TEXAS MEDICAL ASSOCIATION

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VISION: To improve the health of all Texans.

MISSION: TMA supports Texas physicians by providing distinctive solutions to the challenges they encounter in the care of patients.

Summary – HR 3590 (Health System Reform Bill)

As passed by the Senate and House and Signed by the President March 23, 2010

As amended by the
Health Care and Education Reconciliation Act of 2010
Signed by the President March 30, 2010

Readers should note that this new law is very complex and will be considerably influenced by the many regulations that must be adopted under its provisions. This document is a summary of the law and as such it will lose some of the details that are contained within the statutes. Where there is a conflict between the text of this article and the law, keep in mind the language in the law will control. The best use of the summary is to discern which provision of the law may pertain to a particular question or issue for which you seek information. The summary can then be utilized to gain a basic understanding of what the law intends to accomplish before reviewing the actual statutory text. The "Manager's Amendment" and the "Reconciliation Bill" passed subsequent to the Patient Protection and Affordable Care Act are included in the earlier sections of the bill that those provisions amend or to which the amendments best relate. If a section is amended or modified, a citation to the appropriate Manager's Amendment or Reconciliation Bill section is provided. The Manager's Amendment provisions are all those provisions that are enumerated as sections 10000 or above.

TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

SUBTITLE A—IMMEDIATE IMPROVEMENTS IN HEALTH CARE COVERAGE FOR ALL AMERICANS

Sec. 1001 PART A—INDIVIDUAL AND GROUP MARKET REFORMS: SUBPART II—IMPROVING COVERAGE

No Lifetime or Annual Limits. (Sec.2711 as amended by Sec. 10101)

- Group and Individual Health Plans may not establish lifetime maximum benefits on any enrolled person
- Group and Individual Health Plans that begin prior to 2014 can only establish a "restricted annual limit" on essential health benefits. Determined by rule through HHS.

- Essential Health Benefits include:
    - Ambulatory Patient services
    - Emergency Services,
    - Hospitalization
    - Maternity and Newborn care
    - Mental Health and substance abuse disorders
    - 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.
- Benefits that are not considered 'Essential' may have annual and lifetime maximum benefits

Prohibition on Rescissions (Sec. 2712)
A group or individual health benefit insurer may not rescind a health benefit plan, except when a covered person has committed fraud or intentional misrepresentation of a material fact as described in the plan. Prior notice must be given to the enrollee

Coverage of Preventive Health Services (Sec. 2713)
- A group and individual health plan must provide coverage for, and without cost share requirements for:
    - Those preventive services that have an 'A' or 'B' rating in current recommendations of the United States Preventive Services Task Force
    - Recommended Immunizations
    - Preventive care for women and children
- Intervals for when these preventive services must be provided without cost share will be determined by the Secretary of HHS, but cannot be less than annually.
    - *Extension of Dependent Coverage (Sec. 2714 as amended by Sec. 2301)*
    - A group and individual health benefit plan that provides coverage, must continue to make coverage available for ~~unmarried~~ children until the adult child turns 26
    - Does not require that dependents of dependents be covered
    - HHS will create rules to define dependents that must be covered

Uniform Explanation of Coverage Documents and Standardized Definitions (Sec. 2715)
Within 12 months from enactment of the bill, HHS must develop standards for insurers to follow in providing enrollees summaries of benefits and coverage explanations that accurately describe the coverage provided. Requirements include:
- Appearance – Summary cannot exceed 4 pages and print must be at least 12 point font
- Language – Language must be culturally and linguistically appropriate with terminology understandable by the average enrollee.
- Content – must include, but not limited to:
    - Description of coverage including cost share (copayment, deductible, coinsurance)
    - Limitations and exceptions of coverage;
    - Renewability and continuation of coverage provisions;
    - Coverage fact labels that includes examples to illustrate common benefits, such as pregnancy and chronic conditions;
    - Statement that plan document should be consulted for full description of plan.

Summaries must be provided to the applicant at time of application, the enrollee prior to enrollment or re-enrollment, or the policy or certificate holder at time of issuance of policy or certificate
Provision of Additional Information (Sec. 2715A as amended by Sec. 10101)

Requires all health plans to disclose the information for plans participating in the Exchange, such as claims payment policies, financial information and rating practices. Plans that are not offered through the Exchange must submit this information to HHS and the State insurance commissioner and make the information available to the public.

Prohibition on Discrimination in favor of Highly Compensated Individuals (Sec. 2716 as amended by Sec. 10101)
Prohibits health insurance coverage discrimination in favor of highly compensated-individuals in fully-insured group plans with those already in place with respect to self-insured plans.

Ensuring Quality of Care (Sec. 2717)
Requires HHS, within 2 years from enactment to develop reporting guidelines for health plans, in respect to plan benefits and provider reimbursement structures that:

- Improve health outcomes through implementation of quality reporting, case management, care coordination, chronic disease management and medication and care compliance initiatives, including through the use of medical homes model;
- Implement activities in prevent readmission into hospitals through discharge planning and post discharge reinforcement;
- Implement activities to improve patient safety and reduce medical errors; and
- Implement wellness and health promotion

Bringing Down the Cost of Health Coverage (Sec. 2718 as amended by Sec. 10101)

- Health Insurer must report to HHS, which will post on website:
    - Amount of premium revenue spent on clinical services
    - Activities to improve quality
    - The nature of other non-claims costs
- Beginning not later than January 1, 2011 an insurer must
    - Provide an annual rebate check to each enrollee, on a pro rata basis, if the insurer loss-ratio is less than:
        - 85% for large group market
        - 80% for small group or individual market
- Hospital Charges
    - Each Hospital shall develop and make public a list of standard charges for items and services provided by the hospital, including DRG.

Appeals Process (Sec. 2719 as amended by Sec. 10101)

- Requires health plans to implement appeals process for adverse determinations of enrollees issues. At a minimum health plans should:
    - Have an internal appeal process
    - Provide notice of process to enrollees in culturally and linguistically appropriate manner
    - Allow enrollee to review their file and present evidence and testimony as part of the appeal process
- Health Plans will be subject to an external appeal process that;
    - Complies with their state external review process which should include protections in Uniform External Review Model Act set forth by NAIC
    - Meets guidelines set forth by HHS.

Patient Protections (Sec. 2719A as amended by Sec. 10101)
Requires health plans to permit:

- Choice of Health Care Professional
    - If health plan requires designation of PCP, then must allow enrollee to designate any PCP who is available
- Coverage of Emergency Service
    - If plans cover ER services, plan must allow coverage in ER
        - Without pre-authorization
        - Regardless of whether the provider is in network
        - At the same level of coverage as an in network provider even if the ER provider is out of network
- Access to OB/GYN
    - Must recognize participating OB/GYN as PCP if requested by enrollee

Sec. 1002. Health Insurance Consumer Information
HHS shall award grants to states to enable them (or Exchanges working in the state) to establish Offices of consumer assistance or ombudsman programs to:

- Assist with complaint and appeal filings
- Collect, track and quantify problems
- Educate and assist consumers on rights and enrollment
- Resolve problems with obtaining premium tax credits
- Collect and report data to assist HHS in identifying where more enforcement action is necessary

Funding is $30 million appropriated for first fiscal year and subsequently, to be determined.

Sec. 1003. Ensuring Consumers Get Value for Their Dollar

- HHS, in conjunction with the states, shall establish a process for the annual review of unreasonable increases in premiums, beginning with 2010 plan year.
- Health Insurers must provide justification for premium increases to HHS and respective states, prior to the increase.
    - Insurers must post rate increase information on their website
- HHS shall appropriate $250 million in grants for states to monitor and approve, if appropriate under state law, premium increases
- Additionally, states can determine whether insurers should be allowed to participate in upcoming Exchange program based on their practice of excessive or unjustified premium increases
- Establishes Medical Reimbursement Data Centers
    - MRDC will develop fee schedules that reflect market rates for medical services and geographic differences in those rates and update to reflect changes
    - Will make data available on internet website and regularly publish information concerning the methodology

Sec. 10329.
Requires the Secretary, in consultation with interested parties, to develop a method to assess health plans and account for the overall cost of the plan, quality of care under the plan, the efficiency of the plan "in providing care," the risk of enrollees versus other plans, and the comparative value of the plan. A report is due in 18 months.

Sec. 1004. Effective Date.
Subtitle A is effective 6 months after enactment, with exception for Secs. 1002 and 1003 amendments, which are effective upon enactment.

Sec. 10401.
Makes technical changes to Subtitle A.

SUBTITLE B—IMMEDIATE ACTIONS TO PRESERVE AND EXPAND COVERAGE

Sec. 1101. Immediate Access to Insurance for Uninsured Individuals with a Preexisting Condition.
Within 90 days from enactment, HHS shall establish a temporary high risk pool program to provide health coverage for previously uninsured people with a pre-existing condition. This program ends January 1, 2014.

- Individuals are eligible if:
  - US Citizen or is lawfully present in US
  - Has not had creditable coverage in the past 6 months
  - Has a pre-existing condition
- Protection against insurers 'dumping' risk
  - HHS shall determine criteria on whether insurers have discouraged individuals from staying on their plan
- $5 billion dollars appropriated

Sec. 1102. (as amended by Sec. 10102). Reinsurance for Early Retirees
Within 90 days of enactment, creates a program in which participating employer plans are partially reimbursed for providing coverage for retirees and their eligible dependents aged 55 and over but not yet qualified for Medicare coverage.

- Will provide reimbursement to participating employer plans
  - 80% of cost of benefits above $15,000 until $90,000
- $5 billion appropriated

Sec. 1103 (as amended by 10102). Immediate Information That Allows Consumers to Identify Affordable Coverage Options
This provision requires State and Federal governments to reach out to consumers through the internet to inform them of affordable insurance options. The format will be standardized by the Secretary within 60 days of the enactment of the Act. The standardized summary of benefits and coverage explanation must accurately describe the benefits and coverage under the applicable plan or coverage.

Sec. 1104. Administrative Simplification
Requires HHS adoption of uniform standards and operating rules for electronic transactions that occur between providers and health plans that are governed under HIPAA

  - benefit eligibility verification
  - prior authorization
  - electronic funds transfer payments.
- Establishes a process to regularly update the standards and operating rules for electronic transactions
- Rules regarding eligibility for a health plan and health claim status should be adopted no later than 7/1/2011 and effective no later than 2013.
- Rules regarding EFT and healthcare payment and remittance advice should be adopted no later than 7/1/2012 and effective no later than 2014.
  - Requires health plans to certify compliance and establishes penalties for non-compliance

Sec. 10109.
Requires HHS to develop additional transaction standards and operating rules to reduce administrative cost. By January 1, 2012, the department should seek input on the following:

- Electronic and standardized applications for enrollment of health care providers by health plans
- Applying transaction standards to the health care transactions of automobile insurance, worker's compensation, and other programs.
- Whether standardized forms could apply to financial audits required by health plans and Federal and State agencies including State auditors, the Office of the Inspector General of the Department of Health and Human Services, and the Centers for Medicare & Medicaid Services.
- Whether there could be greater transparency and consistency of methodologies and processes used to establish claim edits used by health plans
- Whether health plans should be required to publish their timeliness of payment rules.

Sec. 1105. Effective Date
Subtitle B is effective on date of enactment.

SUBTITLE C—QUALITY HEALTH INSURANCE COVERAGE FOR ALL AMERICANS
PART I—HEALTH INSURANCE MARKET REFORMS

SUBPART I—GENERAL REFORM (as amended by 10104)
No Pre-Existing Condition Clause (Sec. 2704)
A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage
Fair Health Insurance Premium (Sec. 2701)
Allows premium rates to vary only by individual or family coverage, rating area, age, or tobacco use. Preexisting condition prohibition for children is effective immediately (There is controversy over effective date and the administration has announced it will issue rules to clarify).

Guaranteed Availability of Coverage (Sec. 2702)
Each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage.

Guaranteed Renewability of Coverage (Sec. 2703)
If a health insurance issuer offers health insurance coverage in the individual or group market, the issuer must renew or continue in force such coverage at the option of the plan sponsor or the individual.

Prohibiting Discrimination based on Health Status (Sec. 2705)
A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual: Health status; Medical condition (including both physical and mental illnesses); Claims experience; Receipt of health care; Medical history; Genetic information; Evidence of insurability (including conditions arising out of acts of domestic violence); Disability; or any other health status-related factor determined appropriate by the Secretary.

Sec. 10104.
Requires the Secretary to create rules to permit qualified plans to deliver care through qualified primary care medical home plans (as defined by the Secretary). Co-op plans and multi-state plans are included in any reference to qualified health plan unless specifically stated otherwise.

Availability of Non-Physician Providers (Sec. 2706)
The law prohibits a health plan from discriminating with respect to participation against any health care provider based upon the type of license held by the person. Thus, a chiropractor may not be excluded from participation merely because he or she holds a license to practice chiropractic. Effective for plan years after January 1, 2014.

Limitation on Certain Cost-sharing (Sec. 2707)
A group health plan must ensure that any annual cost-sharing imposed under the plan does not exceed limitations. These limitations begin in 2014 and increases are permitted after 2015, provided the amount is rounded down to the next increment that is a multiple of $50.

Prohibition on Excessive Waiting Periods (Sec. 2708)

Nondiscrimination of Persons in Clinical Trials (Sec. 2709 as amended by Sec. 10103)
Insurers may not refuse to cover costs for routine patient costs which include all items and services consistent with the coverage provided in the plan (or coverage) that is typically covered for a qualified individual who is not enrolled in a clinical trial. This includes treatment of cancer or other life-threatening diseases. Effective for plan years after January 1, 2014 as required by Sec. 1253.

PART II- OTHER PROVISIONS

Sec. 1251. (As amended by Sec. 10103). May Keep Current Insurance Coverage
The law essentially ensures that group, individual coverage and family coverage may be maintained and there is no requirement for policyholders to cancel their insurance. Applies provisions related to uniform coverage documents and medical loss ratios to grandfathered health plans for plan years beginning after enactment of this Act.

Clarifies lifetime limits, prohibition on rescissions, limitations on waiting periods, and requirement to provide coverage for children up to age 26 to all existing health insurance plans starting six months after enactment. For group health plans, prohibits preexisting condition exclusions beginning for adults in 2014, restricts annual limits beginning six months after enactment, and prohibits them starting in 2014. For coverage of non-dependent children prior to 2014, the requirement on group health plans is limited to those adult children without an employer offer of coverage.

Sec. 1252. Rating Reforms Must Apply Uniformly
Any state standard or requirement must apply uniformly to all health plans in each insurance market to which the standard applies. Effective January 1, 2014.

SUBTITLE C—AVAILABLE COVERAGE CHOICES FOR ALL AMERICANS
PART I ESTABLISHMENT OF QUALIFIED HEALTH PLANS

Sec. 1301. Qualified Health Plans – Insurance to be Available in Exchanges (as amended by Sec. 10104)
Only qualified health plans may offer coverage on a state health exchange. All coverage must be certified as meeting the plan "essential benefits" minimum and the carrier must be licensed and "in good standing" in the state to offer coverage. Further, the carrier must offer at least one plan in the silver level and one plan in the gold level. Plans offered through the exchange must have the same price as the plan has when sold by an agent. ERISA self funded plans and MEWAS do not fall under the term "health plan." Section 10104 of the law modifies this provision to include CO-OP plans and Multi-State plans offered through the Exchanges.

Sec. 1302. Essential Health Benefits and Levels of Coverage

The basic elements that must be offered (and the type of coverage excluded) in insurance exchange coverage are provided for in these sections. There are limitations placed upon cost-sharing for self-only and family coverage. In the small group market the deductibles are limited to no more than $2000 for an individual and $4000 for other coverage. Those amounts may increase to that level permitted for Flexible Savings Accounts.

The levels of coverage are described in reference to the "full actuarial value of the benefits" which is calculated based on rules adopted by the Secretary with allowance for de minimus variation. The coverage levels are:

Bronze Level – A plan offering coverage that provides a benefit actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan.

Silver Level – A plan offering coverage that provides a benefit actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan.

Gold Level – A plan offering coverage that provides a benefit actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan.

Platinum Level – A plan offering coverage that provides a benefit actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan.

There is an allowance for "catastrophic plans" as well, based upon whether the patient is under the age of thirty and the coverage begins at the level of cost sharing as provided in the Internal Revenue Code provisions for self-only coverage as OR for hardship and affordability cases.

Sec. 1303. Abortion

This provision contains the various prohibitions on the financing and payment for abortions. Note: There is controversy over the scope of the prohibitions in this section of the bill.

Sec. 1304. Definitions (as amended by Sec. 10104)

Group Market- means the health insurance market under which individuals obtain health insurance coverage on behalf of themselves (and their dependents) through a group health plan maintained by an employer.

Individual Market - means the market for health insurance coverage offered to individuals only.

Large And Small Group Markets - mean the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer or by a small employer respectively.

Large Employer - means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

Small Employer- means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on first day of the plan year.

State Option To Treat 50 Employees As Small- In the case of plan years beginning before January 1, 2016, a State may elect to apply this subsection by substituting `51 employees' for `101 employees' in paragraph (1) and by substituting `50 employees' for `100 employees' in paragraph (2).

Sec. 10104.

Adds a definition for *educated health care consumer*. The term means a person who is knowledgeable about the health care system and making decisions regarding health or medical matters. This section also details how to determine the size of an employer**.**

PART II—CONSUMER CHOICES AND INSURANCE COMPETITION THROUGH HEALTH BENEFIT EXCHANGES

Sec. 1311. Affordable Choices of Health Benefit Plans as amended by Secs. 10104, 10108 & 10203).

Establishment of Health Benefit Exchanges

States will be required to develop Exchanges through planning and establishment grants no later than 01/01/2014 to assist small employers (up to 100 employees) in the purchase of health coverage and be 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. The Exchange must:

- facilitates the purchase of qualified health plans
    - Allows states to add to the list of benefits for bronze through platinum level plans.
    - Plain language must be used to describe plan terms and individuals must be given the amount of cost-sharing on request.
    - Plans may be offered across state lines through the exchanges and a federal oversight mechanism is created to regulate such plans.
- provide for the establishment of a Small Business Health Options Program (SHOP Exchange) to assist qualified employers in facilitating the enrollment of their employees. In 2017, allow businesses with more than 100 employees to purchase coverage in the SHOP exchange.

State Exchanges must meet certain requirements

The act sets forth the requirements for an Exchange, including that an Exchange: must be a governmental agency or nonprofit entity that is established by a state;

- may not make available any health plan that is not a qualified health plan;
- must implement procedures for certification of health plans as qualified health plans;
- must require health plans seeking certification to submit a justification of any premium increase prior to implementation of such increase.
- may establish subsidiary Exchanges for geographically distinct areas of a certain size.
- may elect to provide only one Exchange in the State for providing both Exchange and SHOP Exchange services to both qualified individuals and qualified small employers, but only if the Exchange has adequate resources to assist such individuals and employers.
- may make available a qualified health plan notwithstanding any provision of law that may require benefits other than the essential health benefits specified under section 1302(b).
- shall consult with relevant stakeholder such as health care consumers who are enrollees in qualified plans, entities with experience in facilitating enrollment in qualified plans, representatives of small businesses and self-employed individuals, State Medicaid offices and advocates to contact hard to reach populations.
- shall publish the average costs of licensing, regulatory fees, and any other payments required by the Exchange, and administrative costs of such Exchange, on an Internet website to educate consumers. Such information shall also include monies lost to waste, fraud, and abuse.
- may not exclude a health plan on the basis that such plan is a fee-for-service plan; through imposition of premium price controls; or on the basis that plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.
- may operate in more than one State if each State in which such Exchange operates permits such operation; and the Secretary approves such regional or interstate Exchange.
- shall provide as determined by the Secretary:
    - an initial open enrollment period to be made not later than July 1, 2012;
    - annual open enrollment periods, for calendar years after the initial enrollment period;
    - special enrollment periods.

- shall not impose any penalty on an individual who cancels enrollment because the individual becomes eligible for minimum essential coverage or such coverage becomes affordable.

Exchanges must function at a minimum level and are responsible for the provision of guidelines/ procedures consistent with the Secretary's guidelines.
An Exchange shall, at a minimum:--

- implement procedures for the certification, recertification, and decertification, consistent with guidelines of health plans as qualified health plans;
- provide for the operation of a toll-free telephone hotline to respond to requests for assistance;
- maintain an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;
- assign a rating to each qualified health plan offered through such Exchange;
- utilize a standardized format for presenting health benefits plan options in the Exchange, including the use of the uniform outline of coverage;
- inform individuals of eligibility requirements for the Medicaid program, the CHIP program, or any applicable State or local public program and if through screening of the application by the Exchange, the Exchange determines that such individuals are eligible for any such program, enroll such individuals in such program;

Sec. 10203.
Extends funding for CHIP through Fiscal Year 2015 and other CHIP-Related Provisions. This provision also requires the Secretary, by April 1, 2015, to review the benefits offered for children through an Exchange as created by this law. The Secretary will then certify plans that offer benefits in the Exchange that are comparable to the benefits in CHIP.

- establish and make available by electronic means a calculator to determine the actual cost of coverage after the application of any premium tax credit;
- grant a certification attesting that, for purposes of the individual responsibility penalty, an individual is exempt from individual requirement or from the penalty imposed because--
    - there is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual; or
    - the individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;
- transfer to the Secretary of the Treasury--
    (i) a list of the individuals who are issued a certification;
    (ii) the name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit because--
        (I) the employer did not provide minimum essential coverage; or
        (II) the employer provided such minimum essential coverage but it was determined to either be unaffordable to the employee or not provide the minimum actuarial value; and
    (iii) the name and taxpayer identification number of each individual who notifies the Exchange that they have changed employers and of each individual who ceases coverage under a qualified health plan during a plan year (and the effective date of such cessation);
- provide to each employer the name of each employee of the employer who ceases coverage under a qualified health plan during a plan year (and the effective date of such cessation); and
- establish the Navigator program.

Sec. 10108.
Requires employers to provide free choice vouchers to qualified employees.
Employers who offer coverage to employees through an employer-sponsored plan shall also offer employees a voucher to permit the employee to apply toward the premium of exchange coverage. The voucher is equal to the employers contribution in the sponsored plan.

Establishment of Navigator Programs

- The Exchange shall establish a Navigator program under which it awards grants to entities that can demonstrate that it has existing relationships, or one could be established, 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.
- Entities that may qualify as a Navigator include trade, industry, and professional associations, commercial fishing industry organizations, ranching and farming organizations, community and consumer-focused nonprofit groups, chambers of commerce, unions, small business development centers, other licensed insurance agents and brokers, and other entities that are capable of carrying out the duties as a Navigator.

An entity that serves as a Navigator under a grant under this subsection shall--

- conduct public education activities to raise awareness of the availability of qualified health plans;
- distribute fair and impartial 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 to any applicable office of health insurance consumer assistance or health insurance ombudsman or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage; and
- provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange or Exchanges

The Secretary shall establish standards for Navigators. Under such standards, a navigator shall not--

(1) be a health insurance issuer; or

(2) receive any consideration from any health insurance issuer in connection with the enrollment of any qualified individuals or employees of a qualified employer in a qualified health plan.

Health plans will need to be certified as "qualified" plans
Secretary is required to establish criteria for the certification of health plans as qualified health plans, including requirements for meeting market requirements and ensuring a sufficient choice of providers. States are permitted to require qualified health plans to offer additional benefits and requires states to pay for the cost of such additional benefits. Applies mental health parity provisions to qualified health plans. The criteria shall require that, at a minimum, a certified plan shall:

- meet marketing requirements, and not employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs;
- ensure a sufficient choice of providers (in a manner consistent with applicable network adequacy provisions and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers; Does not require a qualified health plan to contract with a provider described in such paragraph if such provider refuses to accept the generally applicable payment rates of such plan.
- include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals, but shall not require any health plan to provide coverage for any specific medical procedure;

- be accredited with respect to local performance on clinical quality measures such as the Healthcare Effectiveness Data and Information Set, patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems survey, as well as consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs by any entity recognized by the Secretary for the accreditation of health insurance issuers or plans (so long as any such entity has transparent and rigorous methodological and scoring criteria); or receive such accreditation within a period established by an Exchange for such accreditation that is applicable to all qualified health plans;
- implement a quality improvement strategy
- utilize a uniform enrollment form that qualified individuals and qualified employers may use (either electronically or on paper) in enrolling in qualified health plans offered through such Exchange, and that takes into account criteria that the National Association of Insurance Commissioners develops and submits to the Secretary;
- utilize the standard format established for presenting health benefits plan options; and
- provide information to enrollees and prospective enrollees, and to each Exchange in which the plan is offered, on any quality measures for health plan performance.
- apply Mental Health Parity requirements in the same manner and to the same extent as parity provisions apply to health insurance issuers and group health plans.

States are permitted to require additional benefits to be offered in a health insurance exchange. However, the state must "make payments to an individual enrolled in a qualified health plan ... or on behalf of an individual directly to the health plan."

Individuals, on request, shall receive from their health plans the "amount of cost-share" that the individual will be responsible for paying with respect to specific items or services by a participating provider. At a minimum this shall be available through a website.

The Office of Personnel Management is charged with entering into contracts with insurance holding companies to offer at least 2 multi-state qualified health plans through Exchanges. At least one contract shall be with a non-profit entity. The insurer must be licensed in each state and must meet all requirements of state law not inconsistent with federal law. States may require additional benefits to be offered beyond those mandated in bronze through platinum levels, but the State must pay for the benefit.

An insurer offered a contract is deemed to be a qualified health plan.

Sec. 10104.
Stipulates that Federal employee health benefit plans are not required to participate.

Establishment of an Enrollee Satisfaction and Rating System for Qualified Plans
The Secretary shall develop an enrollee satisfaction and rating system for qualified health plans offered through an Exchange.

The Secretary shall develop an enrollee satisfaction survey system qualified health plan that had more than 500 enrollees in the previous year. The Exchange shall include enrollee satisfaction information in the information provided to individuals and employers through an Internet portal in a manner that allows individuals to easily compare enrollee satisfaction levels between comparable plans.

In addition, the Secretary shall develop a rating system that would rate qualified health plans in each benefits level on the basis of the relative quality and price. The Exchange shall include the quality rating in the information provided to individuals and employers through the Internet portal.

Establishment of an Internet Portal
The Secretary shall continue to operate, maintain, and update the Internet portal and to assist States in developing and maintaining their own such portal.

The Secretary shall make available a model template for an Internet portal that may be used to direct qualified individuals and qualified employers to qualified health plans, to assist such individuals and employers in determining whether they are eligible to participate in an Exchange or eligible for a premium tax credit or cost-sharing reduction, and to present standardized information (including quality ratings) to assist consumers in making easy health insurance choices.

Establishment of a National Quality Strategy
The Secretary shall develop a national quality strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health. It creates processes for the development of quality measures involving input from multiple stakeholders and for selecting quality measures to be used in reporting to and payment under federal health programs. (National strategy due to Congress by January 1, 2011).

The guidelines developed shall require the periodic reporting to the applicable Exchange of the activities that a qualified health plan has conducted to implement a strategy. The strategy will consist of a payment structure that provides increased reimbursement or other incentives for—

- improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage;
- the implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement;
- the implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; and
- the implementation of wellness and health promotion activities.

Beginning on January 1, 2015, a qualified health plan may contract with:

- a hospital with greater than 50 beds only if such hospital:
    - utilizes a patient safety evaluation system; and
    - implements a mechanism to ensure that each patient receives a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional; or
    - a health care provider if such provider implements such mechanisms to improve health care quality.
- The Secretary may establish reasonable exceptions to the requirements and may by regulation adjust the number of beds.

Sec. 1312. Consumer choice.

Qualified Individuals and Employers

- Qualified individuals and qualified employers will have access to qualified health plans offered by the Exchange as well as are not prohibited from selecting a health plan outside of the Exchange.
    - "Qualified individual" means, with respect to an Exchange, an individual who is a citizen or national of the United States or an alien lawfully present in the United States who is not incarcerated; is seeking to enroll in a qualified health plan in the individual market offered through the Exchange; and resides in the State that established the Exchange
    - "Qualified employer" means a small employer that elects to make all full-time employees eligible for 1 or more qualified health plans in the small group market. in 2017, if a State allows issuers to offer qualified plans to the large group market, the term "Qualified Employer" shall include a large employer that makes all full time enrollees eligible for one or more qualified plans through the Exchange.

Individual Market Risk Pools [As found in Sec. 1312 (c) of the Act]

A health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the individual market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

Small Group Market Risk Pools [As found in Sec. 1312 (c) of the Act]

A health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the small group market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool. A State may require the individual and small group insurance markets within a State to be merged if the State determines appropriate. However, a state is prohibited from requiring by law grandfathered health plans to be included in the individual or small group market pool.

Enrollment Through Agents or Brokers [As found in Sec. 1312 (e) of the Act]

HHS shall establish procedures under which a State may allow agents or brokers to enroll individuals in any qualified health plans in the individual or small group market as soon as the plan is offered through an Exchange in the State and assist individuals in applying for premium tax credits and cost-sharing reductions for plans sold through an Exchange. Such procedures may include the establishment of rate schedules for broker commissions paid by health benefits plans offered through an exchange.

