prevention program to prevent diabetes in adults at high-risk through grants to State and local health departments and other specified entities for community-based diabetes prevention program model sites, establish a training and outreach program for lifestyle intervention instructors, and provide evaluation, monitoring, and technical assistance [Sec. 10501(g), p. 878]

Prevention and Public Health Fund. Creates the Prevention and Public Health Fund to provide grants for programs authorized by the Public Health Service Act for prevention, wellness, and public health, including Community Transformation grants, the Education and Outreach Campaign Regarding Preventive Benefits, and immunization programs [Sec. 4002, p. 423]

- Appropriates $500 million in fiscal year 2010, with $250 million increases each year (e.g. $750 in fiscal year 2011) until fiscal year 2015 and each year thereafter when it is funded at $2.0 billion

Community Transformation grants. For fiscal years 2010 through 2014 creates grant program to assist State agencies and other entities implement, evaluate, and disseminate evidence-based community preventive health activities [Sec. 4201, p. 446]

Grants for immunizations. Authorizes grants between 2010 and 2014 for States to improve the provision of immunizations [Sec. 4204, p. 453]

PUBLIC HEALTH (cont.)

Grants for school-based health centers. Establishes grants for school-based health centers, with a preference for centers that serve a large population of children eligible for Medicaid or CHIP coverage, which may be operated by public health agencies or schools [Sec. 4101, p. 428]

- Between fiscal years 2010 and 2013, appropriates $50 million annually for capital grants
- Authorizes grants for operations, which require a 20% match, between 2010 and 2014

Grants for oral healthcare. [Sec. 4102, p. 432]

- Establishes demonstration grants, for which State public health agencies and hospitals are eligible, related to research-based dental caries disease management activities
- Authorizes, but does not fund, grants for all States for school-based sealant programs
- Authorizes, but does not fund, grants between 2010 and 2014 for States to establish oral health infrastructure (e.g. program guidance, data collection, etc.)
- Authorizes, but not fund, grants between 2010 and 2014 to include all States in the National Oral Health Surveillance System
- Beginning in 2015, States must include oral healthcare measurements to the Pregnancy Risk Assessment Monitoring System

Grants for epidemiology laboratories. Authorizes appropriations totaling $190 million for fiscal years 2010 through 2013 to assist public health agencies in improving surveillance for and responses to infectious diseases [Sec. 4304, p. 466]

Grants for healthy aging. Provides $50 million between fiscal years 2010 and 2014 for five-year pilot program grants to State health departments to provide public health community interventions, screenings, and clinical referrals to individuals between 55 and 64 years of age [Sec. 4202, p. 448]

Grants for pain care management. Authorizes, but does not fund, grants between 2010 and 2012 for public and private entities for the development and implementation of programs to provide education and training to health care professionals in pain care. [Sec. 4305, p. 466]

Grants for Cures Acceleration Network. Authorizes an appropriation of $500 million in fiscal year 2010 for public and private research entities, including universities for supporting development of high need cures [Sec. 10409, p. 860]

- Recipients may receive up to $15 million per year, with a 1:3 matching rate

Grants for Centers of Excellence for Depression. Authorizes appropriations of $100 million per year between fiscal years 2011 and 2015 and $150,000,000 annually between fiscal years 2016 and 2020 for grants of up to $5 million per year, at a 1:5 match, to universities or other research institutions to eventually establish at least 30 Centers of Excellence for Depression to improve treatment standards, clinical guidelines, and diagnostic protocols; provide training, conduct research; educate policymakers, etc. [Sec. 10410, p. 866]

Grants for community health centers for individualized wellness plans. Authorizes, but does not fund, grants for 10 community health centers to provide individualized wellness plans to at-risk

populations based on weight, tobacco and alcohol use, exercise rates, nutritional status, and blood pressure [Sec. 4206, p. 458]

Personal responsibility education grants. Allocates funding to the States based on their share of the national total of individuals between 10 and 20 years of age (with a $250,000 minimum allocation), to provide education to address teen pregnancy and sexually transmitted diseases (emphasizing both abstinence and contraception), as well as adulthood preparation [Sec. 2953, p. 229]

- Appropriated at $75 million for each fiscal year between 2010 and 2014 with reservations of $10 million for innovative strategies, 5% for Tribes, and 10% for program support and evaluation
- States must maintain spending at fiscal year 2009 levels; if a State does not apply for funds a local organization may apply for the State's share beginning in fiscal year 2012

Funding for abstinence education. Appropriates $50 million in each of fiscal years 2010 through 2014 for allocations to States (based on their share of the national total of low-income children) to provide abstinence education [Sec. 2954, p. 234]

