

The Patient Protection and Affordable Care Act
Passed on December 24, 2009¹
(Amendment in the Nature of a Substitute to H.R. 3590
Introduced by Senator Reid (D-NV) on November 19, 2009, with the
Manager's Amendment, Senate Amendment 2786, introduced on December 19, 2009,
With References to the President's Proposal released on February 22, 2010²)

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¹ The Patient Protection and Affordable Care Act, H.R. 3590, available at: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590eas.txt.pdf.

² President's Proposal, available at: <http://www.whitehouse.gov/health-care-meeting/proposal>.

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TITLE I – QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Subtitle A – Immediate Improvements in Health Care Coverage for All Americans

Amendments to the Public Health Service Act

A group health plan and a health insurer: 1) may not establish lifetime benefits limits or unreasonable annual benefits limits; 2) may not rescind an enrollee’s coverage or cancel an enrollee’s plan without notice (except in cases of enrollee fraud and misrepresentation); 3) must cover services (free of cost-sharing) with an A or B rating from the United States Preventive Services Task Force, immunizations, and certain child and women’s preventive services recommended by HRSA; 4) must continue existing dependent coverage until the dependent turns twenty-six; 5) must follow standards developed by the Secretary to provide an accurate summary of benefits and explanation of coverage; 6) may not discriminate on the basis of salary for health-plan eligibility; 7) must create an appeals process, both internal and external, for coverage determinations and claims; 9) must submit to the Secretary a report detailing the percentage of premium revenue expended on clinical-care reimbursement, quality improvement, and other non-claim costs; and 10) must annually provide a pro rata rebate to each enrollee for non-claim costs that exceed 20% in the group market and 25% in the individual market through December 31, 2013. In addition, hospitals must publish a list of standard charges for items and services.

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Manager’s Amendment Changes

The amendment provides an exception for certain restricted annual limits to the ban on lifetime or annual limits provision. Beginning in 2014, group health plans and health insurance issuers may only establish restricted annual limits on the dollar value of benefits with respect to the scope of benefits that are “essential health benefits.” The Secretary must ensure access to needed services with minimal impact on premiums.

The amendment expands the group of individuals who shall receive the summary of benefits and explanation of coverage from health plans and issuers from just enrollees, to applicants, enrollees and policyholders and certificate holders.

The amendment inserts the following new section:

Provision of Additional Information

All plans must disclose certain specified information for participation in an Exchange. Health plans not offered through an Exchange are required to submit certain information (such as claims payment policies and rating practices) to the Secretary and the state insurance commissioner and must make such information available to the public.

The amendment also amends the provision relating to discrimination based on salary to require group health plans to comply with the requirements of the Internal Revenue Code relating to prohibition on discrimination in favor of highly compensated individuals.

The amendment inserts the following new section:

Protection of Second Amendment Gun Rights

Wellness and health promotion activities may not require the disclosure or collection of any information relating to lawfully possessed firearms or ammunition. Premium rates may not be increased, coverage may not be denied, and rebates may not be reduced or withheld based upon the ownership or possession of a firearm.

The amendment changes the requirements relating to the clear accounting for costs by adding that reports submitted to the Secretary must include the ratio of the incurred loss plus the loss adjustment expense to earned premiums and by extending the provision to cover all grandfathered plans. Also, rebates will be provided if the total amount of premium revenue is less than: 1) 85 percent in the large group market; or 2) 80 percent in the small group market (or another percentage as determined by the Secretary if 80 percent may destabilize the individual market). In addition, every hospital must publish a list of standard charges.

The amendment clarifies that there will be an internal and an external review process. The internal appeals process must be updated to comply with the Code of Federal Regulations (CFR), standards established by the Secretary of Labor, and any standards established by the Secretary of Health and Human Services (HHS). The external review process must meet either the consumer protections under the Uniform External Review Model Act set out by the National Association of Insurance Commissioners (NAIC) or minimum standards established by the Secretary.

The amendment inserts the following new section:

Patient Protections

Patients have a choice of health care professional and are entitled to see any participating primary care provider who is available to accept them. Emergency services will be covered without the need for prior authorization determination, whether or not the provider is a participating provider, and out-of-network services will have the same cost-sharing requirement as in-network services. The amendment also increases access to pediatric and obstetrical and gynecological care by allowing pediatricians and gynecologists to serve as primary care providers without authorization or referral.

Health Insurance Consumer Information

The Secretary will award grants to states (or an Exchange) to establish or offer support for health-consumer assistance offices or health insurance ombudsmen programs.

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Offices will assist with the filing of appeals, tracking of complaints, educating consumers about their rights, and assisting with enrollment. Thirty million dollars is provided in funding.

Ensuring that Consumers Get Value for Their Dollars

Beginning in 2010, the Secretary will create a process for reviewing unreasonable increases in health-insurance premiums. Health insurers will be required to submit to the Secretary and the states a justification of an unreasonable increase in premiums. These justifications will be made public by the Secretary and posted on the insurer's website. The Secretary will award grants to states for reviewing health-insurance premium increases and making recommendations to the Secretary. The Secretary may exclude insurers from the state Exchanges for unreasonable premium increases. Through 2014, \$250 million is available in grant funding to states monitoring insurance premium activity.

Addressed in
Title I of the
President's
Proposal

Manager's Amendment Changes

The amendment adds that states will also be allowed to use grant funding to establish reimbursement data centers to collect medical reimbursement information, to analyze and organize information, and to make information available to insurers, researchers and the public.

The amendment inserts the following new section:

Medical Reimbursement Data Centers

Reimbursement data centers will be responsible for developing fee schedules, updating fee schedules, and making cost information available to the public. Protections will be put in place to ensure centers are not influenced by any entity that may make or receive payments for health care services based on the center's analysis of health care costs.

Effective Dates

This subtitle will become effective upon enactment with the exception of provisions relating to health insurance consumer information and ensuring that consumers get value for their dollars. Those provisions become effective on or after a date that is six months after the date of enactment of this Act.