Members of Congress In The Exchange [As found in Sec. 1312 (d) of the Act]

After the effective date, the only health plans that the Federal Government may make available to Members of Congress and congressional staff with respect to their service as a Member of Congress or staff shall be health plans that are either created under this Act or offered through an Exchange.

Sec. 1313. Financial integrity.

An Exchange shall keep an accurate accounting of all activities, receipts, and expenditures and shall annually submit to the Secretary a report concerning such accountings.

Investigations [As found in 1313(a) of the Act]

The Secretary, in coordination with the Inspector General of the Department of Health and Human Services, may investigate the affairs of an Exchange, may examine the properties and records of an Exchange, and may require periodic reports in relation to activities undertaken by an Exchange. An Exchange shall fully cooperate in any investigation conducted under this paragraph.

Audits [As found in 1313(a) of the Act]
An Exchange shall be subject to annual audits by the Secretary and if the Secretary determines that an Exchange or a State has engaged in serious misconduct with respect to compliance with the requirements of, or carrying out of activities required under, this title, the Secretary may rescind from payments otherwise due to such State involved under this or any other Act administered by the Secretary an amount not to exceed 1 percent of such payments per year until corrective actions are taken by the State that are determined to be adequate by the Secretary.

Protections Against Fraud and Abuse [As found in 1313 (a) of the Act]
With respect to activities carried out under this title, the Secretary shall provide for the efficient and non-discriminatory administration of Exchange activities and implement any measure or procedure that is determined appropriate to reduce fraud and abuse in the administration of this title; and the Secretary has authority to implement under this title or any other Act.

Application of the False Claims Act [As found in 1313(a) of the Act]
Payments made by, through, or in connection with an Exchange are subject to the False Claims Act if those payments include any Federal funds. Compliance with the requirements of this Act concerning eligibility for a health insurance issuer to participate in the Exchange shall be a material condition of an issuer's entitlement to receive payments, including payments of premium tax credits and cost-sharing reductions, through the Exchange.

Damages [As found in 1313(a) of the Act]
The civil penalty assessed under the False Claims Act on any person found liable under such Act as described in subparagraph (A) shall be increased by not less than 3 times and not more than 6 times the amount of damages which the Government sustains because of the act of that person.

GAO Oversight [As found in 1313(b) of the Act]
Not later than 5 years after the first date on which Exchanges are required to be operational under this title, the Comptroller General shall conduct an ongoing study of Exchange activities and the enrollees in qualified health plans offered through Exchanges. Such study shall review--

- the operations and administration of Exchanges, including surveys and reports of qualified health plans offered through Exchanges and on the experience of such plans (including data on enrollees in Exchanges and individuals purchasing health insurance coverage outside of Exchanges), the expenses of Exchanges, claims statistics relating to qualified health plans, complaints data relating to such plans, and the manner in which Exchanges meet their goals;
- any significant observations regarding the utilization and adoption of Exchanges;
- where appropriate, recommendations for improvements in operations or policies of Exchanges; and
- how many physicians, by area and specialty, are not taking or accepting new patients enrolled in Federal Government health care programs, and the adequacy of provider networks of Federal Government health care

PART III--STATE FLEXIBILITY RELATING TO EXCHANGES

Sec. 1321. State Flexibility in Operation and Enforcement of Exchanges and Related Requirements.
Establishment of Standards [As found in Sec. 1321(a) of the Act]
The Secretary shall, as soon as possible, in consultation with NAIC, issue regulations setting standards for meeting the requirements under this title, and the amendments made by this title, with respect to--

- the establishment and operation of Exchanges (including SHOP Exchanges);
- the offering of qualified health plans through such Exchanges;

- the establishment of the reinsurance and risk adjustment programs; and
- such other requirements as the Secretary determines appropriate.

Consultation with NAIC [As found in Sec. 1321(a) of the Act]
The Secretary shall consult with the National Association of Insurance Commissioners and its members and with health insurance issuers, consumer organizations, and such other individuals as the Secretary selects in a manner designed to ensure balanced representation among interested parties. Each State that elects to apply the requirements shall, not later than January 1, 2014, adopt and have in effect--

- the Federal standards established under the Act; or
- a State law or regulation that the Secretary determines implements the standards within the State.

Failure To Establish Exchange or Implement Requirements [As found in Sec. 1321(c) of the Act]
If a State is not an electing State or the Secretary determines, on or before January 1, 2013, that an electing State will not have any required Exchange operational by January 1, 2014; or has not taken the actions the Secretary determines necessary to implement the Secretary shall (directly or through agreement with a not-for-profit entity) establish and operate such Exchange within the State and the Secretary shall take such actions as are necessary to implement such other requirements.

Enforcement Authority [As found in Sec. 1321(c) of the Act]
The provisions of Section 2736(b) of the Public Health Services Act shall apply to the enforcement of the provisions relating to Exchanges (without regard to any limitation on the application of those provisions to group health plans). Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title.

Presumption for Certain State-Operated Exchanges [As found in Sec. 1321(e) of the Act]
In the case of a State operating an Exchange before January 1, 2010, and which has insured a percentage of its population not less than the percentage of the population projected to be covered nationally after the implementation of this Act, that seeks to operate an Exchange, the Secretary shall presume that such Exchange meets the standards unless the Secretary determines the Exchange does not comply.

The Secretary shall establish a process to work with a State described in paragraph (1) to provide assistance necessary to assist the State's Exchange in coming into compliance with the standards for approval under this section.

Sec.1322. Federal Program to Assist Establishment of Member-run Health Insurance Issuers.
Consumer Operated And Oriented Plan (Co-Op) [As found in Sec. 1322(a) of the Act]
The Secretary shall establish a program to carry out the purposes of this section to be known as the Consumer Operated and Oriented Plan (CO-OP) program. The purpose of the CO-OP is to foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets in the States in which the issuers are licensed to offer such plans.

Loans And Grants Under The Co-Op Program [As found in Sec. 1322(b) of the Act]
The Secretary shall provide to persons applying to become qualified nonprofit health insurance issuers through the CO-OP program loans to assist in meeting its start-up costs and grants to provide assistance in meeting any solvency requirements of States in which the person seeks to be licensed to issue qualified health plans. If no health insurance issuer applies to be a qualified nonprofit health insurance issuer within a State, the Secretary may use amounts appropriated under this section for the awarding of grants to encourage the establishment of a qualified nonprofit health insurance issuer within the State or the expansion of a qualified nonprofit health insurance issuer from another State to the State.

Requirements For Awarding Loans And Grants For The Co-Op [As found in Sec. 1322(b) of the Act]
In awarding loans and grants under the CO-OP program, the Secretary shall--

- take into account the recommendations of the advisory board
- give priority to applicants that will offer qualified health plans on a Statewide basis, will utilize integrated care models, and have significant private support; and
- ensure that there is sufficient funding to establish at least one qualified nonprofit health insurance issuer in each State.
- require any person receiving a loan or grant under the CO-OP program to enter into an agreement with the Secretary which requires such person to meet (and to continue to meet)--
- requirements for such person to be treated as a qualified nonprofit health insurance issuer; and
- requirements contained in the agreement for such person to receive such loan or grant.

Restrictions On Use Of Federal Funds-[As found in Sec. 1322(b) of the Act]
The agreement shall include a requirement that no portion of the funds made available by any loan or grant under this section may be used for carrying on propaganda, or otherwise attempting, to influence legislation or for marketing.

Failure to Meet Requirements [As found in Sec. 1322(b) of the Act]
If the Secretary determines that a person has failed to meet any requirement of the law and has failed to correct such failure within a reasonable period of time the secretary may impose a penalty of repayment.

Time for Awarding Loans and Grants Under The Co-Op [As found in Sec. 1322(b) of the Act]
The Secretary shall not later than July 1, 2013, award the loans and grants under the CO-OP program and begin the distribution of amounts awarded under such loans and grants.

Advisory Board [As found in Sec. 1322(b) of the Act]
The advisory board under this paragraph shall consist of 15 members appointed by the Comptroller General of the United States. The advisory board shall terminate on the earlier of the date that it completes its duties under this section or December 31, 2015.

Additional Information Required From Co-Op Insurers [As found in Sec. 1322(h) of the Act]
A CO-OP organization shall include on the return the amount of the reserves required by each State in which the organization is licensed to issue qualified health plans and the amount of reserves on hand.

Qualified Nonprofit Health Insurance Issuer [As found in Sec. 1322(c) of the Act]

- "Qualified nonprofit health insurance issuer" means a health insurance issuer that is an organization--that is organized under State law as a nonprofit, member corporation; substantially all of the activities of which consist of the issuance of qualified health plans in the individual and small group markets in each State in which it is licensed to issue such plans; and that meets the other requirements.

Certain organizations may not be treated as a qualified nonprofit health insurance issuer if:

- the organization or a related entity (or any predecessor of either) was a health insurance issuer on July 16, 2009; or
- the organization is sponsored by a State or local government, any political subdivision thereof, or any instrumentality of such government or political subdivision.

Certain governance requirements must be met, such as:

- the governance of the organization is subject to a majority vote of its members;
- its governing documents incorporate ethics and conflict of interest standards protecting against insurance industry involvement and interference; and

- the organization is required to operate with a strong consumer focus, including timeliness, responsiveness, and accountability to members as determined by HHS.

Furthermore, an organization shall not be treated as a qualified nonprofit health insurance issuer unless any profits made by the organization are required to be used to lower premiums, to improve benefits, or for other programs intended to improve the quality of health care delivered to its members.

An organization shall not be treated as a qualified nonprofit health insurance issuer unless the organization meets all the requirements that other issuers of qualified health plans are required to meet in any State where the issuer offers a qualified health plan, including solvency and licensure requirements, rules on payments to providers, and compliance with network adequacy rules, rate and form filing rules, any applicable State premium assessments and any other State law.
An organization shall not be treated as a qualified nonprofit health insurance issuer unless the organization does not offer a health plan in a State until that State has in effect (or the Secretary has implemented for the State) the market reforms required by federal law.

Tax Exemption for Qualified Nonprofit Health Insurance Issuer [As found in Sec. 1322(h) of the Act]
A tax exemption is available for a qualified nonprofit health insurance issuer (within the meaning of this law) which has received a loan or grant under the CO-OP program provided it meets certain requirements.

Establishment of Private Purchasing Council [As found in Sec. 1322(d) of the Act]
Qualified nonprofit health insurance issuers participating in the CO-OP program under this section may establish a private purchasing council to enter into collective purchasing arrangements for items and services that increase administrative and other cost efficiencies, including claims administration, administrative services, health information technology, and actuarial services.

Council May Not Set Payment Rates [As found in Sec. 1322(d) of the Act]
The private purchasing council shall not set payment rates for health care facilities or providers participating in health insurance coverage provided by qualified nonprofit health insurance issuers.

Continued Application of Antitrust Laws [As found in Sec. 1322(d) of the Act]
Nothing in this section shall be construed to limit application of antitrust laws to any private purchasing council or to any qualified nonprofit health insurance issuer participating in such a council.

Limitations On Secretary [As found in Sec. 1322(f) of the Act]
The Secretary shall not:
- participate in negotiations between qualified nonprofit health insurance issuers and any health care facilities or providers, including any drug manufacturer, pharmacy, or hospital; and
- establish a price structure for reimbursement of any health benefits covered by such issuers.

Appropriation of six trillion dollars ($6,000,000,000) is established to carry out this section.

GAO Study and Report [As found in 1322(i) of the Act]
GAO shall conduct an ongoing study on competition and market concentration in the health insurance market in the United States after the implementation of the reforms in such market under the provisions of, and the amendments made by, this Act. Such study shall include an analysis of new issuers of health insurance in such market. The Comptroller General shall, not later than December 31 of each even-numbered year (beginning with 2014), report to the appropriate committees of the Congress the results of the study including any recommendations for administrative or legislative changes the Comptroller General determines necessary or appropriate to increase competition in the health insurance market.

Clarifies lifetime limits, prohibition on rescissions, limitations on waiting periods, and requirement to provide coverage for children up to age 26 to all existing health insurance plans starting six months after enactment. For group health plans, prohibits preexisting condition exclusions beginning for adults in 2014, restricts annual limits beginning six months after enactment, and prohibits them starting in 2014. For coverage of non-dependent children prior to 2014, the requirement on group health plans is limited to those adult children without an employer offer of coverage.

Sec. 1323. Establishment of Community Health Insurance Option

- The Secretary shall establish a community health insurance option to offer, through the Exchanges, (other than Exchanges in States that elect to opt out), health care coverage that provides value, choice, competition, and stability of affordable, high quality coverage throughout the United States.
- A community health insurance option shall offer coverage at each of the levels of coverage required in the Exchange (Bronze through Platinum).
- The Secretary and the National Association of Insurance Commissioners (NAIC), shall develop regulations to establish additional requirements for a community health insurance option.

Only entities that meet requirements will be able to offer a community health insurance option. States are not required to offer community health insurance option and may opt out**.** A community health insurance option is a plan that offers high value for the premium charged, has low administrative costs, promotes high quality care, offers a wide choice of providers, and complies with federal and state laws.

The federal government will offer start up trust fund to provide loans for the initial operations of a community health insurance option. A community health insurance option shall be required to repay any payments by the date that is not later than nine years after the date on which the payment is made.

A community health insurance option must comply with state solvency requirements and with new federal solvency standards as established by the Secretary. The Secretary shall conduct a study into the solvency of community health insurance entities and report annually.

Premiums shall be adjusted geographically to address expected costs (including claims and administrative costs) for that geographic area.

Tax credits are available to individuals enrolled in a community health insurance option in the same manner as an individual who is enrolled in a qualified health plan in the Exchange. If a State requires additional benefits in the Exchange, those additional benefits shall not affect the tax credit available.

Individuals enrolled in community health insurance options are NOT prohibited from paying out-of-pocket the full cost of any item or service not included as an essential health benefit or otherwise covered as a benefit by a health plan. A medical provider is not prohibited from accepting an out-of-pocket payment from an individual enrolled in a community health insurance option for a service otherwise not included as an essential health benefit.

A community health insurance option is prohibited from limiting access to end of life care.

The Secretary shall negotiate rates for the reimbursement of health care providers for benefits covered under a community health insurance option. The rates shall not be higher, in aggregate, than the average reimbursement rates paid by health insurance issuers offering qualified health plans through the Exchange. Subject to the limits a State Advisory Council may develop or encourage the use of innovative payment policies that promote quality, efficiency and savings to consumers.

State Advisory Council [As found in Se. 1323(d) of the Act]
A State shall establish or designate a public or non-profit private entity to serve as the State Advisory Council to provide recommendations to the Secretary on the operations and policies of a community health insurance option in the State.

The Secretary is granted authority to contract with "qualified entities" that may perform administrative functions with respect to a community health option. If a qualified entity is so chosen, certain contracting requirements must be met. The contract must be for a term of at least 5 years, there shall be a competitive bidding process, and a renewal of the contract cannot occur unless the Secretary has determined the entity has met the performance requirements set out in the contract. Further, the Secretary may revoke a contract executed upon the recommendation of the Inspector General and a determination the contractor has engaged in activities including, but not limited to, fraud, waste, deception, negligence or mismanagement.

A State Advisory Council must provide guidance on:

- policies and procedures to integrate quality improvement and cost containment mechanisms into the health care delivery system;
- mechanisms to facilitate public awareness of the availability of a community health insurance option; and
- alternative payment structures under a community health insurance option for health care providers that encourage quality improvement and cost control.

Voluntary Nature - Individual and Provider Participation [As found in Sec. 1323(a) of the Act]
A health care provider is not required to participate in a community health insurance option. Furthermore, an individual may not be required to participate in a community health insurance option.

In a facility controlled by the Federal Government, or by a State, where marketing or promotional materials related to a community health insurance option are made available to the public, making available marketing or promotional materials relating to private health insurance plans shall not be prohibited. Sums as necessary to carry out this Section are appropriated.

Sec. 1324. Level Playing Field.
If certain state or federal laws do not apply to a qualified health plan, a community health insurance option, or a nationwide qualified health plan then those laws will not apply to private insurance plans otherwise offered in the market.

This provision is intended to ensure that the new insurance options available under the PPACA are not granted an advantage in regard to compliance with federal and state laws on:

- guaranteed renewal;
- rating;
- preexisting conditions;
- non-discrimination;
- quality improvement and reporting;
- fraud and abuse;
- solvency and financial requirements;
- market conduct;
- prompt payment;
- appeals and grievances;
- privacy and confidentiality;
- licensure; and

- benefit plan material or information.

PART IV—STATE FLEXIBILITY TO ESTABLISH ALTERNATIVE PROGRAMS

Sec. 1331. State Flexibility to Establish Basic Health Programs for Low-Income Individuals Not Eligible for Medicaid

- The Secretary shall establish a basic health program meeting the requirements of this section under which a State may enter into contracts to offer 1 or more standard health plans providing at least the essential health benefits to eligible individuals in lieu of offering such individuals coverage through an Exchange. A State shall, to the maximum extent feasible, seek to make multiple standard health plans available to eligible individuals within a State to ensure individuals have a choice of such plans. A State may negotiate a regional compact with other States to include coverage of eligible individuals in all such States in agreements with issuers of standard health plans.
- The provisions of **Sec. 1303** shall apply to a State basic health program, and to standard health plans offered through such program, in the same manner as such rules apply to qualified health plans.
- A State may provide that persons eligible to offer standard health plans under a basic health program established under this section may include a licensed HMO, a licensed health insurance insurer, or a network of health care providers established to offer services under the program.
- "Standard heath plan" means a health benefits plan that the State contracts with under this section—
    - under which the only individuals eligible to enroll are eligible individuals;
    - that provides at least the essential health benefits described in the act; and
    - in the case of a plan that provides health insurance coverage offered by a health insurance issuer that has a medical loss ratio of at least 85 percent.

Certifications as to Benefit Coverage and Costs [As found in Sec. 1331(a) of the Act]
The program shall provide that a State may not establish a basic health program unless

- the amount of the monthly premium for the individual and the individual's dependents does not exceed the amount of the monthly premium that the eligible individual would have been required to pay (in the rating area in which the individual resides) if the individual had enrolled in the applicable second lowest cost silver plan offered to the individual through an Exchange; and
- that the cost-sharing required does not exceed the requirement under a platinum plan in the case of an eligible individual with household income not in excess of 150 percent of federal poverty; and
- the cost-sharing required under a gold plan in the case of certain eligible individuals not described elsewhere in the law; and
- the benefits provided under the standard health plans offered through the program cover at least the essential health benefits.

The amount of the monthly premium an individual is required to pay under either the standard health plan or the applicable second lowest cost silver plan shall be determined after reduction for any premium tax credits and cost-sharing reductions allowable with respect to either plan.

Contracting Process [As found in Sec. 1331(c) of the Act]
A State basic health program shall establish a competitive process for entering into contracts with standard health plans, including negotiation of premiums and cost-sharing and negotiation of benefits in addition to the essential health benefits.

Transfer of Funds to States [As found in Sec. 1331(d) of the Act]
If the Secretary determines that a State electing the application of this section meets the requirements of the program, the Secretary shall transfer to the State for each fiscal year for which 1 or more standard health plans are operating within the State the amount determined below. The Secretary shall adjust the payment for any fiscal year to reflect any error in the determinations for any preceding fiscal year.

Use of Funds [As found in Sec. 1331(d) of the Act]
A State shall establish a trust for the deposit of the amounts received and amounts in the trust fund shall only be used to reduce the premiums and cost-sharing of, or to provide additional benefits for, eligible individuals enrolled in standard health plans within the State. Amounts in the trust fund, and expenditures of such amounts, shall not be included in determining the amount of any non-Federal funds for purposes of meeting any matching or expenditure requirement of any federally-funded program.

Eligible Individuals
For the purpose of this provision, an eligible person is a person:

- Who is a resident of the State and is not eligible to enroll in Medicaid;
- Whose income exceeds 133% of federal poverty levels but does not exceed 200% of poverty;
- Who is not eligible for minimum essential coverage or is eligible for an employer sponsored plan that is not considered to be affordable coverage (as determined by Internal Revenue Code provisions); and
- Who is not attained age 65

Eligible individuals are not "qualified individuals" who can be covered by a product offered in an Exchange. Eligible individuals may *not* use the Exchange.

Secretarial Oversight [As found in Sec. 1331(f) of the Act]
The Secretary shall conduct an annual review to ensure state compliance, including:

- eligibility verification requirements for participation in the program;
- the requirements for use of Federal funds received by the program; and
- the quality and performance standards.

Sec. 1332. Waiver for State Innovation.
A State may apply to the Secretary for waiver of all or any requirements with respect to health insurance coverage beginning after January 1, 2017. Such application shall require a comprehensive description of the State legislation and program to implement a plan meeting the requirements for a waiver and a 10-year budget plan that is budget neutral for the Federal Government.

Waiver Consideration and Transparency [As found in Sec. 1332(a) of the Act]
An application for a waiver for state innovation shall be considered by the Secretary in accordance with the regulations described below. Not later than 180 days after the date of enactment of this Act, the Secretary shall promulgate regulations relating to waivers under the law that provide--

- a process for public notice and comment at the State level, including public hearings, sufficient to ensure a meaningful level of public input;
- a process for the submission of an application that ensures the disclosure of the provisions of law that the State involved seeks to waive and the specific plans of the State to ensure that the waiver will be in compliance.
- a process for providing public notice and comment after the application is received by the Secretary, that is sufficient to ensure a meaningful level of public input and that does not impose requirements that are in addition to, or duplicative of, requirements imposed under the

Administrative Procedures Act, or requirements that are unreasonable or unnecessarily burdensome with respect to State compliance;
- a process for the submission to the Secretary of periodic reports by the State concerning the implementation of the program under the waiver; and
- a process for the periodic evaluation by the Secretary of the program under the waiver.

The Secretary shall annually report to Congress concerning actions taken by the Secretary with respect to applications for waivers under this section.

Sec. 1333. Provisions Relating to Offering of Plans in More than One State.

Health Care Choice Compacts [As found in Sec. 1333(a) of the Act]

Not later than July 1, 2013, the Secretary shall, in consultation with the National Association of Insurance Commissioners, issue regulations for the creation of health care choice compacts under which 2 or more States may enter into an agreement under which--

- 1 or more qualified health plans could be offered in the individual markets in all such States but, except as provided below, only be subject to the laws and regulations of the State in which the plan was written or issued;
- the issuer of any qualified health plan to which the compact applies--
    - would continue to be subject to market conduct, unfair trade practices, network adequacy, and consumer protection standards (including standards relating to rating), including addressing disputes as to the performance of the contract, of the State in which the purchaser resides;
    - would be required to be licensed in each State in which it offers the plan under the compact or to submit to the jurisdiction of each such State;
    - must clearly notify consumers that the policy may not be subject to all the laws and regulations of the State in which the purchaser resides; and
    - Shall not take effect before January 1, 2016.

Authority for Nationwide Plans [As found in Sec. 1333(a) of the Act]

Unless a State has "opted out", if an issuer of a qualified health plan in the individual or small group market meets the requirements for a `nationwide qualified health plan, the issuer of the plan may offer the nationwide qualified health plan in the individual or small group market in more than one State; and only the State laws of the State in which such plan is written or issued shall apply to the nationwide qualified health plan with respect to State laws mandating benefit coverage.

Applicable Rules [As found in Sec. 1333(b) of the Act]

The Secretary shall, in consultation with the National Association of Insurance Commissioners, issue rules for the offering of nationwide qualified health plans under this subsection. Nationwide qualified health plans may be offered only after such rules have taken effect.

State Opt-Out [As found in Sec. 1333(b) of the Act]

A State may, by specific reference in a law enacted after the date of enactment of this title, provide that this subsection shall not apply to that State. Such opt-out shall be effective until such time as the State by law revokes it.

Plan Requirements [As found in Sec. 1333(b) of the Act]

With respect to a nationwide qualified health plan, an issuer must meet certain requirements to offer a qualified nationwide plan.

Form Review for Nationwide Plans [As found in Sec. 1333(b) of the Act]
Notwithstanding any contrary provision of State law, at least 3 months before any nationwide qualified health plan is offered, the issuer shall file all nationwide qualified health plan forms with the regulator in each participating State in which the plan will be offered. An issuer may appeal the disapproval of a nationwide qualified health plan form to the Secretary.

State Law Mandating Benefit Coverage by a Health Benefits Plan[As found in Sec. 1333(b) of the Act]
A State law mandating benefit coverage by a health plan is a law that mandates health insurance coverage or the offer of health insurance coverage for specific health services or specific diseases. A state law that mandates health insurance coverage or reimbursement for services provided by certain classes of providers of health care services, or a law that mandates that certain classes of individuals must be covered as a group or as dependents, is not a State law mandating benefit coverage by a health benefits plan.

PART V—REINSURANCE AND RISK ADJUSTMENT

Sec. 1341. Transitional Reinsurance Program for State Individual and Small Group Markets.
Each State must, not later than January 1, 2014, include in Federal standards or State law or regulation requirements regarding exchanges and adopt regulations as developed by the NAIC; and establish or contract with one or more applicable reinsurance entities to carry out the reinsurance program.

Model Regulation [As found in Sec. 1341(b) of the Act]
The Secretary and the National Association of Insurance Commissioners (the `NAIC'), develop model regulations for implementation by the States to regulate the transitional reinsurance required by this provision.

High-Risk Individual; Payment Amounts [As found in Sec. 1341(b) of the Act]
In the regulations to be developed the Secretary shall mandate the method by which individuals will be identified as high risk individuals for purposes of the reinsurance program. The method must include a list of at least 50 but not more than 100 medical conditions that are identified as high-risk conditions.
The regulation must also include the formula for determining the amount of payments that will be paid to health insurance issuers that insure high-risk individuals under this reinsurance program.

Determination of Required Contributions [As found in Sec. 1341(b) of the Act]
The Secretary shall adopt the method for determining the amount each insurer must contribute to the reinsurance program. The law contains several specific mandates that this contribution formula must contain with a total contribution for all States to be equal to Ten Trillion Dollars ($10,000,000,000) for the year 2014. States are permitted to collect amounts above this threshold from carriers.

Applicable Reinsurance Entity [As found in Sec. 1341(c) of the Act]
- An “applicable reinsurance entity” is an entity that may serve as a reinsurer for the Exchange. It must be a not-for-profit organization the purpose of which is to help stabilize premiums during the first 3 years of operation of an Exchange; and
- Which carries out its business to undertake the reinsurance program by coordinating the funding and operation of the risk-spreading mechanisms.

State Discretion [As found in Sec. 1341(c) of the Act]
A State may have more than one applicable reinsurance entity to carry out the reinsurance program under this section within the State and two or more States may enter into agreements to provide for an applicable reinsurance entity to carry out such program in all such States.

Coordination with State High-Risk Pools [As found in Sec. 1341(d) of the Act]
The State shall eliminate or modify any State high-risk pool to the extent necessary to carry out the reinsurance program established under this section. The State may coordinate the State high-risk pool with such program to the extent not inconsistent with the provisions of this section.

Sec. 1342. Establishment of Risk Corridors for Plans in the Individual and Small Group Markets.
The Secretary shall establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016 under which a qualified health plan offered in the individual or small group market shall participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums.
Payments Out (of the Risk Corridor) [As found in Sec. 1342(b) of the Act]
The Secretary must adopt regulations that will pay out to a plan an amount where the plan's allowable costs for any plan year are more than 103 percent but not more than 108 percent of the target amount. The law then mandates that the Secretary pay to the plan an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount.

The regulations must also provide that the Secretary will pay a participating plan's allowable costs for any plan year are more than 108 percent of the target amount in an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.

Payments In [As found in Sec. 1342(b) of the Act]
The Secretary must adopt regulations that require a plan to pay in if the plan's allowable costs for any plan year are less than 97 percent but not less than 92 percent of the target amount, then the plan shall pay an amount equal to 50 percent of the excess of 97 percent of the target amount over the allowable costs. Also, where a participating plan's allowable costs for any plan year are less than 92 percent of the target amount, the plan shall pay an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the excess of 92 percent of the target amount over the allowable costs.

Definitions [As found in Sec. 1342(c) of the Act]
- Allowable Cost is the amount of allowable costs of a plan for any year is an amount equal to the total costs (other than administrative costs) of the plan in providing benefits covered by the plan.
- The target plan amount for any year is an amount equal to total premiums (including premium subsidies under any governmental program), reduced by the administrative costs of the plan.

Sec. 1343. Risk Adjustment
- The Secretary in consultation with the States must establish criteria and methods to be used in carrying out risk adjustment activities.
- Each State shall assess a charge on health plans and health insurance issuers if the risk assumed is less than the average actuarial risk of all enrollees in all plans. The plans do not include self-funded ERISA plans.
- Each State shall provide a payment to health plans and health insurance issuers who have actuarial risk that is greater than the average actuarial risk for all enrollees in all such plans for a year. This does not include self-funded ERISA plans.

Subtitle E—Affordable Coverage Choices for All Americans

PART I—PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS

SUBPART A—PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS

Sec. 1401. Refundable tax credit providing premium assistance for coverage.

- Allows a sliding scale tax credit for the cost of premiums for coverage under a qualified health plan for taxpayers with incomes between 100% and 400% of poverty, beginning in 2014.
- Credits are refundable and advanceable, even for taxpayers that owe no tax. Taxpayers will not have to wait until tax returns are filed before the credit payment is distributed.
- If premium prices grow faster than income, the amount of the credits will be adjusted so that they cover a larger portion of the premium cost.
- Tax credits are not available to taxpayers who are covered in an employer group plan that meets certain affordability standards.
- By 2015, the comptroller is required to study and report on the affordability of coverage and the effect and adequacy of the refundable credits.