Reauthorization of children's emergency medical services demonstrations. Reauthorizes through fiscal year 2014 demonstration projects for emergency medical services for children who need treatment for trauma or critical care with funding growing from $25 million in fiscal year 2010 to $30.4 million in fiscal year 2014, and extends the permissible length of the projects by one year to four years with an optional fifth year [Sec. 5603, p. 561]

Prospective payment system for federally qualified health centers. Requires DHHS to implement under Medicare, by October 1, 2014, a prospective payment system for FQHCs that pays 100% of the estimated amount of reasonable costs in the initial year, an increase according to the Medicare Economic Index in the next year, and an increase according to a market basket of FQHC goods in each subsequent year, but states that Medicare will pay the 80% of the lesser of the actual charge amount or the specified formula; FQHCs must provide requested data by January 1, 2011 [Sec. 10501(i)(3), p. 879]

HEALTH CARE WORKFORCE

Federal Initiatives

National Health Care Workforce Commission. Establishes this federal commission to, among other areas, evaluate education and training activities and loan and grant programs to determine whether the demand for health care workers is being met, evaluate health care workforce supply and distribution and needs over 25 years, identify barriers to effect federal/ State/ local coordination, analyze graduate medical education policies, and make recommendations related to provider compensation [Sec. 5101, p. 478]

Health care workforce assessment. Establishes a National Center for Health Care Workforce Analysis to develop information describing the health care workforce and related issues, and appropriates $4.5 million for each of fiscal years 2010 through 2014 for grants to States for State and Regional Centers for Health Workforce Analysis [Sec. 5103, p. 485]

Rulemaking for determining medically underserved populations and health professions shortage areas. Requires DHHS to establish through negotiated rulemaking a comprehensive methodology for determining medically underserved populations and health professions shortage areas with a target date for publication of July 1, 2010. [Sec. 5602, p. 559]

Key national indicators. Establishes the Commission on Key National Indicators to work with the National Academy of Sciences to establish such indicators. [Sec. 5605, p. 562]

United States Public Health Sciences Track. Establishes the United States Public Health Sciences Track in which the federal government pays the tuition and provides a stipend for students at affiliated health professions education training programs to pursue advance degrees that emphasize team-based service, public health, epidemiology, and emergency preparedness such that the program graduates annually at least 150 medical students, 100 dental students, 250 nursing students, 100 public health students, 100 behavioral and mental health professional students, and 100 physician assistants or nurse practitioner students, and 50 pharmacy students, who must provide at least two years of service in the Commissioned Corps of the Public Health Services for each school year (with certain allowances) [Sec. 5315, p. 518]

Changes to National Health Service Corps loan repayment and scholarship programs. Makes several changes to the National Health Service Corps loan repayment and scholarship programs:

- Permits crediting teaching for up to 20% of obligated service in the National Health Service Corps scholarship and loan repayment programs [Sec. 5508, p. 552]
- Permits service obligation for National Health Service Corps loan repayments and scholarships to be fulfilled by providing half-time services and taking twice as long (language formerly stated "less than full time") [Sec. 10501(n)(1) through (n)(3), p. 884]
- Beginning in fiscal year 2012, increases the annual maximum loan repayment amount from $35,000 to $50,000 with annual inflation thereafter [Sec. 10501(n)(4), p. 885]

Teaching credit for National Health Service Corps. Permits crediting teaching for up to 20% of obligated service in the National Health Service Corps scholarship and loan repayment programs [Sec. 5508, p. 552]

[1]*All section references include amendments made by the Manager's Amendment and reconciliation bill (H.R. 4872)*

National Health Service Corps expansion. Provides for the National Health Service Corps scholarship and loan repayment programs $320.5 million in fiscal year 2010, $414.1 million in 2011, $535.1 million in 2012, $691.4 in 2013, $893.5 million in 2014, $1,154.5 million in 2015, and annual increases thereafter based on the increase in the cost of health professions education and growth in the number of individuals living in health professions shortage areas [Sec. 5207, p. 494]

Elimination of cap on number of Regular Corps officers. Removes the cap of 2,800 commissioned officers in the Regular Corps. [Sec. 5209, p. 495]

Funding for the National Health Service Corps. Appropriates $290 million in fiscal year 2011 for the National Health Service Corps, and increases the appropriation by $5 million reaching $310 million in fiscal year 2015 [Sec. 10503(b), p. 886]

Creation of Ready Reserve Corps. Establishes a Ready Reserve Corps to augment the Regular Corp and respond to national emergencies and public health crises, and provides $5 million annually for recruitment and training of the Commission Corps between fiscal years 2010 and 2014 and $12.5 million annually for the Ready Reserve Corps during the same time period [Sec. 5210, p. 496]

Special grant for Connecticut. Provides $100 million for a health care facility affiliated with an academic health center at a public research university that contains a State's sole public academic medical and dental school; it has been reported that this funding is for the University of Connecticut [Sec. 10502, p. 885]