Subtitle B – Immediate Actions to Preserve and Expand Coverage

Immediate Access to Insurance for Uninsured Individuals with a Preexisting Condition

Requires the Secretary to establish a temporary high-risk health-insurance pool, either directly or through a state or nonprofit entity, for individuals with pre-existing conditions. The high-risk pool must cover at least 65% of costs and have an out-of-pocket limit no greater than that for high-deductible plans. Eligible individuals must be citizens or legal immigrants, have a pre-existing condition, and have been without coverage for at least six

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months. Coverage will end by January 1, 2014 and the Secretary must ensure transition to other coverage for enrollees. An appeals process and certain procedures will be created to prevent fraud, waste, and abuse and establish criteria to determine whether insurers have encouraged high-risk enrollees to disenroll. If so, the insurer will be required to compensate the high-risk health-insurance pool for the enrollee's medical expenses.

Reinsurance for Early Retirees

A temporary reinsurance program is created to reimburse participating employment-based plans for a portion of health benefits to early retirees. Plans will submit claims to the Secretary that contain documentation for the actual costs of items and services and plans will be reimbursed for 80% of the costs above \$15,000 (up to \$90,000 annually). Payments must be used to reduce the costs of the plan and not for general revenues. Payments will not be considered income for tax purposes. The Secretary will create an appeals process and will annually audit claims. Five billion dollars is appropriated and is available until expended.

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Proposal

Manager's Amendment Changes

The amendment clarifies that the reinsurance program applies to plans sponsored by state and local governments for their employees.

Immediate Information that Allows Consumers to Identify Affordable Coverage Options

A new website will allow a resident of any state to identify affordable health insurance coverage options in their state, including information about private health insurance, Medicaid, CHIP, state and national high-risk pools, eligibility, availability, premium rates, cost sharing, and the percentage of total premium revenues spent on health care.

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Manager's Amendment Changes

The amendment clarifies that the website for consumers to identify affordable coverage options will also provide coverage options and information for small businesses.

Administrative Simplification

HIPAA is amended to require the Secretary to adopt operating rules for health information transactions, while maximizing as much uniformity in the implementation of the electronic standards as possible. Operating rules will be consensus-based and reflect the necessary business rules affecting health plans and providers. Health plans must certify that their data and information systems comply with applicable operating rules and the Secretary will conduct periodic audits to ensure compliance. Health information operating rules will be updated regularly by a review committee and through a hearing process. Penalties will be imposed on plans failing to meet the operating rules and standards.

Subtitle C – Quality Health Insurance Coverage for All Americans

PART I – Health Insurance Market Reforms

Amendment to the Public Health Service Act

Health insurers may not impose discriminatory premium rates and may only vary such rates by family structure, community rating area, age (maximum 3:1), and tobacco use (maximum 1.5:1). States must establish community rating areas. The Secretary will review rating areas, and if inadequate, establish new rating areas for that state. The Secretary, in consultation with the National Association of Insurance Commissioners, will establish permissible age bands for rating purposes. For family coverage, the age and tobacco adjustments must be based on the portion of the premium attributable to each family member.

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Health insurance issuers in the individual and group markets must: 1) guarantee coverage to every employer and individual in the state that applies for coverage; 2) guarantee renewability of that coverage regardless of health status and utilization of health services; and 3) meet certain requirements regarding the incorporation of essential benefits into their plans. Annual and special open enrollment periods will be allowed for certain individuals with qualifying lifetime events. Insurers (or the Secretary) may establish varying reimbursement rates based on quality or performance measures. Insurers offering small-group or individual insurance must meet new essential health benefits requirements.

Health insurers in both individual and group markets are prohibited from: 1) imposing any pre-existing condition exclusion or discriminate against any individual based on their health status; 2) setting eligibility rules based on health status, medical history, genetic information and evidence of insurability; 3) discriminating against health care providers acting within the scope of their professional license and applicable state laws; and 4) creating waiting periods that exceed 90 days.

Employers may vary premiums by up to 30% for employee participation in wellness and prevention programs. By 2014, the Secretary will establish a 10-state demonstration project to apply the new wellness-program requirements in the individual health-insurance market.

Manager's Amendment Changes

The amendment clarifies that: 1) rating requirements only apply to insured plans in the large group market and not to self-insured plans; and 2) waiting periods do not apply in the individual market.

The amendment inserts the following new section:

Coverage for Individuals Participating in Approved Clinical Trials

Insurers may not deny qualified individuals participation in certain approved clinical trials. Insurers are prohibited from denying coverage of routine patient costs for services provided in connection with these clinical trials and they may not discriminate against participating individuals.

PART II – Other Provisions

Preservation of Right to Maintain Existing Coverage

No one will be required to terminate existing coverage nor will they be prevented from renewing that coverage later. Family members may be added to existing coverage if the terms of the plan allow it. Group health plans that existed at enactment will be allowed to enroll new employees and their families.

Addressed in Title I of the President's Proposal

Manager's Amendment Changes

The amendment adds that provisions of the Public Health Service Act relating to the development and utilization of uniform explanation of coverage documents, standardized definitions, and bringing down the cost of health care coverage will apply to grandfathered health plans.

Rating Reforms Must Apply Uniformly to All Health Insurance Issuers and Group Health Plans

Any standard adopted by a state under the Act shall be applied uniformly to all health plans in each insurance market to which the standard or requirements applies.

Addressed in Title I of the President's Proposal

Effective Dates for Subtitle C

Effective for plan years beginning on or after January 1, 2014.

Manager's Amendment Changes (apply to Title I, Subtitle C)

The amendment adds that provisions relating to the preservation of the right to maintain existing coverage will take effect on the date of enactment. The provision relating to prohibition of preexisting exclusions as it applies to enrollees under 19 years of age will become effective on or after a date that is six months after the date of enactment of this Act.

The amendment adds the following new sections:

Annual Report on Self-Insured Plans

The Secretary of Labor must prepare an annual report using data collected from self-insured group health plans as well as data from the financial filings of self-insured employers.