Sec. 1402. Reduced cost-sharing for individuals enrolling in qualified health plans.

- Plans must reduce the maximum limits for out-of-pocket expenses for individuals enrolled in qualified health plans whose incomes are between 100% and 400% of the poverty line.
- Federal subsidies will be paid to plans to cover the cost of the reductions.

SUBPART B—ELIGIBILITY DETERMINATIONS

Sec. 1411. Procedures for determining eligibility for Exchange participation, premium tax credits and reduced cost-sharing, and individual responsibility exemptions.

- Establishes a program to verify individual or taxpayer eligibility to purchase plans in the exchanges or to claim income tax credits.
- Requires information about citizenship, income, group plans and provides for coordination with other federal agencies to collect or verify required information.

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

Provides for advance payment of refundable tax credits and cost-sharing reductions directly to health plans on a monthly basis.

Sec. 1413. Streamlining of procedures for enrollment through an exchange and State Medicaid, CHIP, and health subsidy programs.

- Provides for a single eligibility determination process for application to an exchange that automatically notifies individuals of eligibility for Medicaid or CHIP.
- States may elect to provide the single enrollment process in lieu of the federal program.

Sec. 1414. Disclosures to carry out eligibility requirements for certain programs.

- Provides for the IRS to share taxpayer information to facilitate eligibility determinations.

The IRS is authorized to release certain tax information to permit the Health and Human Services Department to determine appropriate cost-share reductions and other eligibility issues. The information is limited to: taxpayer identity information with respect to such taxpayer, the filing status of such taxpayer, the number of individuals for whom certain deductions are permitted, the modified gross income of such

taxpayer (and persons for whom certain deductions are permitted), and any other information as is prescribed by the Secretary by regulation, and the taxable year with respect to which the preceding information relates or, if applicable, the fact that such information is not available.

Sec. 1415. Premium tax credit and cost-sharing reduction payments disregarded for Federal and Federally-assisted programs.
Premium tax credit and cost sharing assistance are not counted as income in determining eligibility for federal programs.

Sec. 10104.
Instructs the Secretary to study whether the application of federal poverty level and whether it may be adjusted to account for variations in cost of living in different areas of the country.

PART II—SMALL BUSINESS TAX CREDIT

Sec. 1421.Credit for employee health insurance expenses of small businesses (as amended by Secs. 10105, 10502, 10503, and 10504).
Provides a tax credit for small employers with fewer than 25 full-time equivalent employees and average annual compensation levels not exceeding $50,000 who provides health care benefits and pays at least half of the premium cost. Credit phases out with employer size and higher employee compensation.

Sec. 10105.
Credit is in effect for tax years starting in 2009.

Sec. 10502.
Authorizes appropriations to HHS for debt service on, or direct construction or renovation of, a health care facility that provides research, inpatient tertiary care, or outpatient clinical services and that meets certain requirements, including that it is critical for the provision of greater access to health care within the state.

Appropriation is $100M for FY 2010.

Sec. 10503.
Establishes Community Health Center Fund to be administered through HHS for expanded and sustained national investment in community health centers. Authorizes mandatory funding to HHS at following levels: $1 billion FY 2011; $1.2 billion FY 2012; $1.5 billion FY 2013; $2.2 billion FY 2014; $3.6 billion FY 2015; and to be transferred to HHS for enhanced funding of National Health Service Corps: $290M FY 2011; $295 FY 2012; $300M FY 2013; $305M FY 2014; and $310M FY 2015.

Sec. 10504.
Requires HHS to establish a 3-year demonstration project in up to 10 states to provide access to comprehensive health care services to the uninsured at reduced fees.

- Possible expansion to additional states after feasibility evaluation by Secretary.
- Each state in which a selected participant is located in will receive up to $2M to establish **and carry out the project.**

SUBTITLE F—SHARED RESPONSIBILITY FOR HEALTH CARE

PART I—INDIVIDUAL RESPONSIBILITY

Sec. 1501. Requirement to maintain minimum essential coverage (as amended by Sec. 10106).

- Requires individuals to maintain "minimal essential health care coverage" beginning in 2014 or incur a tax penalty for every month in which they are uninsured.
- Penalties are phased in and can be up to 2% of income for each non-covered individual but the maximum family penalty is capped at $2,250.
- Provides exceptions for certain low-income individuals, members of Indian tribes, individuals who suffer hardship, individuals who object to health care coverage on religious grounds, individuals not lawfully present in the United States, and individuals who are incarcerated.

Sec. 1502. Reporting of health insurance coverage.

Requires employers and plans to report information about plans and covered individuals to the IRS, beginning in 2014.

PART II—EMPLOYER RESPONSIBILITIES

Sec. 1511. Automatic enrollment for employees of large employers.

Requires employers with 200+ employees to automatically enroll employees in their group plans.

Sec. 1512. Employer requirement to inform employees of coverage options.

- Requires employers to inform employees about the exchange.
- If the employer is providing less than 60% of plan cost they must inform employees about tax credits and cost sharing available to them in the exchange, and about employer health care benefits that will be lost if the employee purchases through the exchange.

Sec. 1513. Shared responsibility for employers.

- Imposes fines on employers with more than 50 full time employees if the employer does not provide minimum essential coverage or imposes waiting periods of more than 60 days and their employees enroll in exchange-provided plans using federal tax credits or cost-sharing assistance.
- Fines can be up to $3,000 per employee who obtains exchange coverage but capped at $750 per total number of employees.
- Full time employees are those that work an average of 30 or more hours per week. The total number of employees may not include seasonal workers under some conditions.

Sec. 1514. Reporting of employer health insurance coverage.

Requires employers with more than 50 full time employees to report information about the health plan coverage they offer, including the plan premium and employer contribution. Employers must also provide information identifying their employees and reporting the enrollment of employees and dependents in the offered plans.

Sec. 1515. Offering of Exchange-participating qualified health plans through cafeteria plans.

Small employers and, starting in 2017, some large employers may allow employees to enroll in exchange-provided plans.

Sec. 10602.
Addresses and clarifies the use and publication of subsequent use of patient centered outcomes research, requiring the researcher to enter into a data use agreement with the Institute for use of the data from the original research.

Sec. 10606.
Provides for stringent fraud sentencing guidelines, and underscores the "need for aggressive and appropriate law enforcement" for health care fraud, and increases penalties for persons convicted of such offenses. With respect to intent for health care fraud, a person need not have actual knowledge of this section or specific intent to commit a violation of this section. The Department of Justice may require subpoena access to any institution or documents relating to any institution that is the subject of an investigation, to determine whether there are any conditions which deprive persons residing or confined to the institution of any rights protected by the Constitution.

Sec. 10607.
Provides for demonstration grants to States for the development, implementation and evaluation of alternatives to current tort litigation for dispute resolution regarding injuries allegedly caused by health care providers or organizations. It provides grants for a period of up to 5 years.

- State desiring a grant shall develop an alternative to current tort litigation that:
    - Allows for dispute resolution of injuries allegedly caused by health care providers or health care organization;
    - Promotes a reduction of health care errors by *encouraging the collection and analysis of patient safety data* by organizations that engage in efforts to improve patient safety and the quality of health care.
- State shall demonstrate how the proposal makes medical liability system more reliable by:
    - Increasing prompt and fair resolutions to disputes;
    - Encourages efficient resolution of disputes;
    - *Encouraging the disclosure of health care errors*;
    - Enhancing patient safety by detecting, analyzing, and helping to reduce medical errors and adverse events;
    - Improving access to liability insurance;
    - Fully informing patients of the difference between litigation and the alternative;
    - Providing patients the ability to opt out of the alternative;
    - Not conflicting with State law that would prohibit the adoption of an alternative;
    - Not limiting a patient's existing legal rights or otherwise abrogate a patient's ability to file a medical malpractice claim.
- Medicare Payment Advisory Commission (MEDPAC) and the Medicaid and CHIP Payment and Access Commission (MACPAC) shall conduct an independent review of the alternatives to current tort litigation, and shall submit a report to Congress.

Sec. 10608.
Adds free clinics to Federal Medical Malpractice Coverage Protections.

Sec. 10609.
Allows for labeling changes, not related to warnings, to be made without considering a drug misbranded.

Subtitle G—Miscellaneous Provisions

Sec. 1551. Definitions.
Definitions of insurance terms from the Public Health Service Act apply to this legislation.

Sec. 1552. Transparency in government.
A list of all new authorities provided to the Secretary of Health and Human Services will be posted on HHS website within 30 days.

Sec. 1553. Prohibition against discrimination on assisted suicide.
Prohibits discrimination against individuals, facilities or organizations that decline to provide assisted suicide, euthanasia, or mercy killing. Does not apply to or affect any limit related to: (1) the withholding or withdrawing of medical treatment or medical care; (2) the withholding or withdrawing of nutrition or hydration; (3) abortion; or (4) the use of an item, good, benefit, or service furnished for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so long as it is not also furnished for the purpose of causing, or the purpose of assisting in causing, death, for any reason.

Sec. 1554. Access to therapies.
No regulation is permitted that:

- creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care or impedes timely access to health care services;
- interferes with communications regarding a full range of treatment options;
- restricts the ability of health care providers to provide full disclosure of all relevant information to patients making health care decisions;
- violates the principles of informed consent and ethical standards of health care professionals; or
- limits the availability of health care treatment for the full duration of a patient's medical needs.

Sec. 1555. Freedom Not to participate in Federal Health Insurance Programs.
Health plans are not required to participate in any federal program.

Sec. 1556. Equity for certain eligible survivors.
Technical amendment to the Black Lung Benefit Act.

Sec. 1557. Nondiscrimination.
Prohibits discrimination by any federal health program on the grounds of race, color, national origin, sex, age, or disability.

Sec. 1558. Protections for employees.
Prohibits employer discrimination against employees who receive benefits in an exchange or against employees who report violations.

Sec. 1559. Oversight.
Inspector General of the Department of Health and Human Services has oversight authority.

Sec. 1560. Rules of construction.
Provision of this act have no effect on anti-trust provisions, on Hawaii's Prepaid Health Care Act, nor on the ability of Universities to offer student health plans.

Sec. 1561. Health information technology enrollment standards and protocols.
Within 180 days, HHS must establish standards for information exchange to facilitate eligibility determination systems and issue grants to develop the eligibility and enrollment systems.

Sec. 1562. Conforming amendments.
Technical revisions

Sec. 10107.
Requires a study of health plan denials.

Sec. 1562. (as amended by by Sec. 10107) GAO Study on Rate of Denial
The GAO shall study the rate of denials for medical services and the reasons for which those services were denied. The study shall be performed on a sample basis and is to be completed in a year.

Sec. 1563. Sense of the Senate promoting fiscal responsibility.
Provides that savings should be reserved for the Social Security program or for the CLASS program.

TITLE II—ROLE OF PUBLIC PROGRAMS

Subtitle A—Improved Access to Medicaid

Sec. 2001, 2101, 10201. Medicaid coverage for the lowest income populations, Additional Financial Federal participation for CHIP, Amendments to Social Security Act Title II of this act. (Medicaid and CHIP Maintenance of Effort)
Prohibits states from establishing more restrictive eligibility requirements or procedures than what is in place on the date of the bill's enactment. The provision applies to adults Medicaid enrollees through January 1, 2014 (when the state Exchange becomes operational) and for children's Medicaid and CHIP until October 2019. This means, for example, the state cannot reduce enrollment in Medicaid CHIP by reducing eligibility or erecting more onerous paperwork requirements. States with budget deficits can seek an exemption for this requirement for adult enrollees with incomes above 133 percent of poverty, except pregnant women or patients with disabilities. It's not clear how the provision applies to patients in nursing homes, though HHSC interprets the provision to include them.

Expands Medicaid to children and adults under age 65 to 133 percent of the federal poverty level, including childless adults. Currently, Texas covers working parents up to 20 percent of the federal poverty level and up to 13 percent of poverty for non-working parents (those on TANF). Childless, healthy adults are not currently eligible. States will have the option to expand coverage to adults as early as April 2010. As in current law, undocumented immigrants are not covered except in an emergency. (Note: for children with incomes at or below 133 percent of poverty who are now enrolled in CHIP, they will be transitioned to Medicaid in 2014). Effective 2014.

Federal matching and payment during the expansion of Medicaid: (Sec. 2001, with amendments in Sec. 1201, HR 4872): 2014-2016 = 100 percent federal funding for expansion population; 2017 = 95 percent; 2018 = 94 percent; 2019 = 93 percent; 2020 forward = 90 percent. Effective 2014.

Medicaid coverage for newly enrolled adults will be based on a benchmark benefit package, which is less generous than the current Medicaid package but will cover essential services, including physician and hospital services, preventive health care, prescription drugs, and mental health. Benchmark package must also comply with mental health parity provisions. Benchmark benefit plans are the actuarial equivalent of one of the following: the largest commercial HMO in the state, the Blue Cross Blue Shield PPO for federal employees, or a package developed by the state and approved by the Secretary. Effective 2014.

Sec. 2002. Income Eligibility for Non-Elderly
To determine an applicant's income, requires states to use an individual's or household's modified gross income to determine income eligibility for Medicaid for non-elderly individuals, without applying any income or expense disregards or assets or resources test. Effective 2014.

Sec. 2003. Requirement to Offer Premium Assistance.
Requires states to offer premium assistance subsidy for employer-sponsored coverage to children under age 19 to extend such a subsidy to all individuals, regardless of age; prohibits a state from requiring, as a condition of Medicaid eligibility, that an applicant (or the parent) apply for enrollment in qualified employer-sponsored coverage. Effective 2014.

Sec. 2004. Medicaid Coverage for Former Foster Care Children [As modified by Sec. 10201]
Requires states to extend Medicaid up to age 25 for children who spent six months or more in foster care (under current Texas law, foster children up to age 23 can continue to receive Medicaid if they are attending college.)

Sec. 2005. Payments to Territories
Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa receive funding under this provision.

Sec. 2006. Special Adjustment for FMAP in certain States.
This section applies only to the State of Louisiana and the Congressional Budget Office has estimated its impact as One Hundred Million Dollars ($100,000,000). Great controversy over this section of the bill.

Effective immediately: Reduces projected decreases in Medicaid funding for States that have experienced major, statewide disasters *(Sec. 2006)* Effective. 2014.

Sec. 2007. Medicaid Improvement Fund Rescission.
This modifies the Medicaid Improvement Fund. This does not impact Texas.

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

Sec. 2101. (As amended by 10201).
Additional federal financial participation for Children's Health Insurance Program (CHIP)
Continues funding through 2015. As noted above, states must maintain current CHIP eligibility until October 2019. Law maintains current rules regarding CHIP benefits and cost-sharing. Effective immediately.

Increases federal CHIP matching rate by 23 percent for each state up to a cap of 100 percent. If federal allotments for CHIP are insufficient and result in states establishing waiting lists, specifies that the children will be eligible for subsidies under the health care exchange. Effective 2015.

Requires states to use a modified gross income standard to determine income eligibility. Effective 2014.

Effective after 2015 states may enroll CHIP-eligible children in health plans participating in the Exchange if the plan is certified by the Secretary to offer comparable benefits and cost-sharing as what is available under the state CHIP plan

Subtitle C—Medicaid and CHIP Enrollment Simplification

Sec. 2201. Enrollment Simplification.
Requires states to simplify Medicaid enrollment, including the ability to apply and reapply electronically, and to establish a coordinated, single web-based pathway for people to apply for coverage and be screened for eligibility simultaneously for coverage available through the health care Exchange, Medicaid, or CHIP. Beginning in 2014.

States must undertake efforts to increase outreach and enrollment of "vulnerable" Medicaid patients, including homeless children, children with special health care needs, and pregnant women. For children's Medicaid and CHIP enrollees who have coverage through the Exchange, the state must ensure coordination of services for well-child services not available under a qualified health plan. Also by 2014.

Requires states to offer coverage via the Exchange for working-age Medicaid-eligible adults (and their family) if their income is between 100 percent and 133 percent of poverty and the enrollee is not pregnant. Beginning in 2014:

Sec. 2202. Permitting Hospitals to Make Presumptive Eligibility Determinations.
Permits hospitals to provide Medicaid services during a period of presumptive eligibility to members of all Medicaid eligibility categories. Effective 2014.

Subtitle D—Improvements to Medicaid Services

Sec. 2301. Coverage for Free-Standing Birthing Centers.
Requires Medicaid coverage for free-standing birthing centers that are licensed or otherwise approved by the state. The provision specifies a state shall make separate payments to providers "administering prenatal labor and delivery or postpartum care" in the FSBC, including nurse midwives and other provides, including "birth attendants" recognized under state law. A birth attendant is defined as someone who is "recognized or registered by the state" to provide health care at childbirth or who provides such care within their scope of practice as defined by the state "regardless of whether the individual is under the supervision of, or associated with, a physician or other health care provider. Nothing in this subparagraph shall be construed as changing State law requirements applicable to a birth attendant.'' Effective immediately.

Sec. 2302. Concurrent Care for Children
Specifies that children receiving hospice services under Medicaid and CHIP do not waive their rights to other services for which they are entitled under Medicaid.

Sec. 2303. State Eligibility Option
Eliminates the need of states to obtain a waiver to establish a Medicaid family planning program. Instead, states may implement the program as an optional Medicaid benefit. Eligibility will be based on the highest eligibility level currently offered in the state under Medicaid or CHIP for pregnant women, which in Texas Medicaid is 185 percent of poverty. Texas currently operates a family planning program via waiver. The program, known as the "Women's Health Program," provides family planning services, excluding abortion, to women ages 18-45. Services included under the program include pap smears, breast exams, and contraceptives. Effective immediately.

Requires that Medicaid payment rates to primary care physicians for furnishing primary care (as defined by HCPCS) services be no less than 100% of Medicare rates in 2013 and 2014. Provides federal funding for the incremental costs to states for meeting this requirement.

Sec. 2304. Clarification of Medical Assistance.
This modifies the definition referred to above.

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

Sec. 2401. Community First Choice Option.
Establishes an optional Medicaid benefit allowing states to offer community-based attendant services and supports to Medicaid patients with disabilities who otherwise would require hospital or nursing facility level of care. Beginning Oct. 1, 2011.

Sec. 2402A. Remove Barriers to Home Services.
Removes barriers to providing Home and Community-Based Services (HCBS). Beginning in Oct. 1, 2011.

Sec. 10202.
Provides enhanced federal matching funds for states that undertake efforts to increase the number of Medicaid enrollees receiving home and community-based care in lieu of placing patients in a nursing home.

Sec. 2403. Money Follows the Person.
Extends authorization of the federal Money Follows the Person demonstrations.

Sec. 2404. Protection for Recipients of Home Services Against Spousal Impoverishment.
Protects against spousal impoverishment in all Medicaid home and community based services programs by requiring states to apply the same spousal impoverishment rules currently applied to the spouses of nursing home residents.

Sec. 2405. Funding to Expand State Aging and Disability Resource Centers.
Allocates funding to continue function of Aging and Disability Resource Centers through 2014.

Sec. 2406. Sense of the Senate on Long-Term Care.
Expresses send of the Senate that Congress should address LTC services in a comprehensive way that guarantees elderly and disabled patients the care they need and that LTC services should be made available within the community as well as institutions.

Sec. 2501. Prescription Drug Rebates.
Increases the federal Medicaid matching rate for most brand-name prescription drugs by 23.1 percent; for generic, non-innovator drugs, the rebate is increased by 13 percent. Effective in January 2010.

Extends prescription drug rebates to Medicaid managed care plans. Currently in Texas, prescription drug coverage for Medicaid HMO enrollees is administered by the state and not the health plans. Effective in 2010.

Subtitle F—Medicaid Prescription Drug Coverage

Sec. 2502. Elimination of Exclusion of Coverage for Certain Drugs.
Adds Medicaid coverage for FDA-approved smoking cessation products, barbiturates and benzodiazepines. Effective 2014.

Sec. 2503. Providing Adequate Reimbursement for Pharmacies.
This provision modifies the amount of reimbursement pharmacies receive under Medicaid. The calculation of the Average Manufacturers Price is adjusted to modify payment for generic drugs.

Subtitle G—Medicaid Disproportionate Share Hospital (DSH) Payments

Sec. 2551. Disproportionate Share Hospital Payments.
(Sec. 2551 and Sec. 10201 and as amended subsequently by Sec. 1203, Reconciliation Act)
Reduces Medicaid disproportionate share payments to hospitals by $18 billion between 2014 to 2020 as follows: 2014: $500 million; 2015: $600 million; 2016: $600 million; 2017: $1.9 billion; 2018: $5 billion; 2019: $5.6 billion; 2020: $4 billion.

The majority of the cuts will occur in 2018 through 2020. Cuts will predominantly impact states with the lowest percent of uninsured patients and where DSH payments do not target their DSH payments on: hospitals with high volumes of Medicaid inpatients and hospitals that have high levels of uncompensated care (excluding bad debt). Effective 2014.

Subtitle H—Improved Coordination for Dual Eligible Beneficiaries

Sec. 2601. 5-Year Period for Certain Demonstration Projects.
Certain waivers granted that provides medical assistance for dual eligible individuals (including any such waivers under which non dual eligible individuals may be enrolled in addition to dual eligible individuals) may be conducted for a period of 5 years and, upon the request of the State, may be extended for additional 5-year periods unless the Secretary so decides the project is not cost-effective or efficient.

Sec. 2602. Federal Coverage for Dual Eligible Beneficiaries.
Establishes a Coordinated Health Care Office within CMS with goal of improving integration of Medicare and Medicaid services for dually-eligible patients and improving coordination between the federal government and the states. Specific responsibilities include simplifying the process for dual eligibles to access services they need either under Medicare or Medicaid; improving the quality of medical and long-term care services; eliminating regulatory conflicts between Medicare and Medicaid; improving continuity of care; and eliminating cost-shifting between Medicare and Medicaid. Effective March 2010.

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

Sec. 2701. Adult Health Quality Measures.
Requires the Secretary to specify core quality measures for the adult Medicaid population (measures for children are already required as part of the 2009 CHIP reauthorization act). The Secretary must look to measures already in place for public or private health plans and that are applicable to the adult Medicaid population. Within 12 months of publishing the core quality measures, the Secretary shall establish a Medicaid Quality Measurement Program in the same manner as now required for children. States will be required to annually report on the quality of care provided to adult Medicaid enrollees. Measures will be updated every 2 years. Effective 2012.

Sec. 2702. Payment Adjustment for Health Care Acquired Conditions
Prohibits Medicaid payments for Hospital-Acquired Conditions as determined by the Secretary. Requires the Secretary to identify state-based initiatives to deny payments for Hospital-Acquired Conditions and to incorporate the best practices that are applicable to Medicaid into federal regulations. Additionally, the law directs the Secretary to align Medicare and Medicaid HAC payment policies to the extent that Medicare payment restrictions are applicable to Medicaid. (note: Starting after Oct. 1, 2008, CMS no longer reimburses hospitals a higher rate for hospital-acquired conditions not present on admission. For dual-eligible patients, CMS instructed states to align Medicaid payment policy with Medicare. In 2009, CMS also issued national coverage determination prohibiting payment for certain medical errors, such as wrong site surgery. Texas Medicaid will abide by this policy as well). Effective July 2011.

Sec. 2703. State Option to Provide Health Homes.
Allows states to set up medical home programs for patients with two or more chronic conditions, one chronic condition, but at risk of developing others, or who has severe persistent mental illness. The Secretary must specify qualifications for qualified medical homes, but at a minimum, the medical home – or team -- must have the ability to provide comprehensive care management, care coordination, health promotion, referral to community and social services, and health information technology to facilitate timely sharing of data. Physicians, rural health clinics, federally qualified health centers, community mental centers, home health entity, or other entities capable of fulfilling medical home responsibilities may be designated. Provides 90 percent federal matching rate for two years for states that pursue this option. Effective 2011.

Sec. 2704. Demonstration Project Regarding Integrated Care Around Hospitalization.
Authorizes a new bundled payment pilot in up to 8 states to integrate payment for services provided in a hospital and concurrent physician services. Requires the Secretary to ensure that payments are adjusted for severity of illness and other characteristics, among other requirements. States could target selected populations, diagnoses, or geographic regions. Participating hospitals required to establish robust discharge planning processes to ensure patients have access to post-acute care. Effective 2012.

Sec. 2705. Medicaid Global Payment System Demonstration Project.
Authorizes new global capitation payment demonstration for safety-net hospital systems or networks. CMS may select up to five states to participate. Effective 2010.

Sec. 2706. Pediatric Accountable Care Organizations.
Establishes a pilot program to evaluate "Pediatric Accountable Care Organizations" in Medicaid. Participating physicians and providers would be eligible to receive a portion of any savings achieved by improving patient care and lowering costs. To be eligible to serve as an ACO, an entity must agree to participate for at least three years. In consultation with the states and pediatric providers, the Secretary will develop guidelines to ensure quality of care in pilot is no less than the care provided outside of it. States, in consultation with Secretary, will establish benchmark savings goal. Effective 2012.

Sec. 2707. Medicaid Emergency Psychiatric Care Demonstration Project.
Directs Secretary to establish a three-year pilot in up to 8 states to allow Medicaid coverage in an Institution of Mental Disease to patients 21 to 65 who are in need of emergency stabilization services. States must apply to participate in the pilot and will be competitively selected. Under current federal Medicaid law, IMD services for adults are excluded from coverage. Effective in 2012.

Subtitle J—Improvements to Medicaid and CHIP Payment and Access Commission (MACPAC)

Sec. 2801. MACPAC Assessment.
Provides funding for the Medicaid and CHIP Payment Access Commission (MACPAC) and expands its role to include Medicaid-enrolled adults, including dual-eligibles. Congress established MACPAC in 2009 as part of the CHIP reauthorization act, but did not fund it at that time. **(50) MACPAC is modeled on the Medicare Payment Advisory Commission. The new entity, which has already been appointed, will evaluate Medicaid and CHIP payment and regulatory policies that undermine Medicaid and CHIP patients' ability to obtain timely health care services. MACPAC and MEDPAC must consult with each other on issues of mutual concern.** Beginning in 2010.

Secs. 2901 and 2902. Special Rules Relating to Indians.
These provisions create special rules and eliminate the sunset of reimbursement for all Medicare Part B services furnished by certain Indian hospitals and clinics.

Subtitle L—Maternal and Child Health Services

Sec. 2951. Maternal, Infant, and Early Childhood Visits.
Provides funding to states to develop and implement evidence-based Maternal, Infant and Early Childhood Visitation models (such as the Nurse-Family Partnership) with the goal of improving maternal and newborn health, reducing rates of child injury and abuse, improving school-readiness for children, and improving self-sufficiency of low-income families. Beginning in 2011.

Sec. 2952. Support, Education, and Research for Postpartum Depression.
Allows the Secretary to provide grants to states to educate the public about post-partum depression as well as to establish and operate cost-effective services for women who have or are at risk of developing post-partum depression. Beginning in 2010.

Sec. 2953. Personal Responsibility Education.
Provides $75 million per year through FY 2014 to states for programs to promote "personal responsibility" including the education of adolescents on abstinence and contraception for the prevention of teenage pregnancy and sexually transmitted infections. Beginning in 2010.

Secs. 10211-10214.
Relates to establishing a Pregnancy Assistance Fund to support Pregnant and Parenting Teens and Women. The fund is limited to providing support under the terms of this provision. For instance, funds may be distributed to colleges and universities to support students and offer, among other things, items such as maternity and baby clothing, baby food (including formula), baby furniture, and similar items to assist parents and prospective parents in meeting the material needs of their children. Education efforts and parenting classes are permitted and supported. Education related to and funds regarding domestic violence is made available.

Sec. 2954. Restoration of Funding for Abstinence Education.
Restores funding for abstinence education. Beginning in 2010.

Sec. 2955. Inclusion of Information About Importance of Having a Health Care Power of Attorney.
Requires the case review system for children aging out of foster care and independent living programs to include information about the importance of having a health care power of attorney in transition planning.

Sec.1202. Reconciliation Act (HR 4872).
Increases Medicaid payments to Medicare parity for primary care services provided by family physicians, general internists, and pediatricians. Primary care services are defined as evaluation and management services or vaccine administration (not all codes billed by PCPs). States will receive 100 percent federal match for the higher Medicaid payments. A key issue for Texas will be enhancing rates for physicians not defined as "primary care" under the new law, including OBGyns and subspecialists, as well as whether to extend increases to CHIP. Effective 2013 and 2014.

TITLE III: IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE

Subtitle A: Transforming the Health Care Delivery System

PART I: LINKING PAYMENT TO QUALITY OUTCOMES UNDER THE MEDICARE PROGRAM

Sec. 3001. Hospital Value-Based purchasing program.
The Secretary is charged to establish a value-based purchasing demonstration programs for: (1) inpatient critical access hospital services; and (2) hospitals excluded from the program because of insufficient

numbers of measures and cases. Essentially hospitals may receive incentive payments for meeting certain standards and measures as may be required by the Secretary.

In the case of a hospital that the Secretary determines meets (or exceeds) the performance standards, the Secretary shall increase the base operating DRG payment by an amount as provided by the statute. The various measures and standards must be developed.

Sec. 10335.
Makes technical corrections to Hospital Value-Based Purchasing Program.