Graduate Medical Education

Counting resident time in non-provider settings. Effective July 1, 2010, specifies that certain resident time spent in non-provider settings may be counted towards the determination of full-time equivalency if the hospital is paying the resident's stipend and benefits and applies these changes retroactively with certain retroactive dates [Sec. 5504 and 5505, p. 541]

Redistribution of unused residency positions. Provides that hospitals that do not have all of their authorized Medicare GME slots filled (according to the highest resident level for any of the three most recent cost reporting periods prior to March 2010) will have 65% of the vacancies eliminated and these positions will be redistributed with priorities for rural States and those with a health professions shortage [Sec. 5503, p. 537]

Redistribution of residency positions from closed hospitals. Provides for the redistribution of Medicare GME slots from hospitals that have closed since March 2008 with priority given to hospitals in the same area, then State, then region of the country, and then according to the standards for redistribution of new slots [Sec. 5506, p. 543]

Payments for teaching health centers. Appropriates $230 for the period of fiscal years 2011 through 2015 for payment (in addition to existing GME) for direct and indirect expenses for teaching health centers operating GME programs [Sec. 5508(c), p. 552]

Graduate nurse education demonstration. Appropriates $50 million for each of fiscal years 2012 through 2015 to design, implement, monitor, and evaluate graduate nurse education demonstration programs for advanced practice registered nurses in five hospitals, which must partner with at least one school of nursing and at least two non-hospital community-based care settings [Sec. 5509, p. 556]

Grants for Training

State workforce development grants. Beginning in fiscal year 2010, establishes state health care workforce development grants to enable State partnerships (a State workforce investment board expanded to include certain representatives) to comprehensively plan and carry out related activities [Sec. 5102, p. 481]

- Planning grants may not exceed one year or $150,000 and require a 15% match (which may be federal); authorizes an appropriation of $8 million in fiscal year 2010 and additional amounts in future years
- Implementation grants may not exceed two years, at least 60% of the grant funds must be distributed to regional partnerships, and require a 25% match (which may be federal);
- Authorizes an appropriation of $150 million in fiscal year 2010 and additional amounts in future years

Primary care training and enhancement. Authorizes an appropriation of $125 million in fiscal year 2010 and additional amounts through 2014 for five-year grants with hospitals, schools of medicine, and other entities to encourage primary care training for physicians and physician assistants through planning and operating accredited training programs, providing need-based financial assistance, etc. (15% is allocated for physician assistance education programs); and appropriates $750,000 in each of fiscal years 2010 through 2014 for programs that integrate academic administrative units [Sec. 5301, p. 497]

Teaching health centers. Authorizes appropriations of $25 million in fiscal year 2010 and $50 million in fiscal years 2011 and 2012 and additional amounts thereafter to establish grants of up to 3 years and $500,000 for teaching health centers (e.g., federally qualified health centers, community mental health centers, rural health clinics) for establishing or expanding primary care (including family medicine, pediatrics, obstetrics/ gynecology, psychiatry, general dentistry, and geriatrics) residency programs [Sec. 5508(a), p. 550]

Long-term care workers. Authorizes an appropriation of $10 million for the period of fiscal year 2011 through 2013 for grants to institutions of higher education partnering with a long-term care facility to offset tuition costs for direct care workers who must agree to work in the field for at least two years [Sec. 5302, p. 499]

Geriatric care. Establishes several initiatives related to geriatric care [Sec. 5305, p. 504]

- Authorizes an appropriation of $10.8 million for the period of fiscal year 2011 through 2014 for up to 24 $150,000 grants to geriatric education centers to provide fellowships focusing on geriatrics, chronic care management, and long-term care to faculty in health professions schools; to receive an award the geriatric education center must use funds to supplement rather than supplant existing resources, and also provide family caregiver and direct care provider training or incorporate best practices related to depression and other mental health issues and medication safety in its materials
- Authorizes an appropriation of $10 million for the period of fiscal year 2011 through 2013 for grants to advanced practice nurses, clinical social workers, pharmacists, or psychology students pursuing an advanced degree in geriatric who agree to practice in the field for at least five years
- Expands eligibility for existing geriatric faculty fellowships beyond physicians to include dentistry, nursing, social work, psychology, pharmacy, and other allied health disciplines
- Authorizes funding through 2014 for comprehensive geriatric education grants and expands the use of awards to include traineeships for advanced nursing degrees in geriatric nursing, long-term care, gero-psychiatric nursing, or other nursing areas that specialize in the care of the elderly

Mental and behavioral health education. For each of fiscal years 2010 through 2013, authorizes appropriations for institutions of higher learning [Sec. 5306, p. 508]