Study of Large Group Market

The Secretary must conduct a study of the fully-insured and self-insured group health markets to compare employers, health plan benefits, financial solvency,

capital reserve levels, and to determine the extent to which reforms are likely to cause adverse selection in the large group market or to encourage small and midsize employers to self-insure.

Subtitle D – Available Coverage Choices for All Americans

PART I – Establishment of Qualified Health Plans

Qualified Health Plan Defined

A qualified health plan is one that: 1) meets the Secretary’s certification requirements; 2) provides the essential health benefits package; and 3) is offered by a licensed health insurer with at least one qualified health plan at the silver and gold levels.

Manager’s Amendment Changes

The amendment adds that any reference to a qualified health plan will include a qualified health plan offered through the Consumer Operated and Oriented Plan program and a multi-state plan unless specifically provided for otherwise. The Secretary shall permit a qualified health plan to provide coverage through a qualified direct primary care medical home plan, so long as the qualified health plan meets all specified requirements. A qualified health plan, including a multi-state qualified health plan, may vary premiums by rating area.

Essential Health Benefits Requirements

An essential health benefits package must include coverage that: 1) provides for the essential health benefits; 2) limits cost-sharing; and 3) provides either bronze, silver, gold, or platinum levels of coverage, or be subject to catastrophic-coverage requirements. The Secretary will define essential health benefits, which cover at least as much as a typical employer plan and including the following: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health, prescription drugs, rehabilitative services, laboratory services, wellness services, chronic-disease management, and pediatric services.

Until 2014, health-plan cost sharing will be limited to the health savings account limits under the Internal Revenue Code. After 2014, the limits will be raised by a premium adjustment percentage, rounded up to the nearest multiple of \$50. Until 2014, small-group market deductibles are limited to \$2,000 for individuals, \$4,000 otherwise. These may be increased by the maximum amount allowed for a flexible spending arrangement. After 2014, these will be increased by a premium adjustment percentage. This limit will not affect the actuarial value of the plan.

Each level of coverage for the individual and small group markets is defined as providing benefits that are actuarially equivalent to some percentage of the actuarial value of the plan: bronze level, 60%; silver level, 70%; gold level, 80%; platinum level, 90%. To be considered a catastrophic plan, the plan must: 1) be offered only on the individual market; 2) enroll only those under thirty years of age who are exempt from self-

employment requirements under the Internal Revenue Code; and 3) offer essential health benefits after the individual has incurred allowed cost-sharing expenses equal to the annual limitation.

In the individual market, catastrophic plans may be offered to individuals under 30 years of age or those who are exempt from the individual responsibility requirement due to financial hardship. Catastrophic coverage must include the essential health benefits and at least three primary care visits, and must also have cost-sharing up to the health savings account out-of-pocket limits.

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Manager's Amendment Changes

The amendment adds that if any item or service covered by a qualified health plan is provided by a federally-qualified health center, the offeror of the plan must pay the center for the item or service no less than the amount that would have otherwise been paid under Medicaid.

Special Rules

The Secretary will ensure that at least one qualified health plan in each Exchange market provides abortion coverage and at least one plan does not provide abortion coverage. If a qualified health plan provides abortion coverage, the issuer of the plan will not use any credit from the Internal Revenue Service or amount attributable to this Act to pay for such services. No provider or facility may be discriminated against for its abortion policy. This does not preempt any state or federal abortion law, nor does it relieve the emergency-services requirements of EMTALA.

Manager's Amendment Changes

A state may prohibit abortion coverage in qualified health plans offered through an Exchange if the state enacts a law to provide for such prohibition. A state may repeal such a law and provide for the offering of such services through the Exchange. Nothing may be construed to require a qualified health plan to provide coverage of services for abortions for which public funding is prohibited or allowed, as part of its essential health benefits for any plan years. The issuer of a qualified health plan will determine whether or not the plan provides coverage of such services as part of such benefits for the plan year. If a qualified health plan provides coverage of services for abortions for which public funding is prohibited, the issuer may not use any amount attributable to the affordability credit or any cost-sharing reduction for purposes of paying for such services and must collect from each enrollee a payment equal to the portion of the premium to be paid directly by the enrollee and an amount equal to the actuarial value of the coverage of the services. Amounts paid by each enrollee for coverage must be deposited into an allocation account established by the plan so that funds for abortion services are paid for exclusively out of that account.

State health insurance commissioners shall ensure that health plans comply with all generally accepted accounting requirements. No qualified health plan offered through an Exchange may discriminate against any individual health care provider or health care

facility because of unwillingness to provide, pay for, provide coverage of, or refer for abortions. Plans providing coverage for which public funding is prohibited must provide a notice to enrollees of such coverage.

Nothing in this Act shall be construed to: 1) preempt state laws regarding the prohibition or requirement of coverage, funding, or procedural requirements on abortions; 2) alter the rights and obligation of employees and employers under the Civil Rights Act; or 3) relieve any health care provider from providing emergency services as required by state or federal law.

Related Definitions

For purposes of this Act, a “large employer” employs at least 101 employees. A “small employer” employs between 1 and 100 employees. A state may elect to treat an employer employing at least 51 employees as a large employer. A small employer that grows above the limit will continue to be treated as a small employer so long as it continues to make enrollment available to its employees. The large group market will include plans offered by large employers.

Manager’s Amendment Changes

The amendment inserts the following new section:

Educated Health Care Consumers

Defined as an individual who is knowledgeable about the health care system and has background or experience in making informed decisions regarding health, medical, and scientific matters.

PART II – Consumer Choices and Insurance Competition Through Health Benefit Exchanges

Affordable Choices of Health Benefit Plans

Within one year of enactment, the Secretary will issue grants to the states to create American Health Benefit Exchanges. By January 1, 2014, each state is required to establish an Exchange that: 1) implements procedures for plan certification; 2) operates a toll-free consumer-assistance hotline; 3) maintains a website with comparative information about qualified health plans; 4) assigns a quality rating to each qualified health plan using the Secretary’s standards; 5) informs individuals about their Medicaid and CHIP eligibility; and 6) establishes a coverage-cost calculator. Exchanges may only offer plans that satisfy the requirements of qualified health plans which offer essential health benefits. States may require that qualified health plans offer benefits in addition to the basic essential health benefits at their own expense.