Sec. 3002. Improvements to the physician quality reporting system.

- PQRI incentive payments extended through 2014.
- PQRI penalties begin in 2015.
- Creates informal appeals process for physicians to review determination that one did not satisfactorily report by 2011.
- Integration of PQRI and EHR reporting by 2012.

The 2010 incentive payment for satisfactorily reporting PQRI measures is 2%. In 2011, the incentive payment drops to 1% and for 2012, 2013 and 2014 the incentive payment drops to 0.5%. In 2015 a penalty of -1.5% will be applied to eligible professionals who did not satisfactorily report and in 2016, and forward; a -2.0% penalty will be assessed. Feedback to eligible professionals on their reporting performance must happen in a timely fashion. There's no definition as to what "timely" is referring to. In addition, by Jan. 1, 2011, an informal appeals process must be in place so eligible professionals who reported but where determined to not have satisfactorily reported can ask for a review. By Jan. 1, 2012 a plan should be in place that would integrate physician quality reporting and EHR reporting.

Sec. 10327.
Provides additional incentive payments to physicians who report and meet quality measures. The increase is .5 percent. A physician who meets certain quality measures and reports through a Maintenance Certification Program is eligible for an additional incentive payment.

Sec. 3003. Improvements to the physician feedback program.

- Confidential reports, composed of claims data and other information, will be made available to physicians (or groups of physicians) measuring resources involved in furnishing care.
- Episode groupers will be created by Jan. 1, 2012.
- Details of episode groupers will be made available to the public.
- Physician comparison reports showing resource use will be made available in 2012.

Episode groupers (combines separate but clinically related items and services into an episode of care for an individual) will be developed by Jan. 1, 2012 and details will be made public. In addition, reports comparing patterns of resource use of individual physicians to patterns of other physicians will be made available in 2012. Adjustments to the reports will be made to account for differences in socioeconomic and demographic characteristics, ethnicity, and health status of individuals. The methodology will be made available to the public. Doesn't allow for administrative or judicial review.

Sec. 10331.
Requires public reporting of Performance Information. Requires the Secretary shall develop a Physician Compare Internet Site on Physicians Enrolled in Medicare and the report shall include, to the extent that scientifically sound measures are developed, information regarding physicians' quality and efficiency. The plan must permit a physician to "review" his results before they are made public. The program must

assure an accurate portrayal of a physician's performance, reflect the care "provided to all patients" in Medicare and "other payors," include appropriate attribution of care when multiple physicians deliver care, ensure timely statistical performance feedback, and use computer systems that will support valid and accurate reporting. In developing the plan the Secretary shall consider how the government can transition to a "value based purchasing system" for health care. The Secretary may also develop a demonstration project to create financial incentives for beneficiaries who receive care from "high quality" physicians. A beneficiary may not be required to pay an increased cost-share.

Sec. 3004. Quality reporting for long-term care hospitals, inpatient rehabilitation hospitals, and hospice programs.
The secretary shall require quality reporting for long-term care hospitals, inpatient rehabilitation hospitals, and hospice programs.

Sec. 3005. Quality reporting for PPS-exempt cancer hospitals.
The secretary shall require quality reporting for PPS-exempt cancer hospitals.

Sec. 3006. Plans for a Value-based purchasing program for skilled nursing facilities and home health agencies.
The secretary shall require plans for a Value-based purchasing program for skilled nursing facilities and home health agencies.

Sec. 10325.
Amendment prevents the implementation of version 4 of the Resource Utilization Groups) as proposed and adopted in the Federal Register on August 11, 2009 and entitled "Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2010."

Sec. 3007. Value-based payment modifier under the physician fee schedule.

- Payment modifier developed for differential payment under physician fee schedule based on quality of care compared to cost.
- The value-based payment adjustment is intended to cut payments to physicians whose patients are incurring higher-than-average Medicare cost unless the physician's patient population rates equally high in the available quality measures. Conversely, it will provide payment increases to physicians when measured quality is high and Medicare cost is low.
- Publication of measures, dates of implementation and performance period to be published by Jan. 1, 2012.
- Information to be provided to physicians regarding the quality of care furnished compared to cost.
- Payment modifier rolled out in two parts: select physicians – Jan. 1, 2015; all physicians – Jan. 1, 2017.
- Payment modifier is budget neutral.

Appropriate measures of quality of care will be established. These measures will be risk adjusted. By Jan. 1, 2012, quality of care and cost measures, implementation dates for modifier and initial performance period will be published. Physicians to be provided with information on the quality of care they provide compared to cost. The payment modifier will be used for specific physicians beginning Jan. 1, 2015. The payment modifier will be used for all physicians beginning Jan. 1. 2017. Special circumstances for physicians in rural areas and underserved communities will be taken into consideration. No administrative or judicial review is provided.

Sec. 10301.
Requires implementation of Value-Based Purchasing for ASC services. The Secretary shall modify payment to ASCs utilizing measures and the reporting, collection, and validation of quality reporting data. Payments to ASCs will then be adjusted according to thresholds or improvements in quality. The information collected shall be reported to the public.

Sec. 3008. Payment adjustment for conditions acquired in hospitals.
Section provides for incentive payments where hospital acquired infections are reduced.

PART II: NATIONAL STRATEGY TO IMPROVE HEALTH CARE QUALITY
Sec. 3011. National Strategy

- Directs the Secretary to establish a national strategy to improve the delivery of health care services, patient health outcomes, and population health
- The Secretary shall identify priorities that have the greatest potential to improve outcomes, efficiency, and patient-centeredness, address gaps in quality and improve Federal payment policy to emphasize quality and efficiency
- Deadline for national strategy: January 1, 2011

Sec. 3012. Interagency Working Group on Health Care Quality
The President shall convene a working group to be known as the Interagency Working Group on Health Care Quality to achieve collaboration and cooperation between Federal Departments and agencies and avoid inefficient duplication of quality improvement efforts and resources.

Sec. 3013. Quality Measure Development (As amended by Sec. 10303)

- Directs the Secretary, at least triennially, to identify gaps where no quality measures exist as well as existing quality measures that need improvement, updating, or expansion, consistent with the national strategy for use in federal health programs. The information will be made public on an internet website.
- Directs the Secretary to award grants, contracts, or intergovernmental agreements to eligible entities for purposes of developing, improving, updating, or expanding such quality measures.
- Requires the Secretary to develop and update periodically provider-level outcome measures for hospitals and physicians, as well as other appropriate providers.
- The Secretary shall create outcome measures for use in identifying gaps in quality.

The Secretary shall create clinical measures and revisit them every three years. The measures must address the 5 most prevalent and resource intensive acute and chronic medical conditions and outcomes for primary care that address chronically ill adults and healthy children. The measures shall be adopted in 2 years for acute/chronic conditions. The measures for primary care shall be adopted in 3 years.
This Section also amends the Patient and Providers Act of 2008 to require the development and identification of best methods.

Sec. 3014. Quality Measurement
Requires the convening of multi-stakeholder groups to provide input into the selection of quality and efficiency measures.

Sec. 10304.
Adds Efficiency and quality standards.

Sec. 3015. Data Collection; Public Reporting. (As amended by Sec. 10305).

- Secretary to establish an overall framework for public reporting of performance information
- The Secretary shall collect data on quality and resource use measures from information systems used to support health care delivery to implement public reporting of performance information
- Authorizes the Secretary to award grants to eligible entities to support new, or improve existing, efforts to collect and aggregate quality and resource use measures
- Secretary to make information on quality measures available to the public through internet.
- Secretary shall develop a plan to carry out public reporting of performance information.
- Secretary can provide grants to other parties for the collection and aggregation of the quality and efficiency measures from information systems used to support health care delivery.

Sec. 10306.

Allows Secretary to limit testing of the new delivery models to certain geographic areas.

PART III: ENCOURAGING DEVELOPMENT OF NEW PATIENT CARE MODELS

Sec. 3021. Establishment of Center for Medicare and Medicaid Innovation within CMS

- Creates within CMS a Center for Medicare and Medicaid Innovation (CMI)
- The purpose of the CMI is to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals.
- Secretary shall ensure that CMI is carrying out described duties not later than January 1, 2011.
- Secretary shall select models to be tested from models where the Secretary determines that there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures.
- Selection of models to be tested:
    - Patient-centered medical home models for high-need applicable individuals, medical homes that address women's unique health care needs, and models that transition primary care practices away from fee-for-service based reimbursement and toward comprehensive payment or salary-based payment
    - Contracting directly with groups of providers to promote innovative care delivery models, such as through risk-based comprehensive payment or salary-based payment
    - Utilizing geriatric assessments and comprehensive care plans to coordinate the care (including through interdisciplinary teams)
    - Promote care coordination between providers of services and suppliers that transition health care providers away from fee-for-service based reimbursement and toward salary-based payment
    - Supporting care coordination for chronically-ill applicable individuals at high risk of hospitalization through a health information technology-enabled provider network that includes care coordinators, a chronic disease registry, and home tele-health technology
    - Varying payment to physicians who order advanced diagnostic imaging services according to the physician's adherence to appropriateness criteria
    - Utilizing medication therapy management services
    - Establishing community-based health teams to support small-practice medical homes
    - Assisting applicable individuals in making informed health care choices by paying providers for using patient decision-support tools
    - Allowing States to test and evaluate fully integrating care for dual eligible individuals in the State and allowing States to test and evaluate systems of all-payer payment reform for the medical care of residents of the State
    - Aligning nationally recognized, evidence-based guidelines of cancer care with payment incentives

    - Improving post-acute care through continuing care hospitals that offer inpatient rehabilitation, long-term care hospitals, and home health or skilled nursing care during an inpatient stay and the 30 days immediately following discharge
    - Funding home health providers who offer chronic care management services to applicable individuals in cooperation with interdisciplinary teams
    - Facilitate inpatient care, including intensive care, of hospitalized applicable individuals at their local hospital through the use of electronic monitoring by specialists, including intensivists and critical care specialists, based at integrated health systems.
    - Encouraging the use of best practices
    - Establishing comprehensive payments to Healthcare Innovation Zones
- The Secretary shall not require that the design model is budget neutral.
- The Secretary may expand the duration and the scope of a model (including implementation on a nationwide basis) through rulemaking

Sec. 3022. Medicare Shared Savings Program

- Not later than January 1, 2012, the Secretary shall establish a shared savings program that promotes accountability for a patient population and coordinates items and services under parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery.
- Groups of providers of services and suppliers meeting criteria specified by the Secretary may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an accountable care organization
- An ACO must meet the following requirements:
    - Must be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it
    - The ACO shall enter into an agreement with the Secretary to participate in the program for not less than a 3-year period
    - The ACO shall have a formal legal structure that would allow the organization to receive and distribute payments for shared savings
    - The ACO shall include primary care ACO professionals that are sufficient for the number of Medicare fee-for-service beneficiaries. At a minimum, the ACO shall have at least 5,000 such beneficiaries assigned to it to be eligible to participate in the ACO program.
    - The ACO shall demonstrate to the Secretary that it meets patient-centeredness criteria the use of individualized care plans.
- ACO shall submit data in order to evaluate the quality of care furnished by the ACO. Such data may include care transitions across health care settings, including hospital discharge planning and post-hospital discharge follow.
- The Secretary may incorporate reporting requirements and incentive payments related to the physician quality reporting initiative (PQRI) under section 1848.

Sec. 10307.

Allows Secretary to implement differing payment models in the Medicare Shared Savings Program. Secretary is authorized to limit the partial capitation model to ACOs that are highly integrated systems of care and capable of bearing risk. The ACO model may not be paid more, in total, than would have otherwise been paid under traditional payment methods.

Sec. 3023. National Pilot Program on Payment Bundling

- Directs the Secretary to establish a pilot program for integrated care (involving payment bundling) for an episode of care provided to an applicable beneficiary around a hospitalization in order to improve the coordination, quality, and efficiency of health care services

- The Secretary will choose which conditions are applicable (will choose a total of eight).
- An episode of care includes 3 days prior to the admission to a hospital for an applicable condition, the length of stay in a hospital, and 30 days following the discharge of the patient.
- Pilot program will be established by January 1, 2013 and conducted over a five-year-period.
- The Secretary shall develop payment methods for the pilot program which may include bundled payments and bids from entities for episodes of care

Sec. 3024. Independence at Home Demonstration Program

- The Secretary shall conduct a demonstration program to test a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams designed to reduce expenditures and improve health outcomes.
- An independence at home medical practice is comprised of an individual physician or nurse practitioner or group of physicians and nurse practitioners that provides care as part of a team that includes physicians, nurses, physician assistants, pharmacists, and other health and social services staff as appropriate who have experience providing home-based primary care to applicable beneficiaries, make in-home visits, and are available 24 hours per day, 7 days per week to carry out plans of care that are tailored to the individual beneficiary's chronic conditions
- The demonstration program shall test whether a model which is accountable for providing comprehensive, coordinated, continuous, and accessible care to high-need populations at home and coordinating health care across all treatment settings, results in reducing preventable hospitalizations, preventing hospital readmissions, reducing emergency room visits, improving health outcomes commensurate with the beneficiaries' stage of chronic illness, improving the efficiency of care, and achieving beneficiary and family caregiver satisfaction.
- The entity shall report on quality measures and report to the Secretary such data as the Secretary determines appropriate to monitor and evaluate the demonstration program.
- Program shall begin no later than January 1, 2012

Sec. 3025. Hospital Readmissions Reduction Program

- Reduces Medicare payments that would otherwise be made to hospitals to account for preventable hospital readmissions
- Directs Secretary to make available a program for hospitals with a high severity adjusted readmission rate to improve their readmission rates through use of patient safety organizations.

Sec. 10309.

Revises the formula in this section.

Sec. 3026. Community-based Care Transitions Program

The Secretary shall establish a Community-Based Care Transitions Program under which the Secretary provides funding to eligible entities that furnish improved care transition services to high-risk Medicare beneficiaries.

Sec. 3027. Extension of Gainsharing Demonstration

Amends the Deficit Reduction Act of 2005 to extend certain Gainsharing Demonstration Projects (demonstration projects to test and evaluate methodologies and arrangements between hospitals and physicians designed to govern the utilization of inpatient hospital resources and physician work to improve the quality and efficiency of care provided to Medicare beneficiaries) through FY2011

Sec. 10308.

Amendment addresses payment bundling. Now 10 conditions must be covered by the pilot and the secretary may expand the pilot if it will reduce spending.

SUBTITLE B—IMPROVING MEDICARE FOR PATIENTS AND PROVIDERS

PART I—ENSURING BENEFICIARY ACCESS TO PHYSICIAN CARE AND OTHER SERVICES

Sec. 3101. *Repealed*. Sec. 10310 Repeals the Physician Payment Update in Sec. 3101.

Sec. 3102. Extension of the work geographic index floor and revisions to the practice expense geographic adjustment under the Medicare physician fee schedule.

- "Extends" the work GPCI floor which expired on 1/1/10, through 2010.
- Change made to the GPCI and its effect on fees is retroactive to Jan 1, 2010.
- Reduces the impact of practice expense variations in the Medicare geographic adjustors with stepped phase-in for 2010 and 2011. The net effect will be a small (1-3%) increase in 2010 fees for "Rest of Texas", Beaumont, and Brazoria, and smaller changes for other areas.
- HR 4872 Sec. 1108 eliminates the stepped phase-in (above), slightly increasing the 2010 impact.
- Requires CMS to analyze various options for revising the methodology for determining geographic adjustors, with emphasis on using different data sources, and revising weights WITHIN the practice expense component.
- Starting in 2012, charges CMS to use better data on office rents and medical office staff cost in calculating geographic adjustments.

Sec. 10324.
Creates protections for a limited subset of States with sparse populations – North Dakota, South Dakota, Utah, Montana, and Wyoming - (Texas does not qualify) a floor is created in regard to Medicare payment adjustments (Hospitals in Frontier States have a payment floor implemented and physicians have the practice expense index set to 1.00 if such index would otherwise be less than 1.00) Budget neutrality is waived.

Sec. 3103. Extension of exceptions process for Medicare therapy caps.
Extends the therapy cap exception process through 2010.
Sec. 3104. Extension of payment for technical component of certain physician pathology services.
Extends through 2010, the exception that allows pathologists to bill Medicare directly for the technical component of pathology services provided to patients of certain grandfathered hospitals.

Sec. 3105. Extension of ambulance add-ons.
Re-instates certain expired increases to ground and air ambulance fees effective April 1 through the remainder of 2010.

Sec. 10311.
Extends increases through 2011.

Sec. 3106. Extension of certain payment rules for long-term care hospital services and of moratorium on the establishment of certain hospitals and facilities.
Extends an exception to certain payment rules for long-term care hospitals and a moratorium on the development or expansion of LTC hospitals through the end of the year.

Sec. 10312.
Extends payment rules through 2011.

Sec. 3107. Extension of physician fee schedule mental health add-on.

Extends the expired provision for a 5% mental health add-on until the end of 2010.

Sec. 3108. Permitting physician assistants to order post-Hospital extended care services.
Allows physician assistants – along with clinical nurse specialist and nurse practitioners – and working in collaboration with a physician, to certify need for post-Hospital extended care services for Medicare payment

Sec. 3109. Exemption of certain pharmacies from accreditation requirements.

- Delays the DME accreditation requirements for pharmacies until 2011.
- Exempts existing pharmacies from the DME accreditation requirement if they derive less than 5% of their revenues from DME sales.

Sec. 3110. Part B special enrollment period for disabled TRICARE beneficiaries.
Allows disabled Tricare beneficiaries an extended period to enroll in Medicare, without the usual premium increase.

Sec. 3111. Payment for bone density tests.

- Provides that dual-energy x-ray absorptiometry services are paid, during 2010 and 2011, at the lesser of 70% of the 2006 RBRVS-calculated fee or the OPD limit. This is an increase over current fee schedule value. Effective date is not clear but it appears to be retroactive.
- Directs the Institute of Medicine to study and report on the effects of the payment reduction

Sec. 3112. Revision to the Medicare Improvement Fund.
Removes 2014 funding for the Medicare Improvement Fund (Note – looks like there is a typographical error in the dollar amount, over stating the previous funding by $20B)

Sec. 3113. Treatment of certain complex diagnostic laboratory tests.
Directs CMS to conduct a demonstration project beginning in 2011, to develop separate payments for complex diagnostic laboratory test, defined as analyses of gene protein expression, topographic genotyping, or cancer chemotherapy sensitivity assays.

Sec. 3114. Improved access for certified nurse-midwife services.
Increase payments of CNMW services from 65% to 100% of comparable physician payments beginning January 1, 2011.

PART II: RURAL PROTECTIONS

Sec. 3121. Extension of outpatient hold harmless provision

- Extends "hold harmless" provisions under the prospective payment system for hospital outpatient department services through 2010.
- Removes the 100-bed limitation for sole community hospitals so all such hospitals receive an 85% increase in the payment difference in 2010.

A hospital located in a rural area and that has not more than 100 beds and that is not a sole community hospital for certain outpatient services furnished on or after January 1, 2006, and before January 1, 2011,the amount of payment under this subsection shall be increased by the applicable percentage of the amount of such difference. For purposes of the preceding sentence, the applicable percentage shall be 85 percent of with respect to such services furnished in 2008 or 2009 or 2010.

- In the case of a sole community hospital for covered outpatient services furnished on or after January 1, 2009, and before January 1, 2011, the amount of paid by the government is increased by 85 percent of the difference in 2010.

Sec. 3122. Extension of Medicare reasonable costs payments for certain clinical diagnostic laboratory test furnished to hospital patients in certain rural areas
Amends the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to extend from July 1, 2010, until July 1, 2011, the reasonable cost reimbursement for clinical diagnostic laboratory service for qualifying rural hospitals with under 50 beds.

Sec. 3123. Extension of the Rural Community Hospital Demonstration Program
Extends the Rural Community Hospital Demonstration Program (the program tests the feasibility and advisability of providing reasonable cost reimbursement for small rural hospitals) for an additional year immediately following the initial five-year period. Expands the maximum number of participating hospitals to 30. Also expands the number of demonstration states with low population densities to 20.

Sec. 10313.
Extends the program for an additional five years and is expanded to 20 states at the Secretary's discretion

Sec. 3124. Extension of the Medicare-dependent hospital program
Extends the Medicare-dependent Hospital Program through fiscal year 2012 (Payment for an MDH's inpatient operating costs are the sum of the Federal payment rate plus half of the amount that exceeds the Federal payment rate based on the highest hospital specific base year costs per discharge for Medicare beneficiaries from 1982 or 1987, trended forward)

Sec. 3125. Temporary improvements to the Medicare inpatient hospital payment adjustment for low-volume hospitals
Temporarily increases the payment to low volume hospitals. For discharges occurring in FY 2011 and 2012, the Secretary shall determine a percentage increase for low-volume hospitals ranging from 25 percent for hospitals with 200 or fewer discharges of Part A Medicare individuals to 0 percent for low-volume hospitals with greater than 1,500 discharges of such individuals.

Sec. 10314.
Expands to include hospitals with 1,600 discharges per year and improves and expands Prospective Payment System Payments.

Sec. 3126. Improvements to the demonstration project on community health integration models in certain rural counties
Includes physician services in the demonstration project and allows additional counties to participate (was limited to six)

Sec. 3127. MedPAC study on adequacy of Medicare payments for rural health care providers
Directs MEDPAC to study and report to Congress on the adequacy of payments for items and services furnished by service providers and suppliers in rural areas under the Medicare program. Includes the analysis of: (1) any adjustments in payments to providers of services and suppliers that furnish items and services in rural areas; (2) access by Medicare beneficiaries to items and services in rural areas; (3) the adequacy of payments to providers of services and suppliers that furnish items and services in rural areas; and (4) the quality of care furnished in rural areas.

Sec. 3128. Technical correction related to critical access hospital services
Allows critical access hospitals to be eligible to receive 101% of reasonable costs for providing outpatient care (regardless of the eligible billing method the hospital uses) and qualifying ambulance services.

Sec. 3129. Extension of and revisions to Medicare rural hospital flexibility program
Extends through fiscal year 2012 FLEX grants under the Medicare Rural Hospital Flexibility Program. Allows the use of grant funding to assist small rural hospitals to participate in delivery system reforms (such as value-based purchasing programs, ACOs, the national pilot program for bundled payments, and other delivery system reforms).

PART III IMPROVING PAYMENT ACCURACY

Sec. 3131. Payment adjustments for home health care.

- Payment methodology for home health to change starting in 2013. Payment to take into consideration factors such the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other factors that the Secretary considers to be relevant.
- Take into consideration differences between hospital-based and freestanding agencies, between for-profit and nonprofit agencies, and between the resource costs of urban and rural agencies.
- 4 year phase in of the change in payment methodology
- MedPAC will study access to care, quality outcomes; the number of home health agencies; and; rural agencies, urban agencies, for-profit agencies, and nonprofit agencies.
- Additional study to evaluate the costs and quality of care among efficient home health agencies relative to other such agencies in providing ongoing access to care and in treating Medicare beneficiaries with varying severity levels of illness.

Secretary will conduct study to review home health services and intensity of services provided to beneficiaries. The Secretary will then devise methods to revise payment for home health services to improve access to needed care. Poverty levels and population density must be considered in the study. A demonstration project will then be initiated to determine if the payment adjustments improve access to care.

Sec. 10315.
Requires Secretary to conduct a study of home health services in medically underserved areas.

Sec. 10316.
Amendment modifies and reduces DSH payments to reflect the belief the reform bill will reduce the uninsured and uncompensated care.

Sec. 3132. Hospice reform.
Study to be started by January 1, 2011 to determine if revisions of payments for hospice care are necessary.

By October 1, 2013 revisions to the methodology for determining the payment rates for routine home care and other services included in hospice care payments should be implemented.

Sec. 3133. Improvement to Medicare disproportionate share hospital (DSH) payments (Amended by Sec. 10316 and Sec. 1104 of the Reconciliation Bill).

- Applicable to payment to Medicare DSHs
- Payment revisions start in 2015
- Reducing payment to 25% of current allowed amount
- Additional payment to hospitals based on numerous factors to be calculated

- Continue to monitor since it impacts hospitals
- Additional payment to hospitals based on numerous factors to be calculated
- Sec. 1104 of the Reconciliation Bill modifies the provisions in this section to delete references to 2015 and replace them with 2014. Thus, the payment revisions will begin in 2014.

Sec. 3134. Misvalued codes under the physician fee schedule

- Establishes a process for CMS to revise relative values independently from the AMA Relative Value Update Committee's (RUC's) work. Allows CMS to commission their own studies, employ contractors and gather data independently.
- Codes that will be targeted for revision include;
    - Codes and families of codes for which there has been the fastest growth, or that have experienced substantial changes in practice expenses
    - Codes for new technologies or services within the first few years after initial values were established
    - Multiple codes that are frequently billed in conjunction with furnishing a single service
    - Codes with low relative values, particularly those that are often billed multiple times for a single treatment
    - Codes which have not been subject to review since the implementation of the RBRVS

Sec. 3135. Modification of equipment utilization factor for advanced imaging services

- Changes RVUs for advanced imaging equipment – modified in reconciliation bill (below)
- Technical component discount on single session imaging involving consecutive body parts to increase from 25% to 50% for services provided on or after July 1, 2010
- HR4872 Sec. 1107 - Reduces RVUs and payments for 2011 and thereafter by requiring an assumption that equipment is used at 75% of capacity.

Sec. 3136. Revision of payment for power-driven wheelchairs

This section limits the benefits for power-driven wheelchairs such that for rentals of such chairs, the payment is limited to 15 percent of the purchase price for each of the first three months and then to six percent of the purchase price for each of the remaining ten months of a powered wheelchair rental.

The purchase of a power driven wheel chair is limited to only chairs for "complex, rehabilitative" power wheelchairs. This means that lump-sum purchases for wheelchairs that are not for complex, rehabilitative wheelchairs are not permitted.

Sec. 3137. Hospital wage index improvement

According to the Senate Committee report "A hospital wage index is used to adjust the standardized amount to account for the local wage variation or cost of labor in the hospital's area. Medicare defines hospital labor market areas using definitions of statistical areas established by the Office of Management and Budget (OMB)…. There is a statutory requirement that the wage index for any urban area in a state cannot be less than the rural wage index of that state (often referred to as the rural floor)…. Section 508 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 provided $900 million for a one-time, three year geographic reclassification of certain hospital who were otherwise unable to qualify for administrative reclassification to areas with higher wage index values." This provision extends the section 508 classifications and then commands the Secretary to promulgate a plan to modify/reform the current wage index values and calculations. The plan is due December of 2011.

Sec. 10317.

Amendment prevents a decrease in payment for 508 classified hospitals without regard to the current wage index. It also requires increased payments to facilities that are reclassified.

Sec. 3138. Treatment of certain cancer hospitals

- Study to determine ambulatory payment classification groups exceed those costs incurred by other hospitals furnishing services
- Take into consideration cost of drugs and biologicals incurred by such hospitals
- Potentially impacts hospital reimbursement

Sec. 3139. Payment for biosimilar biological products

- Payment to be calculated on ASP plus 6 % of amount to be determined.
- Biosimilar biological products defined as a biological product approved under an abbreviated application for a license of a biological product that relies in part on data or information in an application for another biological product licensed under Public Health Service Act.
- Effective date of payment change yet to be determined

Sec. 3140. Medicare hospice concurrent care demonstration program.

- 3 year demonstration project to include no more than 15 hospice programs in both rural and urban areas
- Study to determine if demonstration program improved patient care, quality of life, and cost-effectiveness for Medicare beneficiaries participating in the program

Sec. 3141. Application of budget neutrality on a national basis in the calculation of the Medicare hospital wage index floor

- Directs that the budget neutrality requirement associated with the imputed rural floor on the area wage index shall be implemented via a national adjustment rather than a state-by-state adjustment to the area hospital wage index floor.
- Effective for discharges occurring on or after October 1, 2010

Sec. 3142. HHS study on urban Medicare-dependent hospitals

Directs the Secretary to study and report to Congress the Medicare inpatient margins of urban Medicare dependent hospitals as compared to other hospitals to determine the need for additional payments.

Sec. 3143. Protecting home health benefits

Nothing in the provisions of, or amendments made by, this Act shall result in the reduction of guaranteed home health benefits under title XVIII of the Social Security Act.

SUBTITLE C – PROVISIONS RELATING TO PART C

Sec. 3201. Medicare Advantage payment (Repealed by Sec. 1102 of the Reconciliation Bill).

- ~~Modifies Medicare Advantage plan payments to reduce payments starting in 2011.~~
- ~~Implements MA plan bonus programs based on measures of clinical quality and enrollee satisfaction~~
- ~~Establishes financial penalties if medical loss ratio falls below 85% staring in 2014.~~
- ~~Exempts PACE programs from competitive bidding requirements.~~
- ~~Other competitive bidding provisions~~

Sec. 1102 of the Reconciliation Bill strikes the modifications to Medicare Advantage plan payments and substitutes a new method of reducing payments to Medicare Advantage plans. The various systems for benchmarking plans is modified by this provision. Medicare Advantage plans will be rated on a five-star basis on "quality." Carriers that fail to report will be rated no higher than 3.5 stars. Beneficiaries are eligible for greater rebates if they participate in a high rated plan.