- $8 million for undergraduate and graduate social work programs (at least four recipients must be historically black colleges or other minority-service institutions),
- $12 million for training in graduate psychology for providing behavioral and mental health services including substance abuse prevention and treatment,
- $10 million for establishing or expanding internships or other field placement programs in professional child and adolescent mental health, and
- $5 million for pre-service or in-service training for paraprofessional child and adolescent mental health workers in nonprofit and for-profit organizations

Changes to advanced nursing education grants. Eliminates use of funding for traineeships for doctoral programs (formerly limited to 10% of total traineeships) and clarifies eligible midwifery programs [Sec. 5308, p. 511]

Nurse retention. Authorizes funding for various nurse retention initiatives [Sec. 5309, p. 511]

- Extends existing Nurse Education, Practice, and Quality grants through 2014
- Authorizes, but does not fund, grants in fiscal years 2010 through 2012 to schools of nursing, health care facilities, or partnerships between the two for new nurse retention programs including a career ladder program for non-registered nurses to become RNs, implementing internships, and assisting individuals in obtaining education and training to enter the nursing profession
- Authorizes, but does not fund, grants in fiscal years 2010 through 2012 to schools of nursing, health care facilities, or partnerships between the two to enhance patient care by enhancing collaboration between nurses and other health care professionals and promoting nurse involvement in decision-making processes of a health care facility

HEALTH CARE WORKFORCE (cont.)

Appropriation for various nursing grant programs. Authorizes an appropriation $338 million for fiscal year 2010 and authorizes funding through fiscal year 2016 for advanced nursing education grants; workforce diversity grants; education, practice, and quality grants; and retention grants [Sec. 5312, p. 515]

Family nurse practitioner training programs. Authorizes, but does not fund, grants in fiscal years 2011 through 2014 for awards of up to $600,000 annually for federally qualified health centers and nurse-managed health clinics to establish training demonstration programs to employ and provide one-year training for nurse practitioners who have graduated from a nurse practitioner program for careers as primary care providers [Sec. 5316, p. 524]

Community health workforce. Authorizes, but does not fund, grants in fiscal years 2010 through 2014 for awards to a State, public health department, hospital, federally qualified health center, or other entity to promote positive health behaviors and outcomes for medically underserved communities through the use of community health workers [Sec. 5313, p. 515]

Health professions workforce needs. Appropriates under the Social Services Block Grant funding for demonstration projects to address health professions workforce needs [Sec. 5507(a), p. 545]

- Appropriates $80 million for each of fiscal years 2010 through 2012 and $85 million in fiscal years 2013 and 2014 for grants to States, Tribes, local workforce investment boards and other entities to provide education and training to Temporary Assistance for Needy Families (TANF) and other low-income individuals for occupations in health care; funds may be used for financial aid, child care, case management, and other supportive services
- Appropriates $5 million in each of fiscal years 2010 through 2012 for grants to six States to conduct demonstration projects of up to three years for the purpose of developing core training competencies and certification programs for personal or home care aides

Health professionals in underserved communities. Authorizes appropriations of $5 million for each of fiscal years 2010 through 2014 for State and local governments, health professions schools, and other entities to support distance learning, continuing education activities, and collaborative conferences [Sec. 5403(b), p. 530]

Rural physician training. Authorizes appropriations of $4 million for each of fiscal years 2010 through 2013 for grants to medical schools to supplement existing funding and establish or expand a rural-focused training program with at least 10 students per class giving priority to those who have lived at least two years in an underserved rural community and express a commitment to work in such a community [Sec. 10501(l), p. 882]

Preventive medicine and public health training. Authorizes an appropriation of $43 million in fiscal year 2011 and additional amounts in fiscal years 2012 through 2015 for medical schools, hospitals, State and local health departments, and other entities to operate or participate in a residency or internship program in preventive medicine or public health [Sec. 10501(m), p. 883]

Dental training. Authorizes an appropriation of $30 million in fiscal year 2010 and additional amounts through 2015 for five-year grants with hospitals, schools of dentistry, and other entities

to encourage general, pediatric, and public health dentistry through planning and operating dental training programs, provide traineeships and fellowships, etc.; and providing a faculty loan repayment program that will repay student loans over five years [Sec. 5303, p. 500]

Fellowship training in public health. For each of fiscal years 2010 through 2013, authorizes appropriations of $39.5 million for various public health fellowship programs [Sec. 5314, p. 518]

- $5 million for epidemiology fellowships with the Centers for Disease Control and Prevention and similar epidemiology training programs
- $5 million for laboratory fellowships with the CDC
- $5 million for the Public Health Informatics Fellowship Program
- $24.5 million for expanding the Epidemic Intelligence Service