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Exchanges must be self-sustaining beginning on January 1, 2015, and may charge assessments or user fees in order to support operations. Stakeholders will be able to consult with the Exchange and provide input on its operations and activities. Health plans seeking certification by Exchanges to become qualified health plans must submit

justification for any premium increase prior to the increase. An Exchange may operate in more than one state if both the state and the Secretary approve. A state may establish subsidiary Exchanges if each serves a geographically distinct area. The duties of an Exchange may be performed directly or through a contractor. Exchanges should incentivize plans through increased reimbursement that improve health outcomes, reduce hospital admissions, improve patient safety, and implement wellness and health promotion activities.

Grants will be awarded to entities serving as Exchange navigators who are responsible for conducting public education, distributing impartial information, facilitating enrollment, providing referrals regarding enrollee grievances, and providing information in a culturally and linguistically appropriate manner.

Manager's Amendment Changes

Strikes "may" and inserts "shall" regarding a plan's premium increase as a criterion for plan inclusion or exclusion within the Exchange.

The amendment adds the following new section:

Transparency in Coverage

The amendment adds a new criterion for certification as a qualified health plan. Insurance plans must report to the Secretary at least annually regarding quality reporting measures, data on cost-sharing and out-of-network coverage, and other specified data. In determining whether the purchase of coverage is cost-effective, the Secretary will compare costs relative to the amounts that the state would have paid to obtain comparable coverage for the targeted low-income children involved.

Consumer Choice

A qualified individual lawfully residing in a state may enroll in any qualified health plan available. A qualified employer may offer its employees coverage under a qualified health plan at any level of coverage. A health insurance issuer must consider all enrollees in either a small-group or individual health plan to be members of a single risk pool. A state may require the individual and small-group insurance markets within a state to merge. Individuals will not be compelled to enroll in a health plan through an Exchange. Starting in 2017, large-group insurers may, but are not required to, offer qualified health plans through an Exchange.

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Manager's Amendment Changes

The amendment clarifies that individuals can enroll in qualified health plans if eligibility requirements are satisfied. Procedures may be established at the state level allowing agents or brokers to enroll employers, as well as individuals, in qualified health plans. Removes language about the establishment of rate schedules for broker commissions paid by health benefits plans offered through an Exchange. Deletes language about territorial agreements relating to "qualified individual" with respect to an Exchange.

Financial Integrity

The Secretary may investigate an Exchange, examine its property and records, and may require periodic financial reports and annual audits. The Comptroller General will conduct an ongoing study of Exchange activities. If the Secretary determines that an Exchange or a state has engaged in misconduct, the Secretary may rescind up to 1% of payments due annually. The Secretary may implement reasonable measures to prevent fraud and abuse. All payments from federal funds made through or in connection with an Exchange are subject to the False Claims Act.

Manager's Amendment Changes

The amendment makes the provision relating to the False Claims Act null, void, and of no effect.

The amendment adds that a court shall dismiss an action or claim under this section, unless opposed by the government, if substantially the same allegations or transactions as alleged in the action or claim were publicly disclosed: 1) in a federal criminal, civil, or administrative hearing in which the government is a party; 2) in a congressional, GAO, or other federal report, hearing, audit, or investigation; or 3) from the news media; unless the action is brought by the Attorney General or the person bringing the action is an original source of the information.

The amendment defines "original source" as an individual who either prior to a public disclosure has voluntarily disclosed to the government the information on which allegations or transactions in a claim are based, or who has knowledge that is independent of and materially adds to the publicly disclosed allegations or transactions, and who has voluntarily provided the information to the government before filing an action under this section.

The study conducted by the Comptroller General must include a survey of the cost and affordability of health care insurance provided under the Exchanges for owners and employees of small business concerns, including data on enrollees in Exchanges and individuals purchasing health insurance coverage outside of Exchanges.

PART III – State Flexibility Relating to Exchanges

State Flexibility in Operation and Enforcement of Exchanges and Related Requirements

The Secretary shall issue regulations setting standards for meeting the requirements under this title with respect to: 1) the establishment and operation of exchanges; 2) the offering of qualified health plans through such exchanges; 3) the establishment of the reinsurance and risk adjustment programs; and 4) such other requirements as the Secretary determines appropriate. If a state is operating an Exchange before 2010 it will be presumed that the Exchange is in compliance with the standards.

Federal Program to Assist Establishment and Operation of Nonprofit, Member-Run Health Insurance Issuers

The Secretary will establish a program known as the Consumer Operated and Oriented Plan (CO-OP) program in order to create qualified nonprofit health-insurance issuers to offer qualified health plans in the individual and small-group markets. For persons applying to become qualified nonprofit health-insurance issuers, the Secretary will provide loans for start-up costs and grants to meet licensing solvency requirements in their state. For these loans and grants, the Secretary will take the new advisory board's recommendations into account, give priority to applicants offering statewide qualified health plans with private support, and ensure adequate funding to establish at least one qualified nonprofit issuer in each state.

To be a qualified nonprofit health-insurance issuer, an issuer must be a nonprofit member organization and have substantially all of its activities be the issuance of qualified health plans. In addition, the issuer may not be sponsored by a state or local government and must abide by all state laws applicable to other issuers of qualified health plans. All profits of a qualified nonprofit health-insurance issuer must be used to lower premiums, improve benefits, or for other quality-improvement programs. Qualified nonprofit health-insurance issuers may establish a private purchasing council to enter into collective purchase agreements for items or services to increase efficiency.

The Secretary may not participate in negotiations between qualified nonprofit health-insurance issuers and any healthcare facility or provider, including drug manufacturers and hospitals. The Secretary will not establish price structures or interfere with competition in this market.