Sec. 1103 of the Reconciliation Bill imposes a requirement that Medicare Advantage plans maintain a medical loss ratio of at least 85%. Where a plan fails to meet the measure, the plan must remit the difference between the actual performance and the 85% required ratio. Also, a plan that fails to meet this measure may not engage in new enrollment for 3 years.

Sec. 10318.
Makes minor modifications to extra benefits Under Medicare Advantage.

Sec. 3202. Benefit protection and simplification.
Limitations will be placed on certain cost-sharing for certain benefits, i.e. chemotherapy administration services, renal dialysis services, skilled nursing care, and other services the Secretary feels appropriate. Cost-sharing for these services may not exceed the cost-sharing required for those services under traditional Medicare, parts A and B. For plan years Jan. 1, 2012 and after, rebates, bonuses, and supplemental premiums must be applied fully and in this order: 1) cost sharing reduction, 2) preventive care and wellness benefits coverage, and 3) other benefits not covered under traditional Medicare. Effective January 1, 2011,

Sec. 3203. Application of coding intensity adjustment during MA payment transition (Repealed by Sec. 1102 of the Reconciliation Bill).
~~To ensure payment accuracy, an analysis will be done to show differences between coding patterns in traditional Medicare vs. MA plans. Results will be incorporated into risk scores for 2011 and onward.~~

Sec. 3204. Simplification of annual beneficiary election periods.
- Revises some annual requirements for annual beneficiary election periods.
- Effective 2011, beneficiaries who have elected coverage under an MA plan may switch back to traditional fee-for-service Medicare within the first 45 days of the year.

Sec. 3205. Extension for specialized MA plans for special needs individuals.
- Extension of special needs plans (SNP) through 2013.
- Ability to apply frailty adjustments under PACE payment rules, effective 2011 and onward.
- For 2012 onward, requirement for SNPs to be NCQA approved.
- Improvements to risk adjustment for special needs individuals with chronic health conditions.
- Publication of evaluations and any revisions made.

Sec. 3206. Extension of reasonable cost contracts.
Extension of reasonable cost contracts through 2012.

Sec. 3207. Technical correction to MA private fee-for-service plans.
Effective 2011 and forward, service area extension waiver policy extended to employers who contract directly with the Secretary as a MA private fee-for-service and that had enrollment as of Oct. 1, 2009.

Sec. 3208. Making senior housing facility demonstration permanent.
Creates new type of MA plan called Senior Housing Facility Plan that: 1) restricts enrollment to individuals who reside in a continuing care retirement community, 2) provides primary care services onsite and has a certain ratio of accessible physicians to beneficiaries, 3) provides transportation services for beneficiaries to specialty providers outside the facility, and 4) has participated in a demonstration project. Effective Jan. 1, 2010.

Sec. 3209. Authority to deny plan bids.
If an MA plan or PDP sponsor submits bids that propose significant increases in cost-sharing or decreases in benefits, the Secretary may reject/deny the bid. Effective for contract years beginning Jan. 1, 2011.

Sec. 3210. Development of new standards for certain Medigap plans.
The development of new standards for certain Medigap plans will be done with the assistance of the National Association of Insurance Commissioners (NAIC). Implementation of revised standards to be effective in benefit packages as of Jan. 1, 2015.

SUBTITLE D – MEDICARE PART D IMPROVEMENTS FOR PRESCRIPTION DRUG PLANS & MA-PD PLANS

Sec. 3301. Medicare coverage gap discount program (as amended by Sec. 1101 of the Reconciliation Bill).
A Medicare coverage gap discount program is to be established no later than ~~July 1, 2010~~ January 1, 2011. A model agreement with drug manufacturers will be established by ~~April 1, 2010~~ 180 days after the date of the enactment to give time for a comment period. The agreement will require the manufacturer to provide beneficiaries access to discounted prices for drugs. Manufacturer under an agreement is subject to audits and civil money penalties. Medicare beneficiaries will receive a rebate for the Medicare drug benefit for the year 2010. Subsequent years will see discounts from the charge of generic and brand name drugs on an increasing basis until 2020, when the discount will reach 75%, thereby eliminating the "donut hole" in prescription drug coverage.

Sec. 3302. Improvement in determination of Medicare Part D low-income benchmark premium.
Excludes MA rebate amounts and quality bonus payments from calculation of the low-income benchmark premium. Applies to premiums for months beginning on or after Jan. 1, 2011.

Sec. 3303. Voluntary de minimis policy for subsidy eligible individuals under prescription drug plans for MA-PD plans.
- Waiver of premiums permitted by a MA or MA-PD plan for subsidy eligible individuals if the amount of such premium is de minimis.
- Subsidy eligible individuals can be auto-enrolled in plans that waive de minimis premiums.

Sec. 3304. Special rule for widows and widowers regarding eligibility for low-income assistance.
Special rule allowed for widows and widowers, whose spouse dies during the effective period for a determination or redetermination for low-income assistance, that such effective period should be extended 1 year from date on which determination/redetermination would otherwise cease to be effective. Effective Jan. 1, 2011.

Sec. 3305. Improved information for subsidy eligible individuals reassigned to prescription drug plans and MA-PD plans
Patients enrolled in one drug plan that are switched to a new drug plan must be notified within 30 days of the change of the formulary changes and their appeal rights. Effective January 1, 2011.

Sec. 3306. Funding Outreach and Assistance for Low-Income Programs
State Health Programs to receive $7.5 M in 2009; $15 M in 2010 through 2012. Aging and Disability Resource Centers to receive $5 M in 2009 and $10 M in 2010 through 2012. National Center for Benefits and Outreach Enrollment to receive $5 M in 2009 and $5 M in 2010 through 2012.

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

PDP sponsors will be required to include all covered Part D drugs but they may limit access to such drugs through prior authorization or utilization management rules. These drugs include anticonvulsants, antidepressants, antineoplastics, antipsychotics, antiretrovirals and immunosuppressants for treatment of transplant rejection. These changes are applicable to PDP plan year 2011 and all subsequent plan years.

Sec. 3308. Reducing Part D Premium Subsidy for High-Income Beneficiaries

- Requires part D enrollees with income above $85,000 for an individual or $170,000 for a family to pay higher premiums for Medicare part D plans, starting in 2011.
- No later than September 15 of each year, the amount of the base beneficiary premium for the following year will be disclosed.
- The increased premium will be paid through withholding from social security benefit payments.
- Allows the IRS to share income information needed to make adjustments.

Sec. 3309. Elimination of Cost Sharing for certain Dual Eligible Individuals

Elimination of cost sharing for full-benefit dual eligible institutionalized individuals or couples if they receive services under a home and community-based waiver, State plan amendment or Medicaid managed care organization. Effective as early as January 1, 2012

Sec. 3310. Reducing Wasteful Dispensing of Outpatient Prescription Drugs in Long-term Care Facilities Under Prescription Drug Plans and MA-PD Plans

Requires PDPs to utilize specific, uniform dispensing techniques, such as weekly, daily or automated dose dispensing, for covered part D drugs to enrollees who reside in long-term care facilities in order to reduce waste associated with 30-day fills. Effective to plan years beginning after January 1, 2012

Sec. 3311. Improved Medicare Prescription Drug Plan and MA-PD Plan Complaint System

Requires the development and maintenance of a complaint system on MA-PD and prescription drug plans. The system must be able to initiate appropriate interventions, monitor complaints and to guide quality improvement. The development of a model electronic complaint form must also be developed and be displayed by website. Annual reports on the system must also be submitted to Congress.

Sec. 3312. Uniform Exceptions and Appeals Process for Prescription Drug Plans and MA-PD Plans

Requires the use of a single, uniform exception and appeals process for the determination of prescription drug coverage for an enrollee under PDPs and MA-PD plans. Instant access to the process must be provided to enrollees through a process such as an internet website or toll-free telephone number. Effective on or after January 1, 2012

Sec. 3313. Office of the Inspector General Studies and Reports

The Inspector General of the Department of Health and Human Services must conduct a study of the extent to which formularies used by PDPs and MA-PD plans under part D, include drugs commonly used by full-benefit dual eligibles. A report on the study, along with recommendations must be provided not later than July 1 of each year, beginning 2011.

A study must also be conducted on prices for covered part D drugs and covered outpatient drugs under Title XIX. Study requirements include a comparison of the 200 most frequently dispensed covered part D drugs and covered outpatient drugs under such title as determined by the Inspector General based on volume and expenditures. The comparison must include specific pricing information. Authority is given to collect any information related to prices, necessary to carry out the comparison. A report on the study,

along with recommendations must be provided to Congress not later than October 1, 2011. The report must not include any information that is determined proprietary by the Inspector General.

Sec. 3314. Including Costs Incurred by AIDS Drug Assistance Programs and Indian Health Service in Providing Drugs Toward the Annual Out-of-Pocket Threshold Under Part D
Adds AIDS drug assisted programs and Indian Health Service costs to the permissible out-of-pocket thresholds under the prescription program in Part D. Applies to costs incurred on or after January 1, 2011.

Sec. 3315. Immediate Reduction in Coverage Gap in 2010 (This section is repealed by Sec. 1101, Reconciliation Bill).
~~Increases the initial coverage limit by $500 for the plan year beginning January 1, 2010. The increase does not change premiums or bids, or any other parameters and there is no effect on subsequent years. Procedures must be established which may include a reconciliation process to fully reimburse PDPs and MA-PDs for reductions in beneficiary cost sharing. Requires the development of an estimate of the additional costs associated with increased drug utilization, financing and administrative costs to the PDPs and MA-PDs. The estimate must be used to adjust payments to these plans. Retroactive reimbursement procedures must also be established for retroactive reimbursement as of January 1, 2010.~~

Sec. 10312.
Extends the billing DRGs contained in 42 USC 1395ww for an additional year.

Sec. 10323.
Allows Medicare Coverage for Persons Exposed to certain Health Hazards who would otherwise be ineligible for such coverage. The persons who may qualify were in an emergency declaration area on June 17, 2009 and those who suffer from asbestos related diseases. Budget Neutrality is waived for this section. Funding for this program is $23 million per year until 2014 and $20 million for each 5 year period thereafter.

Sec. 10326.
Amendment implements a pilot for pay-for-performance incentives and disincentives for Long-term Care Hospitals, Rehabilitation Hospitals, PPS-Exempt Cancer Hospitals, and Hospice Programs. Amounts greater than would otherwise be paid to such entities are not authorized.

Sec. 10330.
Requires HHS to plan and prepare a budget for the modernization of CMS computer systems. No funding is provided.

Sec.10332.
Requires HHS to provide, for a fee, Medicare claims data to qualified public and private entities to permit those entities to evaluate the performance of "providers of services." The qualified entities must, *generally*, use standard measures, such as measures endorsed by the entity with a contract with the government and developed under Sec. 931 of the public health act which is added by Sec. 3013 of the Patient Protection and Affordable Care Act relating to grants and contracts to create measures and standards. The qualified entity must make the rating confidentially available to the physician prior to publication and provide an opportunity to appeal and correct errors. The qualified entity must agree to publish results in a report that meets the requirements of the law in order to receive the data.

Sec. 10333.
Establishes a Collaborative Care Network as a consortium of "health care providers" with a joint governance structure that provides "comprehensive coordinated and integrated health care services" to deliver care to low-income populations. The network must have, at least, a hospital and "all federally

qualified health centers" located in a community. Funds must be used to assist low-income individuals to access and "appropriately" use health services; enroll in health coverage programs, and obtain a regular "primary care provider" or medical home. Case management must also be provided, health outreach using "neighborhood health workers." Grant funds must be used provide transportation, expand capacity through telehealth, after-hours services, or urgent care, and provide direct patient care services.

Sec. 10336.
Requires GAO to conduct a study on the impact on Medicare beneficiaries access to high-quality dialysis and oral drugs provided in the treatment of end stage renal disease. The report shall contain recommendations for legislation and administrative action.

SUBTITLE E—ENSURING MEDICARE SUSTAINABILITY

Sec. 3401. Revision of Certain Market Basket Updates and Incorporation of Productivity Improvements into Market Basket Updates That do not Already Incorporate Such Improvements

- Payment reductions occur should a psychiatric hospital fail to report quality data.
- The Secretary will specify certain quality measures for reporting by psychiatric hospitals. The information then reported regarding such measures will be available to the public.

Revises market basket updates and incorporates a full productivity adjustment into any updates that do not already incorporate such adjustments, including inpatient hospitals, home health providers, nursing homes, hospice providers, inpatient psychiatric facilities, long-term care hospitals, inpatient rehabilitation facilities, and Part B providers.

Sec. 10319.
Revises the Market Basket Adjustments. The amendments to 3401 extend its terms by two years. Hospice care sees a reduction in its market basket payments as do outpatient hospitals and long term care.

Section 1105 furthers decreases the market basket update to the fee schedules for inpatient hospitals and rehabilitation facilities, psychiatric and long-term care hospitals, and for outpatient hospital services by applying higher productivity adjustments for 2014 and an even larger adjustment for 2017 through 2019.

Sec. 10322.
Quality measures for psychiatric hospitals will be adopted by the Secretary for the purpose of public reporting regarding those measures. Payment will be reduced should a hospital not report the quality data as required by the Secretary. The measures will be selected in 2012 for reporting beginning in 2014.

Sec. 3402. Temporary Adjustment to the Calculation of Part B Premiums
Continues the 2010 income thresholds for part B premiums for the period of January 2011 through December 2019.

Sec. 3403. Independent Medicare Advisory Board
Establishes an Independent Medicare Advisory Board for the purpose of reducing the per capita rate of growth in Medicare spending. The Board must develop detailed and specific proposals related to the Medicare program. Proposals may be submitted to Congress beginning January 15, 2014.

Proposal requirements are defined. Recommendations must result in a net reduction in total Medicare spending. Recommendations shall not include any provision that would ration health care, raise revenues, increased beneficiary premiums, increased cost sharing or reduce payment rates for services prior to December 31, 2018. Proposals may include, as appropriate, reductions to payments under part C and D, however may not affect the base beneficiary premium percentage. Priority may be given to

recommendations that improve health care delivery, protect access, consider effects of changes in payments to beneficiaries and providers and that consider the unique needs of Medicare beneficiaries.

Requires establishment of a Consumer Advisory Council to advise the Board regarding impact of payment policies on consumers. Consumer Advisory Council meetings will be open to the public.

The Comptroller General of the United States must conduct a study on changes to payment policies and how the changes will impact beneficiaries.

Sec. 10320.
Requires Independent Payment Advisory Board to submit an annual report to Congress even in years when a proposal is not forwarded. The amendment also requires an annual public report which focuses upon health care costs, patient access, utilization, and quality of care. The Secretary is commanded ensure the information reflects the most local level possible.

SUBTITLE F—HEALTH CARE QUALITY IMPROVEMENTS

Sec. 3501. Health Care Delivery System Research; Quality Improvement Technical Assistance

- The Center for Quality Improvement and Patient Safety of the Agency for Healthcare Research and Quality (the "Center") through research must develop training and innovative methodologies that represent "best practices" in health care quality, safety and value.
- The Center must support research which may include establishment of a Quality Improvement Network Research Program (the "Program").
- Research findings must be made available to the public and coordinated with the Office of the National Coordinator of Health Information Technology.
- Technical assistance contracts or grants will be awarded to eligible entities to provide to institutions and providers (including urban and rural providers with limited infrastructure and financial resources, and those with poor performance scores).

Health care provider associations and professional societies are eligible for these contracts.

Research requirements under the Program are defined including the ability to address concerns by providers, must support processes that take into account clinical research and comparative effectiveness research, adaptable in a variety of settings and expand demonstration projects for improving quality of children's health care and HIT. Any entity awarded a contract or grant must agree to make available non-Federal contributions in an amount equal to $1 for each $5.

Sec. 3502. Establishing Community Health Teams to Support the Patient-Centered Medical Home

- Establishment of program to provide grants or contracts to eligible entities to establish health teams to support primary care practices, including obstetrics and gynecology.
- Eligible entities must be a State or State-designated entity or an Indian tribal or tribal organization.
- Program will include capitated payments to primary care providers.
- The health team must include an interdisciplinary, interprofessional team and can include doctors of chiropractic and licensed complementary and alternative medicine (CAM) practitioners.

The entity must provide services to individuals with chronic conditions. Health team activities are defined. The health team's support must include access to pharmacist delivered medication management services, coordination of CAM, 24-hour care management during transitions in care settings and must demonstrate capability to implement and maintain requirements of certified EMR technology.

Sec. 10321.
Revises reference to “physician” to read "physicians or other primary care providers".

Sec. 3503. Medication Management Services in Treatment of Chronic Disease

- Establishment of grants or contracts to eligible entities to implement medication management (MTM) services provided by licensed pharmacists, as a multidisciplinary approach to improve quality of care and reduce cost.
- Targets individuals that take 4 or more prescribed medications, that take any high risk medications, have 2 or more chronic diseases or have undergone a transition of care.
- Effective no later than May 1, 2010.

MTM services provided to targeted individuals must include performing health and functional status of patients, formulation of medication treatment plan agreed upon by the prescriber, recommending or administering medication therapy, monitoring which may include ordering or performing laboratory assessments. Recommendations by the pharmacist must be communicated to other health care providers in a timely fashion, however timeframe is not defined. It is also noted that other patient care services allowed under pharmacist scopes of practice in use in other Federal programs that have implemented MTM services, are allowed. Reports must be submitted to Congress which includes assessments of patient-cost sharing, economic outcomes and possible conflicts of interest for participating pharmacists.

Sec. 10328.
Requires Part D programs to evaluate the management of beneficiaries and the drugs they use. The programs are to see that beneficiaries are appropriately taking their prescription medications and must include, at a minimum, a person to person or telehealth medication review "by a licensed pharmacist or other qualified provider." Changes can be recommended with "input from the prescriber." Enrollees are given an annual opportunity to opt out of the program.

Sec. 3504. Design and Implementation of Regionalized Systems for Emergency Care.
Directs the Secretary to award at least 4 competitive, multi-year grants to states, a coalition of states, or Indian tribes to support the development of “innovative models of regionalized, comprehensive, and accountable” emergency medical and trauma systems. Entities that receive grants will have to provide matching funds. Beginning in 2010.

Directs Secretary to support federal initiatives to expand and increase emergency medical research, including pediatric emergency medical services, with the goal of improving health outcomes and the delivery of emergency medical services, evaluating the role of pediatric emergency services as an integrated component of the overall health system, and enhancing system-wide pediatric emergency care planning. Beginning in FY 2010.

Sec. 3505. Trauma Care Centers and Service Availability.
Establishes a new trauma center grant program for Indian trauma services as well grants to promote universal access to trauma care services provided by trauma centers and trauma-related physician specialties. Grant funding will be available to states. States will in turn provide funding to trauma centers. Public and nonprofit trauma centers as well as safety-net trauma providers are eligible for funding as well as hospitals operating in underserved areas of the state that agree to establish new trauma services. Trauma centers may use the grant dollars to, among other things, support physician compensation in trauma-related physician specialties where there are shortages, reduce overcrowding, establish new trauma services in underserved areas, enhance trauma surge capacity, and expedite transport of patients. Grant dollars may only be awarded if the state agrees that it will use the funds to supplement existing trauma expenditures and not supplant them. Beginning in FY 2010.

Sec. 3506. Program to Facilitate Shared Decision-making

- Purpose is to engage patients, caregivers or authorized representatives and clinicians in decision making. The program also provides information regarding treatment options and incorporates patient preferences and values in the medical plan.
- Allows for establishment of contract with an entity to endorse and develop patient decision aids for preference sensitive care. Contract term is 18 months.
- No specific timeframe for first contract established, bill states "as soon as practicable after the date of the enactment of this section".
- Establishes grants for development of Shared Decision-making Resource Centers and to assist health care providers with implementation.

Patient decision aid requirements are defined, they must include relative cost of treatment, be tested and the entity is required to educate providers on the use of materials. Decision aids produced through contracts or grants must be made available to the public. Shared Decision-making Resource Centers will provide technical assistance to eligible providers to assist in implementation of patient decision aids and shared decision-making. Preference in making grants will be given to health care providers who participate in training through the Resource Centers. Funds cannot be used to purchase or implement decision aids other than those certified in this section.

Sec. 3507. Presentation of Prescription Drug Benefit and Risk Information

Secretary of HHS will determine whether the addition of quantitative summaries of benefits and risks of prescription drugs in a standardized format would improve health care decision-making by clinicians and patients.

In making the determination, review and research criteria are defined. A report of the findings must be provided to Congress no later than 1 year after the date of enactment of the Act. If it is determined that quantitative summaries will improve decision-making, the Secretary must propose regulations no later than 3 years after the date of submission of the report.

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

Establishes that grants may be awarded to entities to carry out demonstration projects to develop and implement academic curricula that integrate quality improvement and patient safety in the education of health professionals. The grant may require inclusion of certain academic programs or schools, collaboration with an organization that accredits such schools and provide data regarding the effectiveness of the project.

The entity must agree to match funds under the grant with Non-Federal funds in the amount of $1 for each $5. Evaluation of the project will be published and made available to the public. Reports will be provided to Congress not later than 2 years after enactment of the Act, and annually thereafter.

Sec. 3509. Improving Women's Health

Establishes an Office on Women's Health within the Office of the Secretary, and defines duties to include establishment of goals and providing expert advice relating to women's health. The Office must also monitor the HHS activities and identify needs relating to women's health.
In addition, the Office must establish a Department of Health & Human Services Coordinating Committee on Women's Health and a National Women's Health Information Center. The Office is also given authority to make grants and enter into contracts to carry out the assigned duties.

The Agency for Healthcare Research and Quality Activities Regarding Women's Health must consult as appropriate, with experts, on administration of policy relating to women. The Director of the Office of Women's Health assumes authority of any projects relating to women's health.

Sec. 3510. Patient Navigator Program
Amended to limit grant periods to no longer than 4 years and requires that grants not be awarded unless an entity meets minimum core requirements. Sums as much as $3,500,000 for FY 2010, may be necessary for each of FY 2011 through 2015.

Sec. 3511. Authorization of Appropriations
Authorizes appropriation of sums as necessary to carry out the subtitle and amendments made by this subtitle.

SUBTITLE G—PROTECTING AND IMPROVING GUARANTEED MEDICARE BENEFITS

Sec. 3601. Protecting and Improving Guaranteed Medicare Benefits.
Guaranteed Medicare Benefits remain and are not reduced or eliminated.

Sec. 3602. No Cuts in Guaranteed Benefits.
Guaranteed Medicare Benefits to participants in Medicare Advantage plans are not reduced or eliminated.

TITLE IV—PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH

SUBTITLE A—MODERNIZING DISEASE PREVENTION AND PUBLIC HEALTH SYSTEMS

Sec. 4001. National Prevention, Health Promotion and Public Health Council.
This section establishes the National Prevention, Health Promotion and Public Health Council which is responsible for federal level coordination and leadership for all federal departments and agencies on prevention, wellness, and health promotion practices. The Council is to prepare recommendations on the most pressing health issues facing the country and propose national wellness, health promotion strategies, and public health goals. The Council must consider evidence-based models, policies, and new prevention approaches to promote individual and community-based prevention and integrative health.

The President is to establish an advisory group to the Council (Advisory Group on Prevention, Health Promotion, and Integrative and Public Health) within DHHS composed of 25 non-federal members including licensed health professionals from different prevention medicine and health promotion areas. The Advisory group shall develop policy and recommendations for lifestyle-based chronic disease prevention and health promotion.

In consultation with the Council, a National Prevention and Health Promotion Strategy shall be developed which sets goals and objectives for improving federally-supported prevention, health promotion, and public health programs and sets up measurable actions and timelines. The Council must develop a report by July 2010 and annually through 2015, describing national health promotion and disease prevention priorities, science-based initiatives to achieve Healthy People 2010 nutrition, exercise, and smoking cessation goals and identifying the five leading disease killers, including a plan for consolidating federal health programs and centers to promote healthy behavior and reduce disease risk. The report must include plans to ensure all non-HHS prevention programs are based on science-based guidelines.

Sec. 10401.
Changes references in Sec. 4001 from Healthy People 2010 to Healthy People 2020.]

Sec. 10404.

Makes minor modifications for employers evaluating wellness programs..

- Establishes National Diabetes Prevention Program. Requires HHS, acting through CDC, to establish national diabetes prevention program targeted at adults at high risk for diabetes.
    - Program activities must include 1) grant program for community-based diabetes prevention program model sites; 2) program within CDC to determine eligibility of entities to deliver community-based diabetes prevention training; 3) training and outreach program for lifestyle intervention instructors; and 4) evaluation, monitoring and technical assistance, and applied research carried out by CDC.
    - Eligible entities for grant include State or local health department, tribal organization, national network of community-based non profits focused on health and well-being, and academic institution, or other entity determined by Secretary.
    - Appropriations Authorization: Such sums as necessary for each FY 2010 through 2014.
- Modifies special payment rules for particular services by directing HHS to implement Medicare Prospective Payment System for payment for services furnished by FQHCs.]
    - System shall: 1) include a process for describing the services furnished by FQHCs, and 2) establish payment rates for specific payment codes based on such descriptions.
    - HHS shall provide, for cost reporting periods beginning on or after Oct. 1, 2014, for payments of prospective payment rates for FQHC services in accordance with prospective payment system developed.
    - Provides for implementation of payments.
- Authorizes a state to award grants to health care providers who treat a high percentage of medically underserved populations or other special populations in the state.
- Rural Physician Training Grants - Requires Secretary, acting through Administrator of the Health Resources and Services Administration (HRSA), to establish a grant program to assist accredited schools of allopathic or osteopathic medicine in: 1) recruiting students most likely to practice medicine in underserved rural communities; 2) providing rural-focused training and experience; and 3) increasing number of recent allopathic and osteopathic medical school graduates who practice in underserved rural communities. Appropriations Authorization: $4M for each of the FY 2010 through 2013.
    - Grantee shall structure rural-focused training program as follows: 1) enroll no fewer than 10 students per class year; 2) give priority to students who have originated from or lived for a period of 2 or more years in an underserved rural community and who express commitment to practice medicine in underserved rural community.
    - Program requires students to enroll in didactic coursework and clinical experience.
    - Where available, the Program shall assist students in obtaining clinical training experiences in locations with post-graduate training programs offering residency training opportunities in underserved rural communities or support and train to practice in underserved communities
    - An entity receiving a grant must submit an annual report to Secretary.
- Preventative Medicine and Public Health Training Grant Program - Requires Secretary, acting through Administrator of HRSA and in consultation with the CDC Director, to award grants or enter into contracts with eligible entities (accredited schools of public health, medicine or osteopathic medicine; accredited non-profit hospital; state, local, or tribal health department; or consortium of 2 or more listed entities) to provide training to graduate medical residents in preventive medicine specialties.

Appropriations Authorization: $43M for FY 2011 and sums as may be necessary for each FY 2012 through 2015.

Sec. 4002. Prevention and Public Health Fund.
This section sets up the Prevention and Public Health Funds totaling $500 million in 2010 and increasing each year thereafter until 2015, when the fund stays at $2 billion. HHS is to use funds to increase funding over FY 2008 to programs as authorized by the Public Health Service Act for prevention, wellness, and public health research, prevention, and screenings under the Community Transformation grant, the Education and Outreach Campaign for Prevention Benefits, and for immunization programs.

Sec. 10401.
Amendment changes "research and health screenings" to "research, health screenings, and initiatives," and replaces "for Preventive" with "Regarding Preventive."

Sec. 4003. Clinical and Community Preventive Services.
Requires (currently allows) the Director of the Agency for Healthcare Research and Quality to convene an independent Preventive Services Task Force to review scientific evidence on the effectiveness, appropriateness, and cost-effectiveness of clinical preventive services in order to develop recommendations for the health care community. These recommendations will update current clinical preventive recommendations published in the Guide to Clinical Preventive Services. Should consider recommendations of the AHRQ, the NIH, CDC, IOM, specialty medical associations, patient groups, and scientific societies. The Task Force is also to develop additional topic areas that require new recommendations and interventions and update recommendations based on new or improved techniques. The Task Force is to improve integration of the recommendations into federal objectives and health improvement targets and enhance dissemination of the recommendations to the health care community.

The Task Force is to coordinate with other federal activities such CDC's Community Preventive Services Task Force, and the Advisory Committee on Immunization Practices to consider how these recommendations have an impact at clinic and community levels.

Sec. 4004. Education and outreach campaign regarding preventive benefits.
The HHS Secretary is to support the planning and implementation of a national public and private partnership for an outreach and education campaign to raise public awareness of how to improve health across the life span. The campaign shall focus on the use of preventive services, a reduction in health disparities, and how to reduce chronic disease. The campaign will promote the use of recommendations of the US Preventive Services Task Force and the Community Preventive Services Task Force and should encourage healthy behaviors to reduce chronic disease. The campaign is to identify preventive care that is available through federal programs and will include general health promotion information. The Secretary is to consult with IOM. The campaign must address nutrition, exercise, smoking cessation, obesity reduction and the five leading disease killers in the country. The Secretary is to maintain a public website to provide science-based information on healthy living guidelines.

The Secretary is to work with CDC to develop a plan for health care providers participating in federal health programs (Medicare, Medicaid, Indian Health Services, VA, etc.) to develop tools for a personalized prevention plan for each patient based on scientific evidence for disease prevention. Funding for the campaign is prioritized at CDC not to exceed $500 million.