Cultural competency and other training. For fiscal years 2010 through 2015 authorizes, but does not fund, grants and contracts with health professions schools, State and local governments, and other entities for developing, evaluating, and disseminating research, demonstration projects, and model curricula for cultural competency, prevention, public health proficiency, reducing health disparities, and aptitude for working with individuals with disabilities [Sec. 5307, p. 510]

Increased funding for Centers of Excellence in health professions education. For each of fiscal years 2010 through 2015, authorizes appropriations of $50 million for Centers of Excellence in health professions education for underrepresented minority individuals [Sec. 5401, p. 524]

Expansion of programs for disadvantaged individuals. Increases the cap on loan repayments and fellowships for individuals working as faculty and from disadvantaged backgrounds with health degrees or in their final year of study from $20,000 to $30,000 and increases funding for this program as well as scholarships for disadvantaged students enrolled in health professions programs [Sec. 5402, p. 526]

- Physician assistant education programs are added to those eligible to participate in these programs [Sec. 10501(d), p. 877]

Expansion of uses of nursing workforce diversity grants. Expands allowable uses of nursing workforce diversity grants to include scholarships and stipends and advanced education preparation. [Sec. 5404, p. 531]

Other Grants and Funding

Community Health Center Fund. Establishes a Community Health Center Fund to provide for expanded and sustained investment in community health centers and appropriates $1 billion in fiscal year 2011, $1.2 billion in 2012, $1.5 billion in 2013, $2.2 billion in 2014, and $3.6 billion in 2015 [Sec. 10503, p. 886]

- Appropriates $1.5 billion for fiscal years 2011 through 2015 for the construction and renovation of community health centers [Sec. 10503(c), p. 886]

HEALTH CARE WORKFORCE (cont.)

Nurse-managed health clinics. Authorizes appropriations of $50 million in fiscal year 2010 and additional amounts in fiscal years 2011 through 2014 for a grant program for nurse-managed health clinics with at least one advanced practice nurse holding an executive management position that serves underserved or vulnerable populations without regard to income or insurance status and is affiliated with a university, independent nonprofit health agency, or other entity [Sec. 5208, p. 494]

Federally qualified health centers. Increases authorization of appropriations for federally qualified health centers to $3.0 billion in fiscal year 2010 and growing to $8.3 billion in fiscal year 2015 with annual increases thereafter, and allows community health centers to contract with rural hospitals and clinics for the delivery of primary health care services for individuals who would otherwise be eligible for free or reduced cost care at the community health center [Sec. 5601, p. 559]

Extension of family-to-family health information centers. Extends funding for family-to-family health information centers through fiscal year 2012 at $5 million per year [Sec. 5507(b), p. 550]

Area health education centers. Authorizes appropriations of $125 million for each of fiscal years 2010 through 2014 for infrastructure development grants and point of service maintenance and enhancement grants for schools of medicine to collaborate with one-stop centers for area health education center programs for disadvantaged individuals or those going to work in underserved areas [Sec. 5403(a), p. 526]

- Grants must be at least $250,000 and require a 50% cash or in-kind match with at least 25% of the match amount coming from cash (a portion of the match may be waived in the first three years of infrastructure development grants)
- At least 10% of clinical education must be provided in community settings
- At least one health education center must be independent of the awardee

Primary Care Extension Program. Authorizes appropriations of $120 million in fiscal years 2011 and 2012 and additional amounts in fiscal years 2013 and 2014 for two year planning grants and six year implementation grants to establish Primary Care Extension Program States Hubs (including the State health department, Medicaid agency, and others) to form Primary Care Extension Agencies that assist primary care providers implement a patient-centered medical home and share best practices [Sec. 5405, p. 531]

Co-locating services in community-based mental health settings. Authorizes appropriations of $50 million in fiscal year 2010 and additional amounts in fiscal years 2011 through 2014 for grants to community mental health programs to establish demonstration projects for co-locating primary and specialty care services for adults with mental illness and co-occurring primary care conditions or chronic diseases [Sec. 5604, p. 561]

Access to affordable care. Authorizes, but does not fund, a program to provide grants for up to $2 million for three-year demonstration projects for up to 10 State-based nonprofit public-private partnerships to provide access to comprehensive health care services to the uninsured at reduced fees. [Sec. 10504, p. 886]

Permission for State grants to certain providers. Permits States to award grants to health care providers that treat a higher percentage of medically underserved populations or other special populations, but the grant program cannot be established within the Medicaid agency and may not use Medicaid, Medicare, or TRICARE funding [Sec. 5606, p. 566]

Alternative dental health care demonstration project. Beginning in 2011 authorizes, but does not fund, 15 five-year grants of at least $4 million for institutions of higher education, federally qualified health centers, State or county public health clinics, or public hospitals or health systems for alternative dental health care in rural and underserved communities (e.g. community dental health coordinators, advance practice dental hygienists, independent hygienists, supervised hygienists, primary care physicians, etc.) [Sec. 5304, p. 503]