Manager's Amendment Changes

No later than July 1, 2013, and prior to awarding loans and grants under the CO-OP, the Secretary will promulgate regulations with respect to the repayment of these loans and grants in a manner that is consistent with state solvency regulations. Loans must be repaid within five years and grants must be repaid within 15 years, taking into consideration any appropriate state reserve requirements, solvency regulations, and requisite surplus note arrangements.

Community Health Insurance Option

The Secretary will establish a community health insurance option that must be a qualified health plan that provides only the essential health benefits. The Secretary will set premiums at a level expected to cover costs with a contingency margin and will negotiate providers' reimbursement rates, which will be no higher than those for other qualified health plans. The solvency and consumer-protection laws of a state will apply. The Secretary may administer the community health insurance option program through contractors. To be qualified, a potential contractor must: 1) be a nonprofit entity; 2) meet solvency standards; 3) meet quality standards; and 4) have in place effective measures to control fraud and abuse.

Manager’s Amendment Changes

The amendment strikes the provision relating to the community health insurance option (also known as the public plan).

Level Playing Field

All health insurance coverage offered under the CO-OP, whether as a community health insurance option or as a nationwide plan, shall be subject to all federal and state laws that apply to private insurers.

Manager’s Amendment Changes

The amendment strikes the reference to the community health insurance option and replaces it with a multi-state qualified health plan.

PART IV – State Flexibility to Establish Alternative Programs

State Flexibility to Establish Health Programs for Low-Income Individuals Not Eligible for Medicaid

The Secretary must establish a basic health program for states to offer standard health plans with essential benefits to eligible low-income individuals. The program must include a competitive process for entering into contracts with standard health plans. States will consider innovation, health and resource difference, managed care, and performance measures in contracting with plans and will make multiple plans available to ensure choice. States electing to cover these individuals will receive an amount equal to 85 percent of the premium tax credits and the cost-sharing reductions that would have been provided for the fiscal year to eligible individuals enrolled in standard health plans if such individuals were allowed to enroll in qualified health plans. Eligible individuals include: 1) residents of the state who are not eligible for the state’s Medicaid program consisting of at least the essential health benefits; 2) whose household income exceeds 133 but not 200 percent of the poverty line, 3) who is not eligible for minimum essential coverage or employer-sponsored coverage; and 4) who is under 65 years of age.

Manager’s Amendment Changes

The payment amount states will receive is changed from 85 percent to 95 percent. Eligible individuals will also include aliens lawfully present with incomes less than 133 percent but who are not eligible for Medicaid by reason of their alien status.

Waiver for State Innovation

State may apply for waivers of requirements relating to qualified health plans, Exchanges, cost-sharing reductions, tax credits, the individual responsibility requirement, and shared responsibility for employers. There will be alternate means for individuals and small employers not qualifying for the premium tax credits, cost-sharing reductions, or small business credits for which they would otherwise be eligible. Waivers will be granted if it is determined that the state plan will provide coverage including the essential health benefits, cost-sharing protections, coverage to a comparable number of residents, and will not increase the federal deficit.

Provisions Relating to Offering of Plans in More than One State

The Secretary will issue regulations for the creation of health care choice compacts under which two or more states (beginning in 2016) may enter into an agreement for offering qualified health plans subject to the regulation of the state in which the plan was written or issued and under which the issuer would continue to be subject to market standards. Each state must enact a law authorizing such agreements to participate and the Secretary must approve the compacts. If an issuer of a qualified health plan meets specified requirements to become a nationwide qualified health plan, the issuer may offer the plan in the individual or small group market in more than one state, and only the state laws in which the plan is written or issued shall apply. Nationwide plans must provide at least the essential benefits package. States may opt out of providing such nationwide plans.

Manager's Amendment Changes

The amendment strikes all provisions relating to nationwide qualified health plans.

The amendment inserts the following new section:

Multi-State Plans

The Director of the Office of Personnel Management (OPM) shall enter into contracts with health insurance issuers (without regard to certain specified statutes) to offer at least two multi-state qualified health plans through each Exchange in each state. OPM will negotiate contracts in a manner similar to contracts for the Federal Employees Health Benefits program (FEHBP); however, the FEHBP will maintain a separate risk pool. OPM may prohibit multi-state plans that do not meet the standards for medical loss ratios, profit margins, and premiums. Plans must comply with the 3:1 age rating. The Director will ensure that at least one contract is entered into with a non-profit entity. A health insurance issuer will be eligible if it agrees to offer a multi-state qualified health plan that meets the requirements in each Exchange in each state, is licensed in each state, complies with the minimum standards for carriers offering health benefits plans, and meets such other specified requirements.

PART V – Reinsurance and Risk Adjustment

Transitional Reinsurance Program for Individual and Small Group Markets in Each State

States must establish one or more applicable reinsurance entities to carry out the reinsurance program. An applicable reinsurance entity is a not-for-profit organization that stabilizes premiums and carries out the reinsurance program by coordinating the funding and operation of the risk-spreading mechanisms. The Secretary will include provisions, when establishing federal standards for state flexibility in operation and enforcement of exchanges, that enable states to establish and maintain a program under which health insurance issuers and third party administrators are required to make payments to an applicable reinsurance entity which then makes reinsurance payments to

health insurance issuers that cover high-risk individuals in the individual market. Contributions must total \$25 billion over three years. The Secretary will include provisions to determine high-risk individuals and a formula for determining the amount of payment high-risk individuals shall provide for equitable allocation of available funds.

Establishment of Risk Corridors for Plans in Individual and Small Group Markets

The Secretary must establish and administer risk corridors (in 2014, 2015, and 2016) under which a qualified health plan can participate in a payment adjustment system. If a plan's non-administrative costs exceed 103 percent of total premiums, the Secretary will make payments to the plan to cover the excess. If the plan's allowable costs are less than 97 percent of total premiums, the plan will have to pay the Secretary a specified amount.

Manager's Amendment Changes

Risk corridors will only be applied and administered by the Secretary in the individual market.