SUBTITLE B—INCREASING ACCESS TO CLINICAL PREVENTIVE SERVICES

Sec. 4101. School-based health centers.
This section establishes a grant program for the support of school-based health centers. Preference for funding is given to school-based health centers that serve a large population of children eligible for a state's Medicaid program, a Medicaid waiver, or the state's CHIP program. An eligible entity can use grant funds for facility costs although no funds can be used to pay for personnel or provide health

services. $50 million in grant funds is available annually for the program through 2013; funding may not supplant current federal or state funding.

School-based health centers must provide comprehensive primary health care services including physical assessment for minor, acute, and chronic medical conditions, mental health and substance use disorder assessments, crisis intervention, counseling and treatment, and referrals as appropriate. To be eligible for funding, the school-based health center must provide a minimum match of 20 percent. A center must be open during the academic day when school is in session and 24 hour coverage through an on-call system and through backup health providers to ensure services are available year round. Consideration for funding will be given to areas with barriers to primary health and mental health care for children.

An entity with 330 funding is not eligible for school based health center funding during the same grant period. All grantees will be monitored for quality performance. Entities may only provide age-appropriate services and obtain parental consent as required for minors under state law.

Sec. 4102. Oral healthcare prevention activities.
A five-year national public education campaign is established to focus on oral health care prevention and education, especially on oral disease in early children and other caries, periodontal disease, and oral cancer. Activities are targeted to children, pregnant women, parents, the elderly, persons with disabilities, and ethnic and racial minority populations.

The Secretary, with the Director of CDC is to award demonstration grants to entities that are community-based providers of dental services, including FQHCs, hospital based or state clinics, or other groups or associations involved in dental, public health, or children's health etc. Grantees are to use funds to demonstrate the effectiveness of research-based dental caries disease management activities.

CDC and the Secretary are to enter into cooperative agreements with states and Indian tribes and tribal organizations to enhance the infrastructure for improving oral health. This includes supporting improved data collection and interpretation, leadership, and program guidance on oral health. A school-based sealant program is amended to provide services in 50 states and to Indian tribes and organizations.

Sec. 10221.
Removes exceptions that would have excluded certain dental services under the Indian Health Care Improvement Act. Surveillance of oral health is also supported by adding oral healthcare to the states that conduct the PRAMS surveillance program and to the National Health and Nutrition Examination Survey. The Secretary is also to expand state participation in the National Oral Health Surveillance system which is to include the measurement of early childhood caries.

Sec. 4103. Medicare coverage of annual wellness visit providing a personalized prevention plan.
Clarifies the preventive services covered under Medicare and by providing for a personalized prevention services plan which includes a screening schedule based on recommendations of the USPSTF and ACIP and the individual's health status, screening history, and other age-appropriate preventive services.

The plan allows for personalized health advice and referral from health care professional as needed for health education or preventive counseling services to reduce the individual's risk factors and improve self-management, or to support lifestyle interventions. In consultation with relevant groups and entities, the Secretary must establish publicly available guidelines for health risk assessment to aide in identifying chronic diseases, injury risks, modifiable risk factors and other health needs of the individual. This may be provided at the community level, by a health care professional, or other means.

In coordination with state insurance programs, area agencies on aging, and others, the Secretary also is to establish standards to assure accessibility to telephone or web-based health risk assessments tools. Coordination with current health information technology that is compatible with electronic medical records and personal health records is to be promoted.

Beneficiaries are eligible for an initial preventive physical examination or personalized prevention plan within 12 months after their part B coverage begins, followed by a yearly schedule.

Sec. 4104. Removal of barriers to preventive services in Medicare.
Removes cost-sharing for certain preventive services. This includes services, screenings and assessments recommended by the U.S. Preventive Services Task Force. The section eliminates a coinsurance requirement for any USPSTF recommendations with an A or B grade.

Sec. 10406.
Changes the amounts paid to be 100 instead of 80 that are appropriate for the individual.

Sec. 4105. Evidence-based coverage of preventive services in Medicare.
Effective January 2010, allows the Secretary to make changes to the preventive services offered under Medicare to be consistent with the recommendations of the U.S. Preventive Services Task Force.

Sec. 4106. Improving access to preventive services for eligible adults in Medicaid.
Makes changes to Medicaid to allow for coverage of preventive services and vaccines as recommended by the USPSTF (A or B grade) and vaccines approved by ACIP. The federal match for Medicaid coverage of these approved preventive services is also increased in each state by 1 percent.

Sec. 4107. Coverage of comprehensive tobacco cessation services for pregnant women in Medicaid.
Allows for comprehensive coverage of preventive services for pregnant women under Medicaid for counseling and pharmacotherapy to support tobacco cessation. This would be effective starting FY 2011.

Sec. 4108. Incentives for prevention of chronic diseases in Medicaid.
This section establishes a five-year grant program on January 2011 for states to conduct initiatives for persons covered by Medicaid to reduce health risks and promote improved health outcomes. The grant program is intended to test new approaches to support behavior modification among Medicaid recipients. Programs do not need to be statewide, as is currently required under the Social Security Act.

$100 million is authorized for appropriation.

Secs. 10401–10402.
Makes slight modifications to "comprehensive primary health services," that are offered by school-based health centers and adds further language for eligibility for beneficiary in definition of annual wellness visits for Medicare recipients.

SUBTITLE C—CREATING HEALTHIER COMMUNITIES

Sec. 4201. Community transformation grants.
Authorizes CDC to award competitive grants to state and local agencies and community-based organizations to implement evidence-based community preventive health activities aimed at reducing chronic disease rates, address health disparities, and develop evidence base. Eligible recipients must design a comprehensive plan that may include promoting healthy school environments, creating infrastructure to improve access to nutritious foods, or addressing needs of a special population. At least 20 percent of the grant money is designated to go toward rural or frontier areas.

Sec. 10403.
Requires not less than 20% of such grants be awarded to rural and frontier areas.

Sec. 4202. Healthy aging, living well; evaluation of community-based prevention and wellness programs for Medicare beneficiaries.
Requires Secretary of HHS, through CDC, to award grants to state and local governments to implement pilot projects aimed at public health interventions for people ages 55-64.

Sec. 4203. Removing barriers and improving access to wellness for individuals with disabilities.
This requires the Architectural and Transportation Barriers Compliance Board, now known as the Access Board, to create technical standards for the medical diagnostic equipment in medical settings, including physician offices, to improve accessibility, regulated by ADA. This includes equipment such as exam tables and chairs, mammography equipment, x-ray machines, etc. This section calls for standards within two years in consultation with FDA and expands responsibilities of the current ADA advisory board to assist the FDA in developing the standards.

Sec. 4204. Immunizations.
Allows HHS to negotiate contracts for the purchase of adult vaccines from vaccine manufacturers, and allows states to purchase adult vaccine at the Secretary's negotiated price. Directs CDC to establish a demonstration program to award grants to states to improve immunization rates through interventions aimed at high-risk populations of children, adolescents, and adults. Interventions may include reminders, subsidizing costs, home visits, assessing immunization providers, etc. Also directs a study examining recommended vaccination and any barriers to coverage for Medicare Part D beneficiaries.

Sec. 4205. Nutrition labeling of standard menu items at chain restaurants.
Requires chain restaurants with 20 or more locations to post the number of calories in each standard menu item and a statement regarding suggested daily caloric intake. Restaurants would also need to make available upon request, information including amount of fat, sodium, carbohydrates, and fiber. Information would need to be posted on menus and on the drive-through displays. Food items sold at a salad bar, buffet line, self-service, and vending machines would also apply.

Sec. 4206. Demonstration project concerning individualized wellness plan.
Creates a pilot program for up to 10 federally qualified community health centers to implement individualized wellness plans for at-risk populations that would include nutritional counseling and physical activity plans.

Sec. 4207. Reasonable break time for nursing mothers.
Requires employers to provide reasonable break time for employees who are nursing, so that they can express breast milk for a child up to one year of age. Also requires employers to provide space, other than a bathroom. This would exclude employers with fewer than 50 employees if the law imposes a hardship.

SUBTITLE D—SUPPORT FOR PREVENTION AND PUBLIC HEALTH INNOVATION

Sec. 4301. Research on optimizing the delivery of public health services.
Requires CDC, to provide funding for, and coordinate public health services and systems research, including examining evidence-based prevention practices, analyzing translational research, and identifying strategies to deliver public health services.

Sec. 4302. Understanding health disparities: data collection and analysis.
Requires HHS to ensure that any federally conducted or supported public health program or activity uniformly collects certain data. This includes data on race, ethnicity, disability status, language, and any other information deemed appropriate regarding health disparities.

Sec. 4303. CDC and employer-based wellness programs.
Requires director of CDC to provide employers with technical assistance and resources in evaluating employer-based wellness programs, and calls for a national worksite health policies and programs survey.

Sec. 4304. Epidemiology-laboratory capacity grants.
This section establishes an Epidemiology and Laboratory Capacity Grant Program that would allows grants to be given to state and local health departments in order to improve laboratory systems, information exchange, and surveillance. The section also authorizes $190 million.

Sec. 4305. Advancing research and treatment for pain care management.
This section requires the Secretary of HHS to enter into an agreement with the Institute of Medicine to convene a Conference on Pain in order to recognize pain as a significant public health problem, establish the Interagency Pain Research Coordinating Committee, and allows grants to implement education and training to health care professionals in pain care.

Sec. 4306. Funding for childhood obesity demonstration project.
Extends $25 million authorization for appropriations for the childhood obesity demonstration project through 2014. The project, under the CMS, is charged with developing a comprehensive model for reducing childhood obesity. Entities, including local health departments, physicians, community-based organizations, are eligible for grants to carry about interventions aimed at reducing childhood obesity.

Sec. 10407.
Requires the production of a national diabetes report card every two years, and if possible, a report for each state. HHS is directed to promote physician education on importance of birth and death certificate data and work with the states to improve vital statistics systems. Also requires a study on the impact of diabetes on the practice of medicine and the appropriateness of the level of diabetes education.

Sec. 10408.
Establishes a $200 employer's grant program for employers of more to provide workplace wellness programs. Eligible employers would employee less than 100 employees who work 25 hours or greater per week and who don't already implement a program. The wellness programs would be consistent with evidence-based practices to increase health awareness and promote healthy behavior. The authorization to be appropriated is $200 million for FY 2011-2015.

Sec. 10409.
Requires the implementation of a Cure Acceleration Network. The network would distribute grants aimed at developing high need cures, such as drugs, devices, or products that are a priority, and for which there are inadequate incentives in the commercial market.

Sec. 10410.
Directs a competitive grant program to establish up to 30 national centers of excellence for depression by 2016. The five-year grants will allow centers to provide comprehensive services and integrate research and implement evidence-based interventions, and provide training to mental health professionals. The section also establishes a national database with data from the centers on the prevalence of the disorders as well as the effectiveness of interventions. Between 2011-2015, $100 million is authorized to be appropriated each year. Between 2016-2020, $150 million is authorized to be allocated.

Sec. 10411.
Allows HHS to enhance infrastructure to better track congenital heart disease and expand research efforts. The section also allows awarding grants to support research and tracking activities and creates the Congenital Heart Disease Surveillance system to monitor the prevalence and promote research.

Sec. 10412.
Reauthorizes appropriations so that grants can be administered to support access to defibrillation programs for schools.

Sec. 10413.
Requires HHS to conduct a national evidence-based education campaign to increase awareness among young women about breast health, risk for breast cancer, early detection. The section also requires the Secretary and NIH to conduct prevention and screening research on breast cancer in younger women.

SUBTITLE E — MISCELLANEOUS PROVISIONS

Sec. 4401. Sense of the Senate concerning CBO scoring.
Section deleted by amendment, Sec. 10405.

Sec. 4402. Effectiveness of federal health and wellness initiatives.
Requires HHS to conduct an evaluation of health and wellness initiatives, as it relates to the health status of the American workforce.

TITLE V—HEALTH CARE WORKFORCE

SUBTITLE A—PURPOSE AND DEFINITIONS

Sec. 5001. Purpose.
Purpose is to improve access to, and delivery of health care services for all, particularly low income, underserved, uninsured, minority, health disparity, and rural populations by:

- Gathering and assessing comprehensive data to enable health care workforce to meet health care needs of populations, including research on supply, demand, distribution, diversity, and skill-sets needed for individual health professions;
- Increasing supply of health care workforce to improve access to care and delivery of services;
- Enhancing health workforce education and training; and
- Providing support to existing health care workforce to improve access and delivery.

SUBTITLE B—INNOVATIONS IN HEALTH CARE WORKFORCE,

Sec. 5101 National health care workforce commission (As amended by Sec. 10501)
Establishes National Health Care Workforce Commission to: 1) review current and projected health professions supply and demand; and 2) make recommendations to Congress and Administration on national health care workforce priorities, goals, and policies.

- 15-member commission to be appointed by Comptroller General by **Sept. 30, 2010**, with members selected for expertise in health care labor market analysis, health care facility management; health care plans and integrated delivery systems; health care workforce education and training; health care philanthropy; health care providers; and other related fields;
- Commission to have broad geographic representation with balance between urban, suburban, rural and frontier areas; (Note: there is no slotted seat for a physician.); and

- Commission is to meet at least quarterly and review current and projected health workforce supply and demand; and make recommendations to Congress.

Sec. 5102. State Health Care Workforce Development Grants
Establishes grant program for states to fund analysis of health care labor markets, identify current and projected needs as well as short and long-term workforce development strategies;

- Grant program to be administered by HRSA in consultation with Commission;
- Eligible grantees include: partnerships of a state workforce investment board and mix of higher education institutions and state education agencies; and
- 1-year planning grants (authorized at $8M); and up to 2-year implementation grants require 25% state match (authorized at $150M).

Sec. 5103. Health Care Workforce Assessment

- Establishes National Center for Health Workforce Analysis at HHS to provide for development of information describing health workforce and workforce-related issues.

SUBTITLE C—INCREASING THE SUPPLY OF THE HEALTH CARE WORKFORCE

Sec. 5201. Federally supported student loan funds.
In regard to student loans for schools of medicine or osteopathic medicine this provision modifies the law such that agreements entered into by schools and students for loans must require that the student agree to practice in "primary care" through the date on which the loan is repaid in full or 10 years, whichever is earlier. This modification adds a 10 year limitation, where previously the mandate required loan repayment. The 10 years includes residency.

Sec. 5202. Nursing student loan program.
This provision increases the amounts available for a nursing school to loan to students of nursing.

Sec. 5203. Health care workforce loan repayment programs.
Establishes new loan repayment program for physicians who are pediatric subspecialists and other health care professionals in child/adolescent mental and behavioral health.

- Eligibility for loan repayment extended to: pediatric subspecialists (max. $35,000/yr.); professionals in: psychology, school psychology, psychiatric nursing, social work, school social work, marriage and family therapy; school counseling or professional counseling; or a mental health service professional who specializes in child and adolescent mental health (max. $20,000/yr.); and
- Requires 2 or 3-yr. commitment to a Health Professional Shortage Area (HPSA) or Medically Underserved Area (MUA), or medically underserved population.

Appropriations Authorization: Pediatric subspecialists: $30M/yr. FYs 2010-2014;
Other pediatric providers in child/adolescent mental and behavioral health: $20 M/yr. FYs 2010-2013.

Sec. 5204. Public Health Workforce Recruitment and Retention Programs.
Establishes new loan repayment program to eliminate shortages of critical public health workforce in certain public agencies.

- Eligible professions: 1) students in public health or health professions programs who commit to employment with certain public agencies, or related training fellowship;
  OR 2) health professionals who graduated within past 10 years with public health or health professions degree who are employed with a public health agency or related training fellowship.
- Requires min. 3-yr. service commitment.

- Offers up to $35,000/yr. per year commitment; additional for those who relocate to priority service area.
- Payment provided for tax liability on loan repayment.

Appropriations Authorization: $195M in FY 1020, as needed for FYs 2011-2015.

Sec. 5205. Allied Health Workforce Recruitment and Retention Programs

Amends Higher Education Act to establish new loan repayment program to eliminate shortages of allied health professionals in certain public agencies.

- Eligible professions: allied health professionals employed: 1) by federal, state, local, and tribal public health agencies, or b) in acute care facilities, ambulatory care facilities, personal residences, and other settings located in HPSAs or MUAs, as recognized by HHS.

Sec. 5206. Grants for State and Local Programs, Training for Mid-Career Public and Allied Health Professionals

Establishes scholarships through educational institutions to mid-career professionals employed in public health and allied health positions at certain public agencies who want to retain or upgrade their education by enrolling in degree or professional training programs in public health, allied health, or related discipline.

Appropriations Authorization: $60M for FY 2010; amounts necessary for 2011-2015; For mid-career professionals, 50% public health; 50% allied health.

Sec. 5207. Funding for National Health Service Corps

Establishes appropriations authorization for National Health Service Corps:
2010, $320.5M; 2011, $414.1M; 2012, $535.1M; 2013, $691.4M; 2014, $893.5M; 2015, $1.2B
2016 and thereafter...amount from previous FY adjusted to reflect % increase in costs of health professions education during prior year; and % change in population residing in HPSAs during prior year.

Sec. 5208. Nurse-Managed Health Clinics

Provides funding for development and operation of nurse-managed health clinics. Advanced practice nurses are to manage and provide primary care or wellness services to underserved or vulnerable populations at clinics associated with a school, college, university or department of nursing, FQHC, or independent nonprofit health or social services agency. Care is to be provided regardless of patient's income or insurance status for duration of grant period. Clinic must establish community advisory committee within 90 days of receipt of grant, with majority representation by clinic patients.

Appropriation is $50M for FY 2010; as necessary for FYs 2011-2014.

Sec. 5209. Elimination of Cap on Commissioned Corps.

Removes current cap of 2,800 on maximum number of commissioned corps.

Sec. 5210. Establishing a Ready Reserve Corps.

Assimilates Reserve Corp Officers into the Regular Corps, subject to call to active duty by Surgeon General in national emergencies and public health crises, as well as service assignment in medically underserved communities.

Appropriations Authorization: Commissioned Corps recruitment and training: $5M yearly, FYs 2010-2014; Ready Reserve Corps: $12.5M yearly, FYs 2010-2014.

SUBTITLE D—ENHANCING HEALTH CARE WORKFORCE EDUCATION AND TRAINING

Sec. 5301. Training in Family Medicine, General Internal Medicine, General Pediatrics, and Physician Assistantship

a) Support and Development of Primary Care Training Programs

Expands current program to issues grant, for up to five years, to hospitals, medical schools, physician assistant (PA) training programs, or public or private nonprofit entities to promote training of primary care physicians (defined to include family medicine, general internal medicine, or general pediatrics) and physician assistants.

- Grants for programs to prepare physicians and PAs who plan to: practice, teach or conduct research in primary care;
- Provides for need-based financial assistance in form of traineeships and fellowships to residents, practicing physicians, or other medical personnel who plan to work in primary care or PAs;
- Grants for demonstration projects: 1) to provide training recommended by Advisory Committee on Training in Primary Care Medicine and Dentistry and National Health Care Workforce Commission, including training and CME that focuses on patient-centered medical homes; or 2) joint degree programs for interdisciplinary and interprofessional graduate training in public health; environmental health, infectious disease control, disease prevention and health promotion, epidemiological studies and injury control.

b) Capacity Building in Primary Care

Grants or contracts with medical schools, for max. of five years, to establish, maintain, or improve programs for clinical teaching and researching the three primary care specialties; or programs that integrate academic administrative units in the three primary care specialties to enhance interdisciplinary recruitment, training, and faculty development.

Grant preferences for establishing academic units or programs in the three primary care specialties; or substantially expanding such units or programs in these specialties.

Priority given to applicants who: propose collaborative projects between academic administrative units of primary care; propose innovative approaches to teaching, such as patient centered medical home, team management of chronic disease, and interprofessional integrated models of health care; have record of training of primary care physicians, underrepresented minorities, rural physicians, or training in care of vulnerable populations; submit joint applications with FQHCs, rural health clinics, etc.; or offer training in cultural competency and health literacy.

Sec. 5302. Training Opportunities for Direct Care Workers

- Targeted towards public-private partnerships between educational institutions and long-term care facilities (e.g., nursing homes, skilled nursing facilities, home and community-based services for disabled populations).
- Program participants receive grants to cover tuition and fees; in return must agree to work min. of two years in geriatrics, disability services, long term care services, or chronic care management.

Appropriations Authorization: $10M for each year, FYs 2011-2013.

Sec. 5303. Training in General, Pediatric, and Public Health Dentistry

Similar to **Sec. 5301** for primary care physicians, this section provides grants for dentists who intend to practice or teach in general, pediatric, or public health dentistry.

Appropriations Authorization: $30M for FY 2010; as needed for FYs 2011-2015.

Sec. 5304. Alternative Dental Health Care Providers Demonstration Project

Relates to potential expansion of dental scope of practice through demonstration projects. However, bill requires grant recipients to certify their compliance with all applicable state health professions licensing requirements.

HHS to award 15 grants of $4M each for demonstration projects over five years for training or employing alternative dental health care providers to increase access to dental health care services in rural and other underserved communities, including independent dental hygienists and even primary care physicians. Alternative dental health care providers are defined to include: community dental health coordinators, and dental hygienists that are in advanced practice, independent, or supervised; primary care physicians, dental therapists, dental health aides, and others as defined by HHS. IOM is to conduct study of demonstration projects.

Sec. 5305. Geriatric Education and Training; Career Awards; Comprehensive Geriatric Education

- Geriatric Fellowships for faculty members in medical schools and other health professions schools with programs in psychology, pharmacy, nursing, social work, dentistry, public health, allied health, or other health disciplines.

Fellowships to be open to current faculty and appropriately credentialed volunteer faculty and practitioners, who do not have formal training in geriatrics, to upgrade their knowledge and clinical skills for the care of older adults and adults with functional limitations and to enhance their interdisciplinary teaching skills. Required to seek designation as a continuing education course.

- Geriatric Career Incentive Awards to foster greater interest among a variety of health professionals in entering the field of geriatrics, long-term care, and chronic care management.

Eligibility to extend to advanced practice nurses, a clinical social worker, pharmacist, or student of psychology pursuing a doctorate or other advanced degree in geriatrics or related fields.

Award recipients would be obligated to teach or practice in geriatrics, long-term care, or chronic care management for a minimum of 5 years. $150,000 grants to a maximum of 24 geriatric education centers with appropriations of $10.8M for 2011-2014; and $10M for 2011-2013.

Sec. 5306. Mental and Behavioral Health Education and Training Grants.

- Amends Part D (Interdisciplinary, Community-Based Linkages) of Public Health Service Act to authorize Secretary to award grants to higher education institutions to support recruitment of students for, and education and clinical experience of the students in, social work programs, psychology programs, child and adolescent mental health, and training of paraprofessional child and adolescent mental health workers.

  Appropriations is $8M – training in social work; $12M – training in graduate psychology (not less than $10M for doctoral, postdoctoral, and internship level training); $10M – training in professional child and adolescent mental health; and $5M – training in paraprofessional child and adolescent work.

Sec. 5307. Cultural Competency, Prevention, and Public Health and Individuals with Disabilities Training.

- HHS to award grants, contracts, or cooperative agreements for development, evaluation, and dissemination of research, demonstration projects, and model curricula for health professions training in cultural competency, prevention, public health proficiency, reducing health disparities, and aptitude

for working with individuals with disabilities training for use in health professions schools and continuing education programs.
- HHS to collaborate with health professional societies, licensing and accrediting entities, health professions schools, experts in minority health and cultural competency, prevention and public health disability groups, and community-based organizations.
- Model curricula developed must be disseminated through the Internet Clearing-house.
- Requires Secretary to evaluate adoption and implementation and facilitate inclusion of competency measures in quality measurement systems.

Sec. 10334.
Redesignates the Office of Minority Health to be part of the office of Secretary of Health and Human Services and authorizes it to award grants to assure improved health status of racial and ethnic minorities. The CDC, the Substance Abuse and Mental Health Services Administration, the Agency for Health Care Research and Quality, the Food and Drug Administration, and CMS shall all also create, within their agencies, an Office of Minority Health.

Sec. 5308. Advanced Nursing Education Grants.
Amends section of Public Health Services Act regarding advanced education nursing grants to Require nurse-midwifery programs, in order to be eligible for advanced education nursing grants, to have as their objective the education of midwives and to be accredited by the American College of Nurse-Midwives Accreditation Commission for Midwifery Education.

Sec. 5309. Nurse Education, Practice and Retention Grants.
Amends section of Public Health Services Act regarding nurse education, practice, and retention grants to show new heading of Nurse Education, Practice, and QUALITY Grants and reauthorizes funds necessary from FY 2010 through 2014.
- Retention Priority Areas. Authorizes Secretary to award grants or enter into contracts to enhance the nursing workforce by initiating and maintaining nurse retention programs.
- Grants for Career Ladder Program. Authorizes Secretary to award grants to and enter into contracts with eligible entities for programs 1) to promote career advancement for nursing workforce; 2) developing and implementing internship and residency programs in collaboration with an accredited school of nursing to encourage mentoring; or 3) to assist individuals in obtaining education required to enter nursing profession.
- Enhancing Patient Care Delivery Systems. Authorizes Secretary to award grants to improve retention of nurses and enhance patient care.
- Other Priority Areas. Authorizes Secretary to award grants or enter into contracts to address other areas of high priority to nurse retention.
- Requires Secretary to submit report to Congress each FY on contracts and grants awarded.

Sec. 5310. Loan Repayment and Scholarship Program.
Makes nurse faculty at an accredited school of nursing eligible for the nursing education loan repayment program.

Sec. 5311. Nurse Faculty Loan Program.
Makes adjustments to federal nursing faculty loan program to:
- Increases max. loans from $30,000 to $35,000 for FY 2010 and 2011, and adjusts thereafter;
- Extends program from 2007 through 2014;
- Recipient must serve as full-time faculty of accredited nursing school for at least 4 years;
- For Masters or equivalent: up to $10K/yr. available; Max. $40K total;
- For Doctorate or equivalent: up to $20K/yr. available; Max. $80K total.

Sec. 5312. Authorization of Appropriations for Parts B through D of Title VIII
Authorizes appropriations for federal nursing workforce programs, including $338M for FY 2010 and as needed for FYs 2011-2016.

Sec. 5313 (as amended by Sec. 10501). Grants to Promote the Community Health Workforce
Requires CDC to award grants to eligible entities to promote positive health behaviors and outcomes for populations in medically underserved communities through use of community health workers.

Sec. 5314. Fellowship Training in Public Health
Authorizes HHS to carry out activities to address documented workforce shortages in state and local health departments in critical areas of applied public health epidemiology and public health laboratory science and informatics.

Sec. 5315. United States Public Health Sciences Track
Establishes U.S. Public Health Sciences Track to develop programs that offer advanced degrees in public health, epidemiology, and emergency preparedness and response. This is to be accomplished through cooperative arrangements with schools of medicine, dentistry, physician assistants, pharmacy, behavior and mental health, public health, and nursing research, consultation, and education.

- Requires Secretary, beginning with FY 2010, to transfer from Public Health and Social Services Emergency Fund such sums as may be necessary.

Sec. 5316. *Repealed.*
See Sec. 10501 for establishment of training demonstration program for family nurse practitioners at FQHCs or nurse-managed health centers.

Sec. 10501.
Amendments to Public Health Service Act, Social Security Act, and Title V of this Act.

- (a) Makes minor modifications to National Health Care Workforce Commission.
- (b) Adds Sec. 5104 (Interagency Task Force to assess and improve access to health care in the state of Alaska) to the end of Subtitle B of Title V of this Act. Establishes the Interagency Access to Health Care in Alaska Task Force to: 1) assess access to health care for beneficiaries of federal health care systems in Alaska; and 2) develop a strategy to improve delivery to such beneficiaries.
    - Makes schools offering physician assistant education programs eligible for loan repayment for health profession faculty.
- (c) Makes minor modifications to Sec. 399V (Grants to Promote Positive Health Behaviors and Outcomes), as added by Sec. 5313.
- (d) Makes schools offering physician assistant education programs eligible for loan repayment for health profession faculty.
- (e) Requires HHS to establish training demonstration program for family nurse practitioners to employ and provide one-year training for nurse practitioners serving as primary care providers in FQHCs or nurse-managed health centers (NMHC).
    - Program is to allow grant recipients to 1) provide new nurse practitioners with clinical training to enable them to serve as primary care providers in FQHCs and NMHCs; 2) train new nurse practitioners to work under a model of primary care consistent with principles set forth by IOM; and 3) create a model of FQHC and NMHC training for nurse practitioners that may be replicated nationwide.
    - Three-year grants of not more than $600,000 per year.]

SUBTITLE E: SUPPORTING THE EXISTING HEALTH CARE WORKFORCE

Sec. 5401. Centers of Excellence.
Revises allocation of funds in existing Public Health Act to assist schools in supporting programs of excellence in health professions education for underrepresented minority individuals and schools designated as centers of excellence.

Sec. 5402 (as amended by Sec. 10501). Health Care Professionals Training for Diversity.
Reauthorizes and increases the amount of loan repayment for health profession faculty and scholarships for disadvantaged students.

Sec. 5403. Interdisciplinary, Community-Based Linkages.
- Reauthorizes and amends current law regarding Area Health Education Centers awards.
- Establishes Title VII grant program to support distance learning, continuing education, collaborative conferences, with priority for primary care.