Student Loan and Scholarship Programs

Limit on time practicing primary care while repaying student loan. Limits the time that individuals that receive certain federally supported student loans must practice in primary care to no more than ten years or such time the loan is repaid (previously had to remain in primary care until repayment without a maximum time limit) [Sec. 5201, p. 488]

Increase caps on nursing student loans. Increases the annual cap on certain nursing student loans to $3,300 (from $2,500) and $5,200 for each of the final two years (from $4,000) and an overall maximum of $17,000 with annual adjustments after fiscal year 2011 (from $13,000) [Sec. 5202, p. 489]

Program for pediatric health care workforce. Establishes student loan repayment program that provides up to $35,000 per year for up to three years for pediatric medical specialists, pediatric surgical specialists and qualified health professionals in child and adolescent mental and behavioral health, who agree to work full-time for at least two years or serve in a residency or fellowship in an area with a shortage of pediatric specialties [Sec. 5203, p. 489]

- Authorizes appropriations of $30 million per year between fiscal years 2010 and 2014 for pediatric medical specialists and pediatric surgical specialists and $20 million per year between fiscal years 2010 and 2013

Program for public health workforce. Establishes a loan repayment program provides up to $35,000 per year for up to three years (if total loan balance is less than $105,000, the repayment is one-third of the total per year) as well as compensation to cover the tax liability for current students in health professions programs and graduates within the past 10 years who agree to work for a federal, State, local, or tribal public health agency for at least three years; authorizes appropriations of $195 million in fiscal year 2010 and additional amounts for fiscal years 2011 through 2015 [Sec. 5204, p. 491]

Allied health professions loan forgiveness. Adds allied health profession to areas of national need, permitting individuals in these positions working for a federal, State, local, or tribal public

health agency or other settings in shortage or underserved areas to receive $2,000 per year in loan forgiveness for up to 5 years. [Sec. 5205, p. 493]

Scholarships for mid-career public and allied health professionals. Authorizes appropriations of $60 million in fiscal year 2010 and additional amounts through 2015 to establishes a grant program to make awards to accredited academic institutions to award scholarships to individuals currently employed in public and allied health positions at the federal, State, local, or tribal level to pursue coursework in public or allied health; 50% of the funding is allotted to public health mid-career professionals and 50% to allied health mid-career professionals [Sec. 5206, p. 493]

Expansion of nurse loan repayment and scholarship program. Extends existing nurse loan repayment and scholarship program to nurse who agree to work for at least two years as nurse faculty at a school of nursing (formerly only available to those who agreed to practice at a health care facility with a critical shortage of nurses) [Sec. 5310, p. 513]

Nurse faculty loan and loan repayment programs. Increases maximum annual nurse faculty loan amount from $30,000 (plus any adjustment made by the DHHS) to $35,500 in 2010 and 2011 with annual adjustments thereafter; creates loan repayment program, which pays $10,000 per year a master's degree and $20,000 for a doctorate for nursing faculty who agree to serve as full-time faculty for at least four years [Sec. 5311, p. 513]

PROGRAM INTEGRITY

Provider Screening and Contracting

Screening providers for fraud, waste, abuse. By September 2010, DHHS will establish procedures for provider screening for the Medicare, Medicaid, and CHIP programs with the level of screening based on the risk of fraud, waste and abuse with respect to the category of provider [Sec. 6401(a), p. 629]

- A $500 fee (which will be indexed for inflation beginning in 2011) will be imposed on each institutional provider of medical or other items or services or supplier (such as a hospital or skilled nursing facility) for which screening is conducted
- The screening applies to new Medicaid and CHIP providers starting one year after enactment and to existing providers two years after enactment; three years after enactment no provider may be enrolled or reenrolled if they have not been screened

Provider disclosures. By March 2011, a provider of medical or other items or services or supplier who submits an application for enrollment or revalidation of enrollment in new programs, Medicaid or CHIP must disclose any current or previous affiliation (directly or indirectly) with a provider of medical or other items or services or supplier that has uncollected debt, has been or is subject to a payment suspension under a federal health care program, or has been excluded from participation in publicly-funded programs [Sec. 6401(a), p. 629]

New compliance program. DHHS will establish core elements for a compliance program for providers or suppliers within a particular industry or category; the specific industries, core elements, and the timing of the implementation of the new program are yet to be determined [Sec. 6401(a), p. 629]