Risk Adjustment

Each state must assess a charge on health plans and health insurance issuers if the actuarial risk of enrollees is less than the average actuarial risk of all enrollees in the state. States must provide a payment to those with actuarial risk greater than average based on the Secretary's established criteria. Risk adjustment applies in the individual and small group markets but does not apply to grandfathered health 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

Refundable Tax Credit Providing Premium Assistance for Coverage under a Qualified Health Plan

The tax code is amended to provide tax credits to assist with the cost of health insurance premiums. There shall be allowed as a credit against the tax imposed by this subtitle for any taxable year an amount equal to the premium assistance credit amount of the taxpayer for the taxable year. This credit means the sum of the premium assistance amounts with respect to all coverage months during the taxable year. The premium assistance amount is equal to the lesser of the monthly premiums or the excess of the adjusted monthly premium for the second lowest cost silver plan over 1/12 of the product of the applicable percentage and the taxpayer's household income. The credit is calculated on a sliding scale ranging from 2.8 to 9.8 percent of income. The applicable percentage with respect to any taxpayer is equal to 2.8 percent, increased by the number of percentage points which bears the same ratio to seven percentage points as: 1) the taxpayer's household income for the taxable year in excess of 100 percent of the poverty line; bears to 2) an amount equal to 200 percent of the poverty line. A special rule is created if a taxpayer's household income is in excess of 100 percent, but not more than

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133 percent of the poverty line, the taxpayer's applicable percentage shall be two percent. The term "applicable taxpayer" means a taxpayer whose household income exceeds 100 percent but does not exceed 400 percent of the federal poverty line. No deduction shall be allowed for the portion of the premiums paid by the taxpayer for coverage of one or more individuals under a qualified health plan equal to the amount of the credit determined for the taxable year with respect to such premiums. The Comptroller General shall conduct a study on the affordability of health insurance coverage.

Manager's Amendment Changes

The amendment makes the following changes: 1) the special rule for taxpayers under 133 percent of the poverty line applies to taxpayers with household incomes equal to or greater than 100 percent, but not more than 133 percent of the federal poverty line; 2) the term "applicable taxpayer" means a taxpayer whose household income equals or exceeds 100 percent but does not exceed 400 percent of the federal poverty line.

Reduced Cost-Sharing for Individuals Enrolling in Qualified Health Plans OK 1402

For an insured person enrolled in a qualified health plan, the Secretary shall notify the issuer of the plan of eligibility and the issuer shall reduce the cost-sharing under the plan to one-third for individuals between 100 and 200 percent of poverty, to one-half for individuals between 200 and 300 percent of poverty, and to two-thirds for those between 300 and 400 percent of poverty. The reduction in cost-sharing shall first be achieved by reducing the applicable out-of-pocket limit based on income (\$5,950 for individuals, \$11,900 for families). Procedures must be established so that the issuer of a qualified health plan can further reduce cost-sharing under the plan in a manner sufficient to increase the plan's share of the total allowed costs of benefits. These reductions will not apply to benefits offered in addition to the essential health benefits or pediatric dental benefits.

SUBPART B – Eligibility Determinations

Procedures for Determining Eligibility for Exchange Participation, Premium Tax Credits and Reduced Cost-Sharing, and Individual Responsibility Exemptions

The Secretary shall establish a program for determining whether: 1) individuals meet the requirements of this title; 2) individuals meet the income and coverage requirements and the amount of the tax credit or reduced cost-sharing; 3) individual coverage under an employer-sponsored health benefits plan is treated as unaffordable; and 4) to grant a certification attesting that individuals are entitled to an exemption from either the individual responsibility requirement or the penalty imposed by such section. Individuals seeking an exemption certificate from any requirement or penalty imposed must provide the required information.

Advance Determination and Payment of Premium Tax Credits and Cost-Sharing Reductions

The Secretary shall establish a program under which, upon request of an Exchange, advance determinations are made with respect to income eligibility for the premium tax

credit allowable and the cost-sharing reductions. The advance determinations must be made during the annual open enrollment period and on the basis of household income for the most recent year. Advance payments will be made on a monthly basis to the issuer of a qualified health plan and the plan shall reduce the premium charged.

Streamlining of Procedures for Enrollment through an Exchange and State Medicaid, CHIP, and Health Subsidy Programs

Establishes a system for residents of each state to enroll, receive eligibility determination, and continue participation in applicable state health subsidy programs. The system must ensure that if an individual is found to be eligible for medical assistance under the state Medicaid plan or state CHIP, the individual is enrolled. Each state health subsidy program shall participate in a data matching arrangement for determining eligibility for participation in the program.

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Disclosures to Carry Out Eligibility Requirements for Certain Programs

The Secretary of Treasury may disclose return information of any taxpayer whose income is relevant in determining premium tax credits or cost-sharing reductions or eligibility for participation in Medicaid, CHIP, or a basic health program.

Premium Tax Credit and Cost-Sharing Reduction Payments Disregarded for Federal and Federally-Assisted Programs

For purposes of determining the eligibility of any individual for benefits or assistance under any federal program or under any state or local program financed in whole or in part with federal funds, any credit or refund will not be taken into account as income or resources. Any cost-sharing reduction or advance payment of the credit allowed shall be treated as made to the qualified health plan in which an individual is enrolled and not to that individual.

Manager's Amendment Changes

The amendment inserts the following new section:

Study of Geographic Variation in Application of Federal Poverty Level

The Secretary shall conduct a study to examine the feasibility and implication of adjusting the application of the federal poverty level for different geographic areas so as to reflect the variations in cost-of-living among different areas. If the Secretary determines that an adjustment is feasible, the study should include a methodology to make such an adjustment.

PART II – Small Business Tax Credit

Credit for Employee Health Insurance Expenses of Small Businesses

The tax code is amended to provide a tax credit to small employers. The credit amount is equal to 50 percent of the lesser of the aggregate amount of nonelective contributions the employer made or the aggregate amount of nonelective contributions that the employer would have made during the taxable year in the credit period. For tax-exempt small

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employers, there shall be treated as a credit the lesser amount of the credit determined or the amount of the payroll taxes of the employer during the calendar year.