Sec. 5404. Workforce Diversity Grants.
Makes revisions to the grant program to increase nursing education opportunities for individuals from disadvantaged backgrounds to include providing: (1) stipends for diploma or associate degree nurses to enter a bridge or degree completion program; (2) student scholarships or stipends for accelerated nursing degree programs; and (3) advanced education preparation.

Sec. 5405 (as amended by Sec. 10501). Primary Care Extension Program.
- Requires the Secretary, acting through the Director of the Agency for Healthcare Research and Quality, to establish a Primary Care Extension Program.
- The program's purpose is to provide support and assistance to educate primary care providers about preventive medicine, health promotion, chronic disease management, mental and behavioral health services, and evidence-based and evidence-informed therapies and techniques, for incorporation into their medical practices and to improve community health by working with community-based health connectors (or health extension agents, as defined in this section).
- Requires the Secretary to award competitive 6-year grants to states for the establishment of Primary Care Extension Program State Hubs to coordinate state health care functions with quality improvement organizations and area health education centers. Also includes 2-year planning grants to eligible entities with the goal of developing a plan for a Hub.
- Appropriations Authorization: $120M each FY 2011 and 2012 and such sums as necessary for FY 2013 through 2014.

SUBTITLE F: STRENGTHENING PRIMARY CARE AND OTHER WORKFORCE IMPROVEMENTS.

Sec. 5501 (as amended by Sec. 10501). Expanding Access to Primary Care Services and General Surgery Services.
Requires Medicare additional incentive payments of 10% of payment amount for service under this part to certain: 1) primary care practitioners (as defined in this section) providing primary care services on or after January 1, 2011, and before January 1, 2016; and 2) general surgeons performing major surgical procedures on or after January 1, 2011, and before January 1, 2016, in a health professional shortage area.

Sec. 5503. Distribution of Additional Residency Positions.
Establishes process for lifting Medicare GME funding caps for qualifying hospitals for redistribution of 65 percent (or less than 300 new positions) of unused Medicare GME funded positions.
- Priority given to teaching hospitals:

    - In states with low resident/pop. ratios (70%) (such as Texas); and
    - In states with large populations in HPSAs or rural (30%);
- No hospital to receive more than 75 slots.
- Small rural hospitals exempted from requirement to return unused Medicare GME-funded positions;
- During first 5 years, recipients cannot have drop in primary care residencies;
- 75% of redistributed positions must be for primary care or general surgery; and
- Maintains current Medicare Indirect Medical Education (IME) funding adjustment for redistributed positions.

Sec. 5504. Counting Resident Time in Nonprovider Settings

Revises Medicare GME payment policies to count the time residents spend in non-provider settings toward funded GME slot if hospital incurs the costs of the stipends and fringe benefits for this slot. *This would avoid issues in Medicare GME funding policies that currently disadvantages primary care residents who train outside the hospital setting. Majority of primary care is delivered outside the hospital; therefore, it is necessary for primary care residents to also train outside the hospital.*

Sec. 5505 (as modified by Sec. 10501). Rules for Counting Resident Time for Didactic and Scholarly Activities and Other Activities

- Revises use of Medicare GME funds to pay residents for some non-patient care activities that are a required part of their residency curriculum.

Sec. 5506. Preservation of Resident Cap Positions from Closed Hospitals

- Allows for redistribution of Medicare GME funded positions from teaching hospitals that are close to other hospitals, based on proximity criteria.

Sec. 5507. Demonstration Projects to Address Health Professions Workforce Needs, Extension of Family-to-Family Health Information Centers

- Requires HHS to award grants for demonstration projects that: 1) provide certain low-income populations with opportunities to train in the health professions that pay well and are expected to experience labor shortages or be in high demand; and 2) develop core training competencies and certification programs for personal or home care aides.
- Authorizes appropriations for FY 2009-2012 for family-to-family health information centers.

Promotes training in health professions for low-income populations.

Sec. 5508. Increasing Teaching Capacity

- Authorizes HHS to award grants to teaching health centers for purpose of establishing new accredited or expanded primary care residency programs;
- Allows up to 50% of time spent teaching by member of National Health Service Corps to be considered clinical practice for purposes of fulfilling service obligation; and
- Requires HHS to make payments for direct and indirect expenses to qualified teaching health centers for expansion or establishment of approved GME programs.

Promotes increase in primary care GME programs and allows NHSC physicians to teach as part of their service obligation.

Sec. 5509. Graduate Nurse Education Demonstration.

- Requires HHS to establish a graduate nurse education demonstration to pay hospitals for hospital's reasonable costs for clinical training to APNs, limited to 5 hospitals; and
- HHS is to report to Congress on demonstration outcomes by Oct. 17, 2017.

SUBTITLE G: IMPROVING ACCESS TO HEALTH CARE SERVICES

Sec. 5601. Spending for Federally Qualified Health Centers (FQHCs).

- Reauthorizes and increases appropriations for health centers to serve medically underserved populations**.**
- Amends current law by adding at the end of the subsection, Rule of Construction with Respect to Rural Health Clinics.

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

- Requires HHS to establish through negotiated rulemaking (as already defined in law) a methodology and criteria for designation of medically underserved populations and HPSAs.
- Requires HHS to consult with relevant stakeholders and take into account 1) data quality and availability; 2) impact on communities and other safety net providers; 3) degree of ease or difficulty in applying for designations; and 4) extent to which methodology accurately measures barriers for those seeking care.
- Target date of rule publication is July 1, 2010 with final rule not later than one year after.

Sec. 5603. Reauthorization of the Wakefield Emergency Medical Services for Children Program. Reauthorizes appropriations for FY 2010-2014 for expansion and improvement of emergency medical services for children who need treatment for trauma or critical care.

Sec. 5604. Co-Locating Primary and Specialty Care in Community-Based Mental Health Settings. Authorizes HHS, acting through the Substance Abuse and Mental Health Services Administration, to award grants and cooperative agreements (with minor limitations of funds) for demonstration projects for provision of coordinated and integrated services to special populations through co-location of primary and specialty care services in community-based mental and behavioral health settings. Appropriates $50M for FY 2010 and such sums as necessary for each FY 2011 through 2014.

Sec. 5605. Key National Indicators.

- Provides for establishment of Commission on Key National Indicators to: 1) conduct comprehensive oversight of newly established key national indicators system; 2) make recommendations on how to improve such system; 3) coordinate with federal government users and information providers to assure access to data; and 4) enter into contracts with the National Academy of Sciences. Including a required annual report to Congress.
- Directs National Academy of Sciences to enable establishment of such system by creating its own institutional capability or by partnering with independent private nonprofit organization to create Key National Indicators Institute to implement such system.
    - Responsibilities for establishing key national indicator system: 1) identifying and selecting issue areas to be represented; 2) identifying and selecting measures used for key national indicators within issues areas identified; 3) identifying and selecting data to populate key national indicators described; 4) designating, publishing, and maintaining a public website that contains freely accessible database to access key national indicators; 5) developing quality assurance framework to ensure rigorous and independent processes and selection of data; 6) developing budget for construction, and management of key national indicator system; 7) reporting annually to the Commission regarding selection of issue areas, key indicators, data, and progress toward establishing a web-accessible database; and 8) responding directly to the Commission in response to any recommendations and to the Academy regarding any inquiries.

- If an Institute is established, the Comptroller General will conduct an annual audit and programmatic assessments as necessary.
- Directs Comptroller General to conduct study of previous work conducted by all public agencies, private organizations, or foreign countries with respect to best practices for a national indicator system and submit study to Congress.

TITLE VI—TRANSPARENCY AND PROGRAM INTEGRITY

SUBTITLE A—PHYSICIAN OWNERSHIP AND OTHER TRANSPARENCY

Secs. 6001 and 6003. Stark Anti-Referral - Physician Ownership & Certain Radiological Imaging

- The "whole hospital" exception in the Stark Anti-Referral law and rules has been significantly narrowed. A physician who owns a whole hospital that does NOT meet the new requirements for an exception is prohibited from making referrals to that facility and receiving payment for those services. In other words, the general prohibition will apply unless the new requirements are met.
- An annual report must be submitted to the Secretary containing the identity of each physician owner and "any other owners or investors."
- Ambulatory surgical centers that were hospitals prior to the effective date of the Act are not eligible for a Stark exception.
- Hospitals that do not have any physician available on the premises at all times must, prior to admission, provide notice of the lack of physician availability with a signed acknowledgment.
- There is a limitation on the ability of physician owned hospitals to expand and still fall under the new hospital Stark exceptions.
- The Stark exception for imaging has been modified for MRIs, CTs, PET scans, and any other imaging added by the Secretary. Physicians must now inform the patient in writing at the time of the referral that the individual may obtain services from other providers and provide a list of suppliers who provide such services in the area in which the patient resides.

The Stark Law, which prohibits self referrals, is modified by this section of the Act to limit the application of the "whole hospital" exception which permitted physicians to own hospitals and still receive payment for the services provided in those hospitals (and permit the hospital to be paid for its services). The exception only applies to physician ownership interests that existed on or before February 1, 2010 and which have a provider agreement with Medicare (otherwise they are prohibited).

Sec. 10601.
Extends certain dates on limiting ownership by 6 months. For Hospitals to Qualify for Rural Provider and Hospital Exception to Ownership or Investment Prohibition, the hospital must have physician ownership or investment on August 1, 2010 (extended from February 1, 2010). The Secretary shall implement the process on February 1, 2012 (from August 1, 2011) under which an applicable hospital may apply for an exception from the requirement pertaining to a limitation on expansion of facility capacity; and regulations promulgated to carry out the process for a hospital to apply for an exception will be January 1, 2012 (from July 1, 2011). The deadline of November 1, 2011 has been extended to May 1, 2012, for the HHS to conduct audits to determine if hospitals violate the requirements.
Furthermore, the hospital, generally, may not increase the number of operating rooms or beds, the percentage value of physician ownership may not increase, the terms offered to physicians must not be offered on a more favorable basis than non-physician owners, the hospital does not guarantee a loan or subsidize loans for any physician owner, profits are distributed based upon ownership interest, physicians do not receive any guaranteed receipt of or right to purchase other business interests, and the hospital does not offer a physician owner the opportunity to purchase or lease any property under the hospital's control.

A process shall implement a process by which a grandfathered hospital may apply for expansion. The process shall provide individuals and entities in the community to provide input as to whether an exception should be granted. A hospital may request expansion only once every two years.

Sec. 1106 of the Reconciliation Act modifies the timelines put into place by the Manager's Amendment in Sec. 10601. Thus, for Hospitals to Qualify for Rural Provider and Hospital Exception to Ownership or Investment Prohibitions under Stark, the hospital must have physician ownership or investment on December 31, 2010. The Reconciliation Act also adds a provision addressing hospitals without contracts with Medicare. The provision added states "or, in the case of a hospital that did not have a provider agreement in effect as of such date (of enactment) but does have such an agreement in effect on December 31, 2010, the effective date of such provider agreement)."

Finally, Sec. 1106 of the Reconciliation Act amends the expansion applications for currently owned physician hospitals to allow for expansion of "high Medicaid facilities."

Sec. 6002. Amending Sec. 1128G.Transparency Reports and Reporting of Physician Ownership in Drug, Device, Biological, or Medical Supply Manufacturers

This provision requires disclosure of ownership of drug, device, biological, or medical supply manufacturer by physicians. In addition, any "transfer of value" to a physician or teaching hospital must be reported quarterly. The transfer of value includes: consulting fees; compensation for services other than consulting; honoraria; gift; entertainment; food; travel; education; research; charitable contribution; royalty or license; current or prospective ownership or investment interest; direct compensation for serving as faculty or as a speaker for a medical education program; grant; or any payment.

There are many exceptions to disclosure such as anything with less than a $10 value (to a limit of $100 annually), product samples that are intended for patient use, educational materials, certain discounts, credit for short-term trial periods, warranties, anything provided to a physician when the physician is the patient, and in-kind items for the provision of charity care.

The penalties for non compliance with the disclosure requirements begin at $1,000 to no more than $10,000 for each payment not reported in a timely manner and for certain organizations is limited to $150,000 total. If the violation is "knowing" the penalty begins at $10,000, but not more than $100,000 for each payment or other transfer of value not reported. A report regarding the transfers of value shall be submitted to Congress on an annual basis beginning 2013.

Sec. 6004. Prescription Drug Sample Transparency. Sec. 1128H of the Social Security Act.

Drug manufacturers must file with the Secretary a record of the drug samples distributed in a year aggregated by the physician name, address, and professional designation as well as any other information required by the Secretary. Drug manufacturers must submit by April 1 of each year the name address, professional designation, and signature of the practitioner making a request for drug samples. This provision relates to drugs for which a prescription is required. The reporting begins in the year 2012.

Sec. 6005. Pharmacy Benefit Managers Transparency.

A pharmacy benefits manager contracted with a qualified health plan (offered through the new Exchanges) or a prescription drug plan sponsor is required to report to the Secretary the percentage of prescriptions provided through retail pharmacies versus mail order pharmacies, the amount and type of rebates received, inventory management fees, product stocking allowances, and other fees associated with administrative services. The information also includes the aggregate amount difference between the amount paid to the PBM and the amount paid to retail and mail order pharmacies and the total number of prescriptions dispensed. The information submitted to the Secretary is confidential, but the Secretary may report aggregate information that does not identify particular PBMs or plans nor discloses prices.

SUBTITLE B—NURSING HOME TRANSPARENCY AND IMPROVEMENT

PART I—IMPROVING TRANSPARENCY OF INFORMATION

Sec. 6101. Required Disclosure of Ownership and Additional Disclosable Parties Information.
A facility shall have the information available to the Secretary, the Inspector General of the Department of Health and Human Services, the State in which the facility is located, and the State long-term ombudsman, from the time of enactment to the time the information is made public under this Act.

Facilities must make disclosure of certain information to the federal government, state government, and public. The information to be disclosed includes the identity of and information on:

- each member of the governing body of the facility;
- each person or entity who is an officer, director, member, partner, trustee, or managing employee of the facility;
- each person or entity who is an additional disclosable party of the facility, and the organizational structure of the additional disclosable party.

Under the law an "additional disclosable party" is any person or entity who exercises operational, financial, or managerial control of the facility or is an owner that meets certain requirements. One year after final regulations are adopted the information reported is available to the public.

Sec. 6102. Accountability Requirements for Skilled Nursing Facilities and Nursing Facilities

- On or after 36 months after the enactment of this section, a facility shall have in operation a compliance and ethics program that is effective in preventing and detecting criminal, civil, and administrative violations and in promoting quality of care.
- Not later than 3 years after the promulgation of regulations, the Secretary shall complete an evaluation of the compliance and ethics programs.
- By the end of 2011, Secretary must implement a quality assurance and performance improvement program for these facilities and provide technical assistance in development of best practices.

This provision requires the adoption of an ethics and compliance program within skilled nursing facilities. Secretary will adopt regulations outlining the program requirements as well as evaluate the programs.

Sec. 6103. Nursing Home Compare Website.
Requires public information, on an official website, to compare nursing homes. Information included will be staffing data such as turnover, information regarding the outcome of complaints, adjudicated instances of criminal violations within the facility or by a facility employee, links to State surveys, and a complaint form. The Secretary shall review the accuracy, clarity, timeliness, and comprehensiveness of information on such website. Not later than 1 year after the enactment, the Secretary shall modify or revamp such website. In conducting the review, the Secretary shall consult with State long term care ombudsman programs, consumer advocacy groups, provider stakeholder groups, and other appropriate groups.

A skilled nursing facility and nursing facility must have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years available for any individual to review upon request, and post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.

Sec. 6104. Reporting of Expenditures.
Skilled nursing facilities shall separately report expenditures for wages and benefits for direct care staff.

Sec. 6105. Standardized Complaint Form

- The Secretary shall develop a standardized complaint form for use by a resident in filing a complaint with a State survey and certification agency.
- The State must establish a complaint resolution process, which includes procedures to assure accurate tracking of complaints, to determine the likely severity of a complaint and for the investigation, and deadlines for responding to a complaint and notifying the complainant of the outcome.
- The amendment shall take effect 1 year after the date of the enactment of this Act.

Sec. 6106. Ensuring Staffing Accountability.

Not later than 2 years after the enactment of this subsection, the Secretary shall require a facility to electronically submit to the Secretary direct care staffing information based on payroll and other verifiable and auditable data in a uniform format.

Sec. 6107. GAO Study And Report On Five-Star Quality Rating System.

This section requires the Comptroller General to study the Five-Star Quality Rating System and analyze the system's implementation, problems, and potential improvement. Not later than 2 years after the enactment, the Comptroller General shall submit to Congress a report containing the results of the study.

PART II—TARGETING ENFORCEMENT

Sec. 6111. Civil Money Penalties.

This section provides for the scope and collection of civil money penalties from skilled nursing facilities and nursing facilities, allowing for reductions for self-reporting, and allowing for informal dispute resolution. The amendments take effect 1 year after the date of the enactment of this Act.

Sec. 6112. National Independent Monitor Demonstration Project.

This section provides for the creation of a demonstration project to develop, test, and implement an independent monitor program to oversee interstate and large intrastate chains of skilled nursing facilities and nursing facilities, which will be conducted over a 2 year period. The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, will evaluate the demonstration project and submit to Congress a report not later than 180 days after the completion of the demonstration project. The report will contain the results of the evaluation, recommendations whether it should be established permanently along with procedures, and any legislation and administrative action deemed appropriate.

Sec. 6113. Notification of Facility Closure.

The amendment to this section requires public notice of a potential facility closure, and a plan for relocation and transfer of residents. An administrator's failure to comply with this requirement can result in a monetary penalty and exclusion from participation in Federal health care programs. Any administrator that fails to comply with these requirements shall be subject to a civil monetary penalty up to $100,000, may be excluded from participation in Federal health care programs, and may be subject to other penalties. The amendments made by this section shall take effect 1 year after enactment.

Sec. 6114. National Demonstration Projects On Culture Change And Use Of Information Technology In Nursing Homes.

- One or more grant awards will be awarded shall be awarded to facility-based settings for the development of best practices (relating to culture change and information technology).
- Each demonstration project shall take into consideration special needs of residents who have cognitive impairment.
- The demonstration projects shall be conducted for a period not to exceed 3 years.

- The projects shall be implemented not later than 1 year after enactment of this Act.

This section provides for 2 demonstration projects in skilled nursing and nursing facilities. One is for development of best practices involved in the "culture change movement". The other is for the development of best practices in use of information technology to improve patient care. Not later than nine months after the completion of the project, the Secretary shall submit a report to Congress.

PART III—IMPROVING STAFF TRAINING

Sec. 6121. Dementia And Abuse Prevention Training.
This section amends sections by including, in initial and ongoing training for skilled nursing and nursing facilities, dementia management training and patient abuse prevention training. The provision also clarifies the definition of Nurse Aide to include those who provide such services through an agency or under contract. The amendments made by this section shall take effect 1 year after enactment.

SUBTITLE C—NATIONWIDE PROGRAM FOR NATIONAL AND STATE BACKGROUND CHECKS ON DIRECT PATIENT ACCESS EMPLOYEES OF LONG-TERM CARE FACILITIES AND PROVIDERS

Sec. 6201. Nationwide Program For National And State Background Checks On Direct Patient Access Employees Of Long-Term Care Facilities And Providers.
HHS will establish a program to identify "efficient, effective, and economical procedures for long term care facilities or providers to conduct background checks on prospective direct patient access employees on a nationwide basis. Fingerprinting will be required, and coordination of State and federal background checks. The state shall provide for the designation of a single State agency to be responsible for overseeing the coordination of any State and national criminal history background checks requested by a provider utilizing a search of State and Federal criminal history records, including a fingerprint check.
Funding
Newly Participating States
- State shall guarantee that the State will make available a particular amount of non-Federal contributions, as a condition of receiving a Federal Match (discussed below).
- Payment to each State shall be 3 times the amount the State makes available, up to $3,000,000.

Previously Participating States
- State shall guarantee that the State will make available a particular amount of non-Federal contributions, as a condition of receiving a Federal Match.
- Payment to each State shall be 3 times the amount the State makes available, up to $1,500,000.

SUBTITLE D—PATIENT-CENTERED OUTCOMES RESEARCH

Sec. 6301. Patient-Centered Outcomes Research.
This section establishes a non-profit corporation, the "Patient-Centered Outcomes Research Institute" to provide independent comparative effectiveness research, to evaluate and compare health outcomes and clinical effectiveness, risks, and benefits of two or more medical treatments or services. Conflicts of interest are prohibited. Such research findings will be available to clinicians, patients, and the general public to assist in making informed health decisions by advancing the quality and relevance of evidence concerning the manner in which diseases, disorders, and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed through research and evidence synthesis that considers variations in patient subpopulations, and the dissemination of research findings with respect to the relative health outcomes, clinical effectiveness, and appropriateness of the medical treatments, and services.

The Institute shall have access to data collected by the CMS under various programs, as well as data networks developed under the Public Health Service Act. The Institute may also obtain data from Federal, State, or private entities, and date from clinical databases and registries.

The Institute may appoint permanent or ad hoc advisory panels to assist in identifying research priorities. The Institute shall appoint expert advisory panels in carrying out randomized clinical trials. The Institute shall appoint an expert advisory panel for assisting in the design of the research study for rare disease. The expert advisory panel shall include representatives who have experience in the relevant topic, as well as experts in integrative health and primary prevention strategies.

Dissemination And Building Capacity For Research
This section provides for the dissemination of, and access to, research findings of the Patient Centered Outcomes Research Institute. The Office of Communication and Knowledge Transfer shall assist users of health information to promote the timely incorporation of research findings disseminated, into clinical practices and to promote the ease of use of such incorporation.

Limitations On Certain Uses Of Comparative Clinical Effectiveness Research

- The Secretary may only use findings from research under sec. 1181 to make a determination regarding coverage under title XVIII if such use is through an iterative and transparent process.
- Nothing shall be construed to limit comparative clinical effectiveness research or any other research, evaluation, or dissemination of information concerning the likelihood that a health care treatment will result in disability.
- The Institute shall not develop or employ a measure that discounts the value of a life because of an individual's disability as a threshold to establish what type of health care is cost effective or recommended.

Trust Fund Transfers To Patient-Centered Outcomes Research Trust Fund
Funds shall be transferred from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary medical Insurance Trust Fund under section 1841, in proportion to the total expenditures that are made under title XVIII from the respective trust fund, to the Patient-Centered Outcomes Research Trust Fund (PCORTF).

Patient-Centered Outcomes Research Trust Fund
"Patient-Centered Outcomes Research Trust Fund" (PCORTF) is created and appropriated: for 2010, $10,000,000; for 2011, $50,000,000; for 2012, $150,000,000; for 2013, an amount equal to net revenues received in Treasury from fees imposed under another provision of law and $150,000,000.

Financing For Fund From Fees On Insured And Self-Insured Health Plans

- A fee will be imposed on each specified health insurance policy for each policy year ending after 9/30/12, a fee equal to the product of $2 multiplied by the average number of lives covered under the policy; The issuer of the policy will pay the fee; and Adjustments will be made for increases in the projected per capita amount of National Health Expenditures.
- A fee will be imposed on any applicable self insured health plan for each plan year ending after 9/30/12, a fee equal to $2 multiplied by the average number of lives covered under the policy; The fee imposed shall be paid by the plan sponsor.

Sec. 6302. Federal Coordinating Council for Comparative Effectiveness Research. (Repealed)

SUBTITLE E—MEDICARE, MEDICAID, AND CHIP PROGRAM INTEGRITY PROVISIONS

Sec. 6401. Provider screening and enrollment requirements under Medicare, Medicaid, and CHIP

This section provides for the screening of providers and suppliers, a provisional period of enhanced oversight, disclosure requirements, a temporary enrollment moratoria, and compliance programs.

Provider Screening

- Not later than 180 days after enactment, the Secretary shall establish procedures for screening with respect to providers of medical or other items or services.
- The Secretary shall determine the level of screening according to risk of fraud, waste, and abuse.
- The Manager's Amendment deletes this provision: ~~The Secretary shall impose a fee on each individual provider (such as a physician) with respect to the screening. The fee will be $200 for 2010, and adjusted by consumer price index for subsequent years.~~ [Sec. 10603 Amendment Strikes Provisions on Individual Provider Application Fees]
- The Secretary shall impose a fee on each institutional provider with respect to the screening. The fee will be $500 for 2010, and adjusted by CPI for subsequent years.
- There will be a hardship exception for fees, for certain Medicaid providers.
- The fees collected will be used by the Secretary for program integrity efforts.

Provisional Period of Enhanced Oversight for New Providers of Services and Suppliers

- There will be a provisional period of between 30 days and 1 year during which new providers would be subject to enhanced oversight, such as prepayment review and payment caps.

Increased Disclosure Requirements

- A provider who submits an application for enrollment or revalidation of enrollment shall disclose any current or previous affiliation with a provider that has uncollected debt, has been or is subject to a payment suspension, has been excluded from participation in Medicare, Medicaid, or CHIP, or has had its billing privileges denied or revoked.
- Such previous affiliation may cause the denial of such application.

Authority to Adjust Payments of Providers of Services and Suppliers with the Same Tax ID Number for Past-Due Obligations

- The Secretary may make any necessary adjustments to payments to the applicable provider, in order to satisfy any past-due obligations.

Temporary Moratorium on Enrollment of New Providers

- The Secretary may impose a temporary moratorium on the enrollment of new providers under this title, the Medicaid program, or under the CHIP program, if the Secretary determines such moratorium is necessary to prevent or combat fraud, waste, or abuse.
- There shall be no judicial review of a temporary moratorium.

Compliance Programs

- A provider shall, as a condition of enrollment in the program, establish a compliance program that contains the core elements established (following).
- The Secretary shall establish core elements.
- The Secretary shall determine the timeline for the establishment of the core elements, and the date of the implementation, for providers.

Sec. 1304 of the Reconciliation Act.

- This section grants the Secretary with the authority to withhold payment from a durable medical equipment contractor for the first 90 days following the contractor's enrollment.

Medicaid Screening of Certain Suppliers and Providers

Provider and Supplier Screening, Oversight, and Reporting Requirements

- The State is required to comply with the process set forth in the previous section, pertaining to screening providers, a provisional period of enhanced oversight, disclosure requirements, and a temporary moratorium on enrollment of new providers or suppliers.
- The State has the option to impose periods of enrollment moratoria or other limits, for providers or suppliers identified by the Secretary as being at high risk for fraud, waste or abuse. The State must determine the limits would not adversely impact beneficiaries' access to medical assistance.

Compliance Programs and Reporting of Adverse Provider Actions

- The State requires providers to establish a compliance program that contains the core elements.
- The State must comply with the national system for reporting convictions, sanctions, negative licensure actions and other adverse provider actions to the Secretary.

Enrollment and NPI of Ordering or Referring Providers

- The State requires all ordering or referring providers to be enrolled under the State plan or a waiver of the plan as a participating provider.
- The national provider identifier will be specified on any claim for payment based on an order or referral the provider.

Other State Oversight

- The State is permitted to engage in additional provider screening or oversight activities.

Disclosure of Medicare Terminated Providers and Suppliers to States

- CMS shall make available to the State agency responsible for administering a State Medicaid plan, or a child health plan, the name and other information of any provider that is terminated from participation under the Medicare or CHIP program, within 30 days of the termination.

CHIP

- Provider and supplier screening, oversight, and reporting requirements also apply in CHIP.

Sec. 6402. Enhanced Medicare and Medicaid Program Integrity Provisions.

Adds Medicare and Medicaid program integrity provisions for data matching and sharing, such as for claims and payment data, in a system of records. The Inspector General of HHS may obtain information from any provider, or others who directly or indirectly order, provide manufacture, prescribe items or services payable by any Federal health care program, including documents necessary to validate claims such as a prescribing physician's medical records. Any individual or entity that knowingly makes any false statement, omission or misrepresentation of a material fact in an application, agreement, bid or contract under a Federal health care program may be subject to penalties, and violations of this section could also constitute health care fraud. The Secretary may suspend payments to a provider or supplier pending an investigation of a credible allegation of fraud against the provider or supplier. This section also creates increased funding to "fight fraud and abuse."

The Inspector General of HHS may obtain information from any individual or entity that is a provider, or others who directly or indirectly order, provide manufacture, prescribe items or services payable by any Federal health care program. Information obtainable includes supporting documents necessary to validate claims, including a prescribing physician's medical records.

If a provider has received an overpayment, he or she shall report and return such overpayment.
An overpayment must be reported and returned by the later of 60 days after overpayment was identified or the date any corresponding cost report is due. Any overpayment retained by a person is an "obligation" under for the purposes of other federal laws.

Access To Data
HHS may use data to conduct oversight, evaluation, and enforcement. Data may be used by the Attorney General and the Comptroller General of the U.S. to carry out health oversight activities. Data matches will be performed with respect to potential fraud, waste, and abuse, including matches of non-Federal records. The Commissioner of Social Security shall enter into an agreement with the Secretary or Inspector General for the purpose of matching data of the SSA and the records of the HHS.
Permissive Exclusions And Civil Monetary Penalties
Application is to any individual or entity that knowingly makes any false statement, omission or misrepresentation of a material fact in an application, agreement, bid or contract under a Federal health care program. This section clarifies treatment of certain charitable programs. The Secretary may delegate the authority to Inspector General of HHS for purposes of any investigation under this section.
Health Care Fraud
In addition to the penalties provided for in section 1128A, a violation of this section constitutes a false or fraudulent claim. The law is modified such that a person need not have actual knowledge of this section or specific intent to commit a violation of this section in order to be found in violation.