Provider enrollment moratorium. To combat fraud, waste, or abuse, DHHS may impose a temporary moratorium on enrollment of new providers for Medicare, Medicaid, or CHIP; similarly, States may impose temporary` enrollment moratoria or other caps or limits for providers or suppliers identified by DHHS as being at high-risk for fraud, waste, or abuse if the State determines that the imposition of any such period, cap, or other limit would not adversely impact beneficiaries' access to medical assistance [Sec. 6401, p. 629]

Mandatory enrollment of ordering providers. Effective January 1, 2011, States must require all ordering or referring physicians or other professionals to be enrolled under the Medicaid State plan or a waiver of the plan as a participating provider [Sec. 6401(b), p. 634]

Provider termination from the Medicaid program. Effective January 1, 2011, providers will be terminated from the Medicaid program if they are terminated from the Medicare program [Sec. 6501, p. 658]

- CMS will provide notification to states within 30 days of termination for medical providers and within 90 days for non-medical providers [Sec. 6401(b), p. 634]

[1]*All section references include amendments made by the Manager's Amendment and reconciliation bill (H.R. 4872)*

Provider exclusion from the Medicaid program. Effective January 1, 2011, States must exclude any individual or entity from participation in Medicaid if such individual or entity owns, controls, manages, or is affiliated with an entity that has unpaid overpayments that are delinquent, is suspended or excluded from participation under or whose participation is terminated under Medicaid [Sec. 6502, p. 658]

Prohibiting payments to providers outside the US. Effective January 1, 2011, a State may not make Medicaid payments to any financial institution or entity located outside of the United States [Sec. 6505, p. 659]

Fraud, Abuse and Overpayments

Overpayments.

- Effective January 1, 2011, a provider must report and return an overpayment by the later of the date which is 60 days after the date on which the overpayment was identified or the date any corresponding cost report is due, if applicable [Sec. 6402(a), p. 637]
- DHHS will promulgate regulations that require States to correct federally identified claims overpayments, of an ongoing or recurring nature, with new Medicaid Management Information System (MMIS) edits, audits, or other appropriate corrective action [Sec. 6506(b), p. 659]

Suspension of payments. The federal government may withhold funds for claims by any individual or entity to which the State has failed to suspend payments under the plan during any period when there is a pending investigation of a credible allegation of fraud unless the State determines there is good cause not to suspend such payments [Sec. 6402(h), p. 642]

State reporting requirements.

- For claims data submitted on or after January 1, 2010, additional data elements may be required that DHHS determines to be necessary for program integrity, program oversight, and administration, including the requirement that managed care organizations may need to report to the State [Sec. 6504, p. 658]
- Effective January 1, 2011, the State must have in effect a system of reporting information with respect to any final adverse action (not including settlements in which no findings of liability have been made) taken against a health care provider, supplier, or practitioner by a State law or fraud enforcement agency [Sec. 6403(b), p. 646]
- Effective January 1, 2011, each State licensing or certification agency and State law or fraud enforcement agency shall report corrections of information already reported about any formal proceeding or final adverse action [Sec. 6403(b), p. 647]

Performance statistics on fraud and abuse. States must provide DHHS with such performance statistics (including the number and amount of overpayments recovered, the number of fraud referrals, and the return on investment of such activities by the entity) requested by DHHS [Sec. 6402(j), p. 644]

Recovery audit contractor. Not later than December 31, 2010, the States must establish a program under which the State contracts with one or more recovery audit contractors for the purpose of identifying underpayments and overpayments in Medicaid and recouping overpayments [Sec. 6411(a), p. 656]

- Payment for collecting overpayment must be on a contingency basis while the State may specify the payment methodology for identifying underpayments

Claims Processing and Adjudication

NPI on all claims.

- By January 1, 2011, all providers of medical or other items or services and suppliers in the Medicare or Medicaid programs that qualify for a national provider identifier to include their national provider identifier on all enrollment applications and claims for payment [Sec. 6402(e), p. 638]
- Effective January 1, 2011, States must require the NPI of all ordering or referring physicians or other professionals on any claim submitted for payment [Sec. 6401(b), p. 634]

Encounter reporting requirements. Federal matching payments will be withheld for any amounts expended for medical assistance for individuals for whom a State does not report enrollee encounter data to the Medicaid Statistical Information System (MSIS) in a timely manner [Sec. 6402(c), p. 639]

Timing of submission of Medicare claims. Effective January 1, 2010, claims from Medicare providers must be submitted within one calendar year of the service date [Sec. 6404(a), p. 649]

- In the case of services furnished before January 1, 2010, a bill or request for payment must be filed not later than December 31, 2010 [Sec. 6404(b), p. 650]

Physician orders for DME and home health in the Medicare program.