The term “credit period” means the 2-consecutive-taxable year period beginning with the first taxable year in which the employer offers one or more qualified health plans to employees through an Exchange. “Eligible small employer” means an employer with no more than 25 full-time equivalent employees for the taxable year, the average annual wages of which do not exceed twice a specified dollar amount in effect for that year. The specified dollar amount for 2011, 2012, and 2013 will be \$20,000 and for subsequent years will be \$20,000 multiplied by a cost-of-living adjustment. No credit period will be required in 2011, 2012, and 2013. The credit shall be determined without regard to whether the taxable year is in a credit period and using different specified percentages.

No deduction will be allowed for the portion of the premiums for qualified health plans or for health insurance coverage in years beginning in 2011, 2012, or 2013, paid by an employer which is equal to the amount of the credit. This credit will be allowed against the alternative minimum tax for businesses and will be effective as of December 31, 2010.

Manager’s Amendment Changes

The amendment changes the specified dollar amount from \$20,000 to \$25,000 and changes the dates to start calculating the dollar amounts as of 2010, instead of starting in 2011. The amendment also changes the dates regarding when no credit period will be required from 2011, 2012, and 2013, to 2010, 2011, 2012 and 2013. The provision relating to when no deduction will be allowed is also changed from 2011, 2012 and 2013, to 2010, 2011, 2012 and 2013. All amendments made by this section will apply to amounts paid or incurred in taxable years beginning after December 1, 2009. Amendments to the credit allowed against the alternative minimum tax will apply in taxable years beginning after December 31, 2009.

Subtitle F – Shared Responsibility for Health Care

PART I – Individual Responsibility

Requirement to Maintain Minimum Essential Coverage

Beginning in 2014, a penalty, or a shared responsibility payment, will be imposed on applicable individuals not meeting the requirement of minimum essential coverage. The penalty for any month is equal to 1/12 of the applicable dollar amount for the calendar year. The amount can not exceed 300 percent of the applicable dollar amount. The applicable dollar amount will be phased in starting at \$95 in 2014 and \$350 in 2015. Starting in 2016, the applicable dollar amount will be \$750 and this amount will be increased by the cost-of-living adjustment for all subsequent years. Amounts will vary based on age, family size, and household income. Applicable individuals are those who are not exempt and exclude incarcerated individuals and non-citizens. Exempt individuals include: 1) members of recognized religious sects; 2) individuals whose monthly

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contributions exceed eight percent of their taxable income; 3) taxpayers with income under 100 percent of the poverty line; 4) members of Indian tribes; and 5) individuals who the Secretary determines have suffered a hardship.

Minimum essential coverage is defined as government sponsored programs (such as Medicare and Medicaid, CHIP, TRICARE, veteran's health care, or plans provided to Peace Corp volunteers), employer-sponsored plans, plans offered through the individual market within a state, grandfathered health plans, and other plans recognized by the Secretary.

Manager's Amendment Changes

The amendment makes several additions to the effects of the requirement to maintain minimum essential coverage and also clarifies that the penalty will apply not only to individual taxpayers who fail to acquire minimum essential coverage, but also to taxpayers who are responsible for certain dependents or who are filing their taxes jointly and are responsible for their spouse.

The amendment increases the applicable dollar amount for 2015 from \$350 to \$495. The amendment changes the amount of the penalty to the lesser of: 1) the sum of the monthly penalty amounts for months in the year during which one or more failures occurred; or 2) the national average premium for qualified plans which have a bronze level of coverage. The monthly penalty amount will be an amount equal to 1/12 of the greater of the following: 1) specified flat dollar amount; or 2) specified percentage of income (0.5 percent for 2014, 1.0 percent for 2015, and 2.0 percent for years after 2015).

Reporting of Health Insurance Coverage

Every person who provides minimum essential coverage to an individual must make a return. The Secretary of the Treasury will send notification of services available through the Exchange to each individual filing an individual income tax return and who is not enrolled in minimum essential coverage.

PART II – Employer Responsibilities

Automatic Enrollment for Employees of Large Employers

An employer with more than 200 full-time employees offering enrollment in one or more health benefits plans must automatically enroll new full-time employees in one of the plans offered and continue the enrollment of current employees. There must be adequate notice and the opportunity for an employee to opt out of any automatic coverage.

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Employer Requirement to Inform Employees of Coverage Options

An employer must provide each employee at the time of hiring written notice of the Exchange, eligibility requirements for a premium tax credit and a cost-sharing reduction, and the forfeiture of the employer premium contribution if the employee enrolls in the Exchange.

Shared Responsibilities for Employers

Imposes an assessable payment equal to the product of the applicable payment amount and the number of individuals employed full-time by the employer if any large employer fails to offer full-time employees the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan for any month, and at least one full-time employee has been certified to the employer as having enrolled in a qualified health plan with respect to an applicable premium tax credit or cost-sharing reduction. An assessable payment will be imposed on any applicable large employer that requires a waiting period exceeding 30 days to enroll. The amount will be \$400 if the waiting period is between 30 and 60 days, and \$600 for waiting periods over 60 days. Applicable large employers are those who employed an average of at least 50 full-time employees on business days during the preceding calendar year. The Secretary of Treasury may provide for the payment of any assessable payment provided by this section on an annual, monthly, or other periodic basis. The Secretary of Labor shall conduct a study to determine whether employees' wages are reduced by reason of the application of the assessable payments.

Manager's Amendment Changes

The amendment changes the application of the penalty from employers with 30-day waiting periods to employers with 60-day waiting periods and changes the amount to \$600 for those with waiting periods exceeding 60-days.

The amendment also includes employers with substantial annual gross receipts attributable to the construction industry as "applicable large employers" if they employed an average of at least five full-time employees and their annual payroll expenses exceeded \$250,000 for the preceding year.

Reporting of Employer Health Insurance Coverage

Every applicable large employer must report to the Secretary whether it offers its full-time employees and their dependents the opportunity to enroll in minimum essential coverage, the length of the waiting period, the lowest cost option, the employer's share of the total costs of benefits under the plan, and the names and number of employees receiving coverage.