Suspension of Medicare and Medicaid Payments Pending Investigation Of Credible Allegations Of Fraud

- Medicare is amended by adding a new subsection pertaining to suspension of payments pending investigation of credible allegations of fraud.
- Secretary may suspend payments to a provider or supplier pending an investigation of a credible allegation of fraud against the provider or supplier.
- The State can determine Medicaid suspension in accordance with regulations that there is good cause not to suspend payments.

Increased Funding To Fight Fraud and Abuse
Provision provides for additional funding, $10,000,000 for each year 2011-2020.
Medicare Integrity Program

- There is a requirement to provide performance statistics to the Secretary and the Inspector General of HHS.
- The Secretary shall conduct evaluations of eligible contracted entities, not less than every 3 years.
- Within 180 days after the end of each fiscal year (beginning 2011), the Secretary shall submit a report to Congress identifying the use of funds and the effectiveness of the use of such funds.

Medicaid Integrity Program

- There is a requirement to provide performance statistics to the Secretary and the Inspector General of HHS, including amount of overpayments recovered, number of fraud referrals, and return on investment.
- The Secretary shall conduct evaluations of eligible contracted entities, not less than every 3 years. Sec. 1303 of the Reconciliation Act provides for funding of fraud and abuse enforcement activities in addition to the funding outlined above. That funding is:
- For fiscal year 2011, $95,000,000.
- For fiscal year 2012, $55,000,000.
- For each of fiscal years 2013 and 2014, $30,000,000.
- For each of fiscal years 2015 and 2016, $20,000,000.

Sec. 6404. Elimination Of Duplication Between The Healthcare Integrity And Protection Data Bank And The National Practitioner Data Bank.
HHS shall maintain a national health care fraud and abuse data collection program for the reporting of final adverse actions against health care providers and suppliers, and such information will be furnished to the National Practitioner Data Bank. Formal proceedings related to licensing or certification actions concluded against a practitioner must be reported, as well as "any adverse action" taken against a health

care provider by a State law or fraud enforcement agency. No person or entity will be held civilly liable for reporting of information, without knowledge of the falsity of the information reported.

Collected information shall be available from the National Practitioner Data Bank to the agencies, authorities, and officials listed in the law. The State must have a system of reporting formal proceedings (related to licensing or certification actions) concluded against a practitioner or entity.
The State must have in effect a system of reporting information regarding any final adverse action taken against a health care provider, supplier, or practitioner by a State law or fraud enforcement agency.
The Secretary shall provide for disclosure of the information reported, to the health care practitioner. Corrections of information already reported, will be reported. No person or entity will be held liable in any civil action with respect to any reporting of information, without knowledge of the falsity of the information reported.

HHS shall implement a transition process under which the Secretary shall cease operating the Healthcare Integrity and Protection Data Bank and shall transfer all data collected in the Healthcare Integrity and Protection Data Bank to the National Practitioner Data Bank.

Sec. 6404. Maximum Period For Submission Of Medicare Claims Reduced To Not More Than 12 Months.
The submission of Medicare claims is one calendar year after the date of service (from 3 years). The effective date is for services furnished on or after January 1, 2010. The Secretary may specify exceptions to the 1 calendar year period. Effective date: Services furnished on or after January 1, 2010. Services furnished before 2010 must have a bill or request for payment filed not later than December 31, 2010.

Sec. 6405. Physicians Who Order Items Or Services Required To Be Medicare Enrolled Physicians Or Eligible Professionals.
This section requires certifications and written orders to be made by enrolled physicians and health professions. These amendments shall apply to all written orders and certifications made after 7/1/2010.

Sec. 10604.
Makes technical corrections to section 6405(b), such as clarifying its application to a "physician enrolled," as opposed to a "physician."

Sec. 6406. Requirement For Physicians To Provide Documentation On Referrals To Programs At High Risk Of Waste And Abuse.
HHS may revoke enrollment (of not more than 1 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. These amendments shall apply to orders, certifications, and referrals made on or after 1/1/2010.

Sec. 6407. Face To Face Encounter With Patient Required Before Physicians May Certify Eligibility For Home Health Services Or Durable Medical Equipment Under Medicare (as amended by Sec. 10605).
This section requires a face to face encounter with a patient prior to certification of home health services, and allows for a face to face encounter with a physician, PA, nurse practitioner, or clinical nurse specialist prior to certification of durable medical equipment. This section amended later in the Act, by allowing these other health professionals to have a face to face encounter for home health service certification as well. Prior to certifying eligibility for home health services under Medicare, a physician must document that the physician has had a face-to-face encounter with the individual within a reasonable timeframe. Prior to certifying eligibility for durable medical equipment, the order must be written pursuant to the physician documenting that a physician, physician assistant, nurse practitioner, or a clinical nurse

specialist has had a face to face encounter with the individual involved during the 6 month period preceding such written order. These requirements may apply to other areas under Medicare, as the Secretary may determine. These requirements will apply to Medicaid.

Sec. 10605.
Clarifies that certain other providers, not just physicians, are permitted to conduct face-to-face encounters for Home Health services. This section now allows a nurse practitioner, clinical nurse specialist, certified nurse midwife, or a physician assistant to conduct face to face encounters.

Sec. 6408. Enhanced Penalties.
There will be civil monetary penalties for false statements or delaying inspections on or after 1/1/2010.

Sec. 6409. Medicare Self-Referral Disclosure Protocol.
HHS shall establish, within 6 months of the enactment of this Act, a protocol to enable health care providers and suppliers to disclose an actual or potential violation of self-referral prohibitions, pursuant to a self-referral disclosure protocol. The Secretary shall post information on the public Internet website of the Centers for Medicare & Medicaid Services to inform relevant stakeholders of how to disclose actual or potential violations pursuant to an SRDP. The Secretary is authorized to reduce the amount due and owing for all violations under the self-referral prohibitions.

Sec. 6410. Adjustments To The Medicare Durable Medical Equipment, Prosthetics, Orthotics, And Supplies Competitive Acquisition Program.
This section provides an expansion of Round 2 of the DME Competitive Bidding Program. HHS shall include the next 21 largest metropolitan statistical areas by total population for such round. This section also provides the requirement to either competitively bid areas or use competitive bid prices by 2016.

Sec. 6411. Expansion Of The Recovery Audit Contractor (RAC) Program.

- Not later than December 31, 2010, the State shall establish a program to contract with 1 or more RACs for the purpose of identifying underpayments and overpayments and recouping overpayments under the State plan and under any waiver of the State plan.
- This section provides for the expansion to Medicare Parts C and D.
- The Secretary shall enter into contracts to require RACs to ensure that each MA plan under part C has an anti-fraud plan in effect and to review its effectiveness, and to ensure that each prescription drug plan under part D has an anti-fraud plan in effect and to review its effectiveness.
- The Secretary shall submit an annual report to Congress on the effectiveness of the RAC program under Medicaid and Medicare, and recommendations for its expansion and improvement.

SUBTITLE F—ADDITIONAL MEDICAID PROGRAM INTEGRITY PROVISIONS

Sec. 6501. Termination Of Provider Participation Under Medicaid If Terminated Under Medicare Or Other State Plan.
This section provides for the termination of the participation of any individual or entity in Medicaid if, subject to exceptions, participation of such individual or entity is terminated under title XVIII or any other State plan under this title.

Sec. 6502. Medicaid Exclusion From Participation Relating To Certain Ownership, Control, And Management Affiliations.
This section provides that a State agency exclude any individual or entity from participation in the program under the State plan, if such individual or entity owns, controls or manages an entity that has unpaid overpayments, is suspended or excluded from participation, or is affiliated with an individual or entity that has been suspended or excluded from participation.

Sec. 6503. Registration of Billing Agents, Clearinghouses, Or Other Alternate Payees Under Medicaid

Any agent, clearinghouse, or other alternate payee that submits claims on behalf of a provider must register with the State and Secretary.

Sec. 6504. Requirement To Report Expanded Set Of Data Elements Under Mmis To Detect Fraud And Abuse.

Requires the submission of data from the automated data system, and applies to contract years as of January 1, 2010. For data submitted to the Secretary on or after January 1, 2010, included should be data elements from the automated data system that is necessary for program integrity, oversight, and administration.

Sec. 6505. Prohibition On Payments To Institutions Or Entities Located Outside Of The U.S.

This section provides that the State shall not provide any payments for items or services provided under the State plan or waiver to any financial institution or entity located outside of the United States.

Sec. 6506. Overpayments.

This section extends the period for collection of overpayments due to fraud from 60 days to 1 year.

If the State is unable to recover a debt which represents an overpayment due to fraud, because there is no final determination of the amount of overpayment due to a judicial or administrative process, no adjustment shall be made in the Federal payment to such State on account of such overpayment. These amendments take place on the date of enactment of this Act. The Secretary shall promulgate regulations requiring States to correct Federally identified claims overpayments of an ongoing or recurring nature with new MMIS (Medicaid Management Information System) edits, audits or other action.

Sec. 6507. Mandatory State Use Of National Correct Coding Initiative

Effective for claims filed on or after October 1, 2010, compatible methodologies of the national Correct Coding initiative and such other methodologies will be used by States. The Secretary shall identify those methodologies of the National Correct Coding Initiative which are compatible to claims filed under this title, and identify those methodologies of such Initiative that should be incorporated into claims filed under this title. Not later than March 1, 2011, the Secretary shall submit a report to Congress that includes the notice to States and an analysis supporting the identification of the methodologies.

Sec. 6508. General Effective Date.

Except as otherwise provided, this subtitle and amendments made by this subtitle take effect on January 1, 2011, regardless of whether final regulations have been promulgated.
There will be a delay if State legislation is required.

SUBTITLE G—ADDITIONAL PROGRAM INTEGRITY PROVISIONS

Sec. 6601. Prohibition On False Statements And Representations

This section amends The Employee Retirement Income Security Act of 1974 by adding a prohibition on false statements and representations, pertaining to the financial condition, benefits, or regulatory status of a plan. This section applies to a "multiple employer welfare arrangement.

No person in connection with a plan that is a multiple employer welfare arrangement shall make a false statement or false representation of fact, knowing it to be false, in connection with the marketing or sale of such plan, concerning the financial condition, benefits, or regulatory status of such plan. This section does not apply to any plan that does not fall within the meaning of the term 'multiple employer welfare arrangement.' Criminal penalties will be impost for violations of the law.

Sec. 6602. Clarifying Definition.
Section adds "Employee Retirement Income Security Act of 1974" to section 24(a)(2) of title 18, USCA.

Sec. 6603. Development Of Model Uniform Report Form.
This section adds a uniform fraud and abuse referral format for private health insurance issues to refer suspected fraud and abuse to State agencies for investigation.

The NAIC will develop a model uniform report form for private health insurance issuer seeking to refer suspected fraud and abuse to State agencies for investigation.

Sec. 6604. Applicability Of State Law To Combat Fraud And Abuse.
This section provides that a person engaged in providing insurance through a multiple employer welfare arrangement is subject to laws of the States.

The Secretary may adopt regulatory standards establishing that a person engaged in the business of providing insurance through a multiple employer welfare arrangement is subject to the laws of the States in which such person operates which regulate insurance.

Sec. 6605. Issuance of Administrative Summary Cease And Desist Orders And Summary Seizures Orders Against Plans That Are In Financially Hazardous Condition.
This section amends the Employee Retirement Income Security Act of 1974 by allowing the Secretary to issue a cease and desist order pertaining to a multiple employer welfare arrangement, in situations including imminent danger to the public or fraud.

The Secretary may issue a cease and desist order if it appears to the Secretary that the alleged conduct of a multiple employer welfare arrangement is fraudulent, or creates an immediate danger to the public safety or welfare, or can be reasonably expected to cause significant, imminent, and irreparable public injury.

Sec. 6606. MEWA Plan Registration With Department Of Labor.
Multiple employer welfare arrangements are required to register with the Secretary prior to operation.

Sec. 6607. Permitting Evidentiary Privilege And Confidential Communications.

- An evidentiary privilege and confidentiality of communications may be promulgated between or among the following entities, and their agents, consultants, or employees: A State insurance department; A state attorney general; the NAIC; The Department of Labor; The Department of the Treasury; The Department of Justice; The Department of Health and Human Services; and any other Federal or state authority that the Secretary determines is appropriate.
- The privilege shall apply to communications related to any investigation, audit, examination, or inquiry conducted or coordinated by any of the agencies. various agencies

SUBTITLE H—ELDER JUSTICE ACT

Sec. 6701. Elder Justice Act of 2009.
Subtitle creates the establishment of Social Services for the prevention and enforcement of elder abuse, neglect and exploitation. Block grants will be provided to states for social services, councils and boards will be created, forensic centers will be established, and provisions made for the reporting of elder abuse, neglect and exploitation including those within long term care facilities and nursing facilities. This section also creates provisions for enhancing long term care, including activities to provide incentives for individuals to train for, seek, and maintain employment providing direct care in long-term care. Additionally, the Secretary is authorized to make grants to long term care facilities for the purpose of

assisting such entities in offsetting the costs related to purchasing, leasing, developing, and implementing certified EHR technology.

Sec. 6702. Definitions.
Definitions in section 2011 of the Social Security Act will be used in this subtitle.

Sec. 6703. Establishment of Elder Justice protections.
This section amends Title XX of the Social Security Act by adding "Elder Justice" to "Social Services."
This section adds a subtitle, "Subtitle A-Block Grants to states for Social Services."
This section also a subtitle entitled "Elder Justice" and a section including definitions for abuse and "Adult Protective Services." Adult protective services means services provided to adults such as: 1) reports of adult abuse, neglect, or exploitation; 2) investigating such reports; 3) case planning and other case work services; 4) and providing for the provision of medical, social service, economic, legal, housing, law enforcement, or other protective support services. An "elder" is an individual age 60 or older. Elder Justice means efforts to prevent, detect, treat, intervene in, and prosecute elder abuse, neglect, and exploitation; and protect elders with diminished capacity while maximizing their autonomy.

Within the Office of the Secretary, there will be an Elder Justice Coordinating Council (Council) composed of HHS, the Attorney General, the head of each Federal department or agency or other governmental entity having responsibilities relating to elder abuse, neglect, and exploitation

Establishment of a 27 member advisory board on elder abuse to create multidisciplinary strategic plans to: 1) enhance communication on promoting quality of, and preventing abuse, neglect, and exploitation in, long term care; 2) develop consensus around the management of certain quality related factors; and 3) prepare an annual report to Coordinating Council and relevant Congressional committees.

The Secretary shall promulgate guidelines to assist researchers with issues relating to human subject protections. For 2011, $6,500,000 and 2012-2014, $7,000,000 per year has been appropriated.

HHS shall make grants to establish and operate stationary and mobile forensic centers to develop expertise regarding and provide services relating to elder abuse, neglect, and exploitation. To carry out this section, between $4,000,000 and $8,000,000 has been appropriated annually in 2011-2014.

HHS shall carry out activities to provide incentives for individuals to train for, seek, and maintain employment providing direct care in long-term care. The Secretary is authorized to make grants to long term care facilities for the purpose of assisting such entities in offsetting the costs related to purchasing, leasing, developing, and implementing certified EHR technology. The Secretary shall adopt electronic standards for the exchange of clinical data by long-term care facilities, including standards for massaging and nomenclature. Not later than 10 years after the date of enactment, the Secretary shall have procedures in place to accept the optional electronic submission of clinical data by long-term care facilities. Authorized annual appropriations are between $20,000,000 and $15,000,000 in 2011-2014.

HHS shall provide funding to State and local adult protective services offices that investigate abuse. Funds made available may only be used by States and local government to provide adult protective services $100,000,000 is appropriated to carry out this subsection (grants to enhance the provision of adult protective services) for fiscal years 2011-2014.

HHS shall make grants to entities with relevant expertise and experience in abuse and neglect in long term care facilities or long term care ombudsman programs.

To be eligible for a grant, an applicant shall agree to provide the entity conducting an evaluation with information required. The Secretary shall reserve a portion of funds appropriated to each program to provide assistance to conduct evaluations of the activities funded.

The Secretary shall submit a report to the Coordinating Council and Congressional committees by October 1, 2014 concerning the State reports and containing recommendations.

New rules of construction to be used by courts in interpreting this new Elder Justice law. Congress states that nothing in the Elder Justice Act shall be construed as limiting any cause of action related to obligations under its terms or creating a private cause of action for a violation of the Act.

The State shall indicate whether it intends to assist individuals to train for, seek, and maintain employment providing direct care in a long term care facility or in other occupations related to elder care. HHS shall enter into a contract with an entity for the purpose of establishing and operating a National Training Institute of Federal and State surveyors. The Secretary shall make grants to State agencies that perform surveys of skilled nursing facilities or nursing facilities.

Reporting to Law Enforcement of Crimes Occurring in Federally Funded Long-Term Care Facilities: Each individual who is covered by this law shall report to the Secretary and one or more law enforcement entities any reasonable suspicion of a crime against any individual who is a resident of or is receiving care from the facility. An individual that violates this subsection shall be subject to a civil money penalty of not more than $200,000 and may be excluded from participation in any Federal health care program. If a covered individual violates this subsection, and such violation exacerbates the harm to the victim or causes harm to others, the covered individual shall be subject to a civil penalty of not more than $300,000. There shall be additional penalties for a long-term care facility's retaliation to an employee.

National Nurse Aide Registry
The Secretary shall conduct a study on establishing a national nurse aide registry. The Secretary shall take into consideration the findings and conclusions of relevant reports.

SUBTITLE I—SENSE OF THE SENATE REGARDING MEDICAL MALPRACTICE

Sec. 6801. Subtitle I: Sense of the Senate Regarding Medical Malpractice.
Expresses the sense of the Senate that: (1) health reform presents an opportunity to address issues related to medical malpractice and medical liability insurance; (2) states should be encouraged to develop and test alternative models to the existing civil litigation system; and (3) Congress should consider state demonstration projects to evaluate such alternatives.

TITLE VII – IMPROVING ACCESS TO INNOVATIVE MEDICAL THERAPIES

SUBTITLE A. BIOLOGICS PRICE COMPETITION AND INNOVATION

Sec. 7002 – 7003. Improving Access to Innovative Medical Therapies
Grants drug makers a 12 year exclusivity period on biologics before they face competition from biosimilar or generic alternatives.

SUBTITLE B—MORE AFFORDABLE MEDICINES FOR CHILDREN AND UNDERSERVED COMMUNITIES

Sec. 7101 – 7103. More Affordable Medicine for Children and Underserved Communities

- **Expands participation in the 340B Drug Pricing Program through which certain federally funded grantees and other safety net health care providers may purchase prescription medication at significantly reduced prices.**
- The GAO has 18 months to make recommendations on improvements to the 340B program.

TITLE VIII – CLASS ACT

Sec. 8001. Title.
Community Living Assistance Services and Supports Act (CLASS Act)

Sec. 8002. Establishment of National Voluntary Insurance Program for Purchasing Community Living Assistance and Support

- Establishes a self-funded public long-term care insurance program for the purchase of community living assistance services and support by individuals with functional limitations.
- Requires the HHS to develop actuarially sound benefit plans that ensures solvency for 75 years;
- Requires enrollees to pay monthly premium of no more than $30
- Requires five-year vesting period for eligibility of benefits
- Creates benefit triggers that allow for the determination of functional limitation;
- Provides cash benefit that is not less than an average of $50 per day.

Sec. 10801.
Makes various technical corrections to provisions in 3203, 3204, and 8002.

TITLE IX—REVENUE PROVISIONS

SUBTITLE A—REVENUE OFFSET PROVISIONS

Sec. 9001. Excise tax on high cost employer-sponsored health coverage (as amended by Sec. 10901 and by HR4872, Sec. 1401).

- Starting in 2018, imposes a 40% tax on employer-provided tax-excluded health benefits that exceed $10,200 for employee coverage or $27,500 for family plans.
- Plan cost includes employer and employee share including contributions to health savings or reimbursement accounts including FSAs, HSAs and HRAs, but does not include the cost of separate vision or dental plans.
- Provides exceptions for retirees over the age of 55 and offers an adjustment based on age and gender of employees.
- Applies higher taxability thresholds to employees in high-risk occupations, defined to include longshoremen, law enforcement, firefighters, emergency medical technicians, paramedics, and others who provide out-of-hospital emergency medical care. Also included are individuals in construction, mining, agriculture, forestry, and fishing industries.]
- Taxability thresholds increase by inflation plus 1 percent for 2019 and based on inflation thereafter.

The Reconciliation Act, Sec. 1401 did extensive revision to both the provisions of Sec. 9001 and of Sec. 10901. The combined effect is incorporated in the summary above.

Sec. 10901.
Modifies excise tax on high cost employer-sponsored health coverage to exclude high longshoremen, professions defined to include law enforcement, firefighters, emergency medical technicians, paramedics, and others who provide out-of-hospital emergency medical care. Also included are individuals in construction, mining, agriculture, forestry, and fishing industries.

Sec. 9002. Inclusion of cost of employer-sponsored health coverage on W–2.

- Requires employers to disclose the value of all tax-excluded health benefits on employee's W-2

Sec. 9003. Distributions for medicine qualified only if for prescribed drug or insulin.

- Over-the counter drugs can no longer be purchased tax–free using FSAs, HSAs, or HRAs, starting in 2011.

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

- HSA and MSA contributions withdrawn for non-medical spending are subject to a 20% tax penalty, starting in 2011.

Sec. 9005. Limitation on health flexible spending arrangements under cafeteria plans (as amended by Sec. 1403).

- Limits FSA contributions to $2,500 starting in 2013

Sec. 10902.
Includes an inflation adjustment of limitation on health flexible spending arrangements under cafeteria plans.

Sec. 9006. Expansion of information reporting requirements.

- Expands required reporting of financial transactions. (Not a health care provision)

Sec. 9007. Additional requirements for charitable hospitals.

- Charitable hospitals face tax penalties unless they meet new requirements to:
    - Conduct a community health needs assessment every two years and adopt a strategy to meet the community health needs,
    - Adopt a written policy for patients who require financial assistance for hospital care;
    - Limit the amounts charged for emergency or other medically necessary care provided to individuals eligible under their written financial assistance policy to the ~~lowest amount charged~~ amount generally billed to individuals who have insurance covering such care.
    - Refrain from taking extraordinary collection actions against a patient until hospital has made reasonable efforts to determine whether patient is eligible for financial assistance.
- Requires a report to multiple Congressional Committees on the charity care, bad debt and unreimbursed costs of government programs for taxable and tax-exempt hospitals.

Sec. 10903.
Makes modification of limitation on charges by charitable hospitals from the "lowest amount charged" to the "amount generally billed".

Sec. 9008. Annual fee on branded prescription pharmaceutical manufacturers and importers. (as amended Sec. 1404)
Imposes a tax on large pharmaceutical companies, beginning in 2011 with a total tax of $2.5 billion, increasing to $4.1 billion in 2018.

Sec. 9009. Imposition of annual fee on medical device manufacturers and importers.
Repealed by Section 1405 and replaced with a different tax.

Sec. 10904.
Modifies the implementation of annual fee from 2009 to 2010.

Sec. 9010. Imposition of annual fee on health insurance providers (as amended by Sec. 10905 and Sec. 1406)
Imposes an annual tax on large health insurance companies, beginning in 2014 at $8 billion and gradually increasing to $14.3 billion in 2018.

Sec. 10905.
Modifies the annual fee on certain health insurance providers, including exclusions from taxation for specific non-profit plans and TPAs.

Sec. 9011. Study and report of effect on veterans health care.
Requires the VA secretary to report on the impact of the new fees on cost and access for veterans.

Sec. 9012. Elimination of deduction for expenses allocable to Medicare Part D subsidy (as amended by Sec. 1407).
Eliminates a tax deduction for Medicare-eligible retiree pharmaceutical plans, effective in2012

Sec. 9013. Modification of itemized deduction for medical expenses.
Increases the threshold for tax deductibility of medical expenses from 7.5% to 10% of adjusted gross income, in most cases.

Sec. 9014. Limitation on excessive remuneration paid by certain health insurance providers.
In 2013, imposes a $500,000 limitation on the deductibility of remuneration paid to officers, directors, employees, and service providers of health insurance issuers who derive at least 25% of their gross premiums from providing health insurance coverage that meets minimum essential coverage requirements.

Sec. 9015. Additional hospital insurance tax on high-income taxpayers [As amended by Sec. 10906]
Imposes an additional Medicare payroll tax of ~~0.5~~ 0.9% on taxpayers earning $200,000 ($250,000 for joint returns.) HR4872 Section 1402 specifies that withholding and estimated tax payments are required.

Sec. 10906. Amendment increase additional Medicare payroll tax from 0.5% to 0.9%.

Sec. 9016. Modification of section 833 treatment of certain health organizations.
Requires Blue Cross or Blue Shield organizations or other nonprofit organizations that provide health insurance to maintain a medical loss ratio of at least 85% to be eligible for special tax benefits currently provided to such organizations.

Sec. 9017. Excise tax on elective cosmetic medical procedures.

- ~~Places tax on elective cosmetic medical procedures.~~ Sec.10907 strikes this bullet.
- 10% tax beginning in July, 2010
- Exemption provided for phototherapy service performed by a licensed medical professional.

Sec. 10907.
Modifies tax to one on indoor tanning services in lieu of elective cosmetic medical procedures.

Sec. 10908.
Excludes the benefits received from loan repayment or forgiveness programs for health care professional from the calculation of taxable income.

Sec. 10909.
Increases the tax credit for adoption expenses.

SUBTITLE B—OTHER PROVISIONS

Sec. 9021. Exclusion of health benefits provided by Indian tribal governments.

- Health benefits for Indian tribes are tax excludable.

Sec. 9022. Establishment of simple cafeteria plans for small businesses.

- Provides for simple cafeteria plans for employers with 100 or fewer employees.

Sec. 9023. Qualifying therapeutic discovery project credit.

- Allows a 50% tax credit or Treasury–provided grant in 2009 and 2010 for investment in any qualifying "therapeutic discovery project", designed to:
  - treat diseases by conducting pre-clinical activities, clinical trials, and clinical studies, or carrying out research projects to approve new drugs or other biologic products;
  - diagnose diseases or conditions to determine molecular factors related to these; or
  - develop a product, process, or technology to further the delivery of therapeutics.

Sec. 1301 of the Reconciliation Act. Community Mental Health Centers.
This section of the Reconciliation Act ensures that services provided in the patient's home, an inpatient setting, or residential setting do not fall under the definitions of partial hospitalization services under Medicare. The services at issue include but are not limited to, occupational rehabilitation, patient education, and social work services.

RECONCILIATION ACT FREESTANDING PROVISIONS

Sec. 1109. Payment for qualifying hospitals

- Provides $400 million for additional payments to hospitals located in counties with low total "age, sex and race adjusted" Medicare spending,

Sec. 1302 of the Reconciliation Act. Prepayment Medical Review Limitations
This section of the Reconciliation Act repeals section 1874A(h) of the Social Security Act regarding conduct of random prepayment reviews. That section (which is now deleted) read:
(h) Conduct of Prepayment Review.—

(1) Conduct of random prepayment review.—

(A) In general.—A Medicare administrative contractor may conduct random prepayment review only to develop a contractor-wide or program-wide claims payment error rates or under such additional circumstances as may be provided under regulations, developed in consultation with providers of services and suppliers.

(B) Use of standard protocols when conducting prepayment reviews.—When a Medicare administrative contractor conducts a random prepayment review, the contractor may conduct such review only in accordance with a standard protocol for random prepayment audits developed by the Secretary.

(C) Construction.—Nothing in this paragraph shall be construed as preventing the denial of payments for claims actually reviewed under a random prepayment review.

(D) Random prepayment review.—For purposes of this subsection, the term "random prepayment review" means a demand for the production of records or documentation absent cause with respect to a claim.

(2) Limitations on non-random prepayment review.—

(A) Limitations on initiation of non-random prepayment review.—A Medicare administrative contractor may not initiate non-random prepayment review of a provider of services or supplier based on the initial identification by that provider of services or supplier of an improper billing practice unless there is a likelihood of sustained or high level of payment error under section 1893(f)(3)(A).
(B) Termination of non-random prepayment review.—The Secretary shall issue regulations relating to the termination, including termination dates, of non-random prepayment review. Such regulations may vary such a termination date based upon the differences in the circumstances triggering prepayment review.

Sec. 1402. Unearned income Medicare contribution

- Starting in 2013, imposes a 3.8 percent tax on the lesser of
    - net investment income
    - or adjusted gross income above $200,000 for an individual or $250,000 for a joint tax return.
- Net investment income includes interest, dividends, annuities, royalties, rents and income from other passive investments or the sale of property. It does not include distributions from qualified retirement plans.

Sec. 1405. Excise Tax on Medical Device Manufacturers

- Imposes a 2.3 % tax on all medical devices sold.
- Exempts eyeglasses, contact lenses, hearing aids, other items determined by rule.

Sec. 1408. Elimination of unintended application of cellulosic biofuel producer credit

Not related to health care

Sec. 1409. Codification of economic substance doctrine and penalties

Relating to the tax treatment of transactions that have no business purpose other than tax reduction or avoidance. Imposes increased penalties for non-disclosure and tax underpayment.

Sec. 1410. Time for Payment of corporate estimated taxes

Requires increased early payments of corporate estimated taxes.