- Effective with written orders on or after July 1, 2010, physicians who order DME or home health items or services are required to be Medicare-enrolled physicians; DHHS may extend this provision to other providers as well [Sec. 6405(a), p. 650]
- DHHS may revoke enrollment, for a period of not more than one year for each act, for a physician or supplier that fails to maintain and provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by such physician or supplier under this title [Sec. 6406(a), p. 651]
- Effective January 1, 2010, a physician must document that he/she, a nurse practitioner or clinical nurse specialist in the practice, or a physician assistant in the practice, has had a face-to-face encounter (including through telehealth) with the individual in the six months prior to certifying eligibility for home health or DME under the Medicare and Medicaid programs [Sec. 6407, p. 651]

Registration of billing agents. Effective January 1, 2011, any agent, clearinghouse, or other alternate payee that submits claims on behalf of a health care provider must register with the State and DHHS [Sec. 6503, p. 658]

Use of National Correct Coding Initiative. Effective for Medicaid claims filed on or after October 1, 2010, States must incorporate compatible methodologies of the National Correct Coding Initiative administered by the Secretary [Sec. 6507, p. 660]

- Not later than September 1, 2010, the Secretary will identify those methodologies of the NCCI that are compatible to Medicaid claims and identify those methodologies that should be incorporated into claims with respect to items or services for which States provide medical assistance and no national correct coding methodologies have been established

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Insurance Reforms
Employee notifications (March)

Health Insurance Exchanges
Federal approval of a State's Exchange
Grants/loans to establish CO-OPs

Children's Health Insurance Program
Funding, elimination of enrollment bonuses (Oct.)
Funding, extension through 2015 (Oct.)

Medicaid
Primary care services reimbursement
Disproportionate Share Hospitals, cuts

2013 – OPTIONAL

Medicaid
Medicaid Preventive Services

2013 – NO ACTION

Insurance Reforms
Geographic variation in poverty level study

Medicare and Federal Initiatives
Cancer hospital quality reporting (Oct.)
Hospitals, disproportionate share payments (Oct.)
Medication therapy management (March)
Payment bundling, national pilot program

[1] *All provisions are effective January 1 (or immediately in the case of 2010) unless otherwise noted.*

Provisions of the Patient Protection and Affordable Care Act (H.R. 3590)[1]

INDEX BY IMPLEMENTATION DATE[1]

2014 – MANDATORY

Insurance Reforms
- Cafeteria plans
- Coverage, availability and renewability
- Coverage, clinical trials
- Coverage requirements
- Coverage, use of health status
- Discrimination against providers
- Electronic funds transfers for Medicare
- Employer penalties
- Free Choice Vouchers
- Health insurance coverage reporting
- Health promotion and disease prevention programs
- Financial assistance, advance determinations
- Financial assistance, eligibility for other programs
- Premiums, limits on variance
- Preexisting conditions
- Waiting periods

Health Insurance Exchanges
- Construct of Exchanges (includes entire section except health care choice compacts and waivers for innovation, which occur later)
- Administration of Exchanges (includes entire section except federal assistance, federal approval, and self-funding, which are noted in the appropriate years)

Children's Health Insurance Program
- Eligibility, modified adjusted gross income

2014 – OPTIONAL

2014 – NO ACTION

Insurance Reforms
- Individual responsibility and penalties
- Financial assistance, premium assistance tax credits
- Financial assistance, reduced cost-sharing

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Provisions of the Patient Protection and Affordable Care Act (H.R. 3590)[1]

INDEX BY IMPLEMENTATION DATE[1]

2014 – MANDATORY (cont.)

Medicaid
- Coverage expansion, 138% FPL
- Coverage expansion, former foster children
- Disproportionate Share Hospital, cuts
- Eligibility, modified adjusted gross income
- Eligibility, online enrollment
- Enhanced funding, FMAP for new eligibles
- Employer sponsored insurance, premium assistance
- HCBS eligibility/ enrollment, spousal impoverishment rules

Smoking cessation, barbiturates, benzodiazepines

2014 – OPTIONAL (cont.)

Medicaid
- Eligibility, presumptive eligibility

2014 – NO ACTION (cont.)

Medicaid
- Enhanced funding, expansion States

Medicare and Federal Initiatives
- Facility quality reporting
- Home health care payments
- Hospital acquired conditions (Oct.)
- Medicare Advantage plans for special needs individuals
- Medicare Improvement Fund elimination

Public Health
- Prospective Payment System, FQHCs (Implementation) (Oct.)

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Provisions of the Patient Protection and Affordable Care Act (H.R. 3590)[1]

INDEX BY IMPLEMENTATION DATE[1]

2015 – MANDATORY

Health Insurance Exchanges
- Qualified health plan contractors
- Self-funding options

2015 – OPTIONAL

Children's Health Insurance Program
- Funding, enhanced FMAP (Oct.)

2015 – NO ACTION

Medicare and Federal Initiatives
- Medigap benefit package standards
- Value-based payment modifier for physicians

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