Manager's Amendment Changes

The amendment adds that the Secretary will have the authority to review the accuracy of the information provided in the reporting of health insurance coverage by large employers.

Offering of Exchange-Participating Qualified Health Plans through Cafeteria Plans

Qualified benefit shall not include any qualified health plan offered through an Exchange, except to an employee whose employer is a qualified employer offering the employee the opportunity to enroll through such an Exchange in a qualified health plan in a group market.

Subtitle G - Miscellaneous Provisions

Definitions

Unless specifically provided for otherwise, the definitions contained in Section 2791 of the Public Health Service Act will apply with respect to this title.

Transparency in Government

The Secretary must publish on the HHS website a list of all of the authorities provided to the Secretary under this Act no later than 30 days after the date of enactment.

Prohibition Against Discrimination on Assisted Suicide

The federal government, any state or local government or health care provider that receives federal financial assistance may not discriminate against an individual or institutional health care entity on the basis that the entity does not provide any health care item or service for the purpose of causing or assisting in causing the death of any individual, such as by assisted suicide, euthanasia, or mercy killing.

Access to Therapies

The Secretary is prohibited from promulgating any regulation that creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care or impedes timely access to health services.

Freedom Not to Participate in Federal Health Insurance Programs

No individual, company, business, nonprofit entity, or health insurance issuer offering group or individual health insurance coverage is required to participate in any federal health insurance program.

Equity for Certain Eligible Survivors

The limitation that prevented provisions of the Black Lung Benefits Act (BLBA) from being applied to claims filed on or before the effective date of the BLBA is removed. It also removes the claim-refiling requirement that persons eligible for benefits under the BLBA who had claims on or after the effective date of the BLBA. These changes apply to claims filed under Part B or Part C of the BLBA after January 1, 2005, that are pending on or after the date of enactment of this Act.

Nondiscrimination

No individuals will be excluded from participation in, denied benefits of, or be subjected to discrimination under any health program or activity which receives federal assistance on the grounds set out under Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, or Section 504 of the Rehabilitation Act of 1973. This in no way invalidates or limits the rights, remedies, procedures, or legal standards available to individuals aggrieved under the aforementioned Acts, nor shall this supersede any state laws that provide additional protections against discrimination on any basis. The Secretary may promulgate regulations to implement prohibitions against discrimination based on such grounds.

Protections for Employees

Employers are prohibited from firing or discriminating against any employees with respect to his or her compensation, terms, conditions, or other privileges of employment because the employee has received a work-share credit or for other specified reason. Any employee who believes he or she has been discharged or discriminated against by an employer for these reasons may seek relief in accordance with the procedures, notifications, burdens of proof, remedies, and statutes of limitation set forth in 15 U.S.C. 2087(b) which addresses whistleblower protections.

Oversight

The Inspector General of HHS will have oversight authority with respect to the administration and implementation of Title I regarding quality, affordable care for all Americans as it relates to HHS.

Rules of Construction

Nothing in Title I of the Act: 1) modifies, impairs, or supersedes the operation of any antitrust laws; 2) modifies or limits the application of the exemption for Hawaii's Prepaid Health Care Act under ERISA; 3) prohibits an institution of higher education from offering a student health insurance plan; and 4) modifies any existing federal requirement concerning the state agency responsible for determining eligibility for Medicaid and CHIP.

HIT Enrollment Standards and Protocols

The Secretary shall develop interoperable and secure standards and protocols that facilitate enrollment of individuals in federal and state health and human services programs. Standards and protocols for electronic enrollment in the federal and state programs will allow for electronic matching against existing federal and state data, simplify the submission of documents, and expand enrollment systems. The Secretary will award grants to eligible entities to develop new technology and adapt existing technology systems to implement the HIT enrollment standards and protocols.

Manager's Amendment Changes

The amendment inserts the following new sections:

GAO Study Regarding the Rate of Denial of Coverage and Enrollment by Health Insurance Issuers and Group Health Plans

The Comptroller General will conduct a study of the incidence of denials of coverage for medical services and denials of applications to enroll in health insurance plans by group health plans and health insurance issuers. The study shall consider data from both qualified health plans and plans that are not qualified health plans.

Small Business Procurement

All laws or regulations establishing procurement requirements relating to small business concerns may not be waived with respect to any contract awarded under any program or other authority under this Act.

Free Choice Vouchers

Employers that offer health care coverage and make a contribution toward the cost of the health care coverage must provide free choice vouchers to qualified employees so they may purchase qualified health plans through the Exchange. Employees who spend between 8 and 9.8 percent of their income on insurance premiums (and thus not eligible for premium subsidies) will qualify. The contribution amount to the voucher must be equal to the amount the employer contributes to their own health plan. The voucher is taxable neither to the employer nor the employee. An employee who receives a voucher is not eligible for a premium credit and the employee’s employer is not subject to a penalty.

Development of Standards for Financial and Administrative Transactions

The Secretary will solicit input from various stakeholders on whether there could be greater uniformity in financial and administrative activities and whether such activities should be considered financial and administrative transactions for which the adoption of standards and operating rules would improve the operation of the health care system and reduce administrative costs. The Secretary will also solicit input from stakeholders regarding the crosswalk between the Ninth and Tenth Revisions of the International Classification of Diseases and make recommendations about appropriate revisions. Revisions will be posted on the CMS website.

TITLE II – ROLE OF PUBLIC PROGRAMS

Subtitle A – Improved Access to Medicaid

Medicaid Coverage for the Lowest Income Populations

Beginning January 14, 2014, individuals who are under 65 years of age, who are not described previously, and who are in families whose income (as determined by the Secretary and the Health Choices Commissioner) does not exceed 133 percent of the official poverty line applicable to a family of the size involved will be eligible for Medicaid. Also the FMAP amounts expended for newly-eligible individuals are increased to 100% beginning January 1, 2014 and ending on December 31, 2016.

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Starting January 1, 2011 and ending January 1, 2014, a state may elect to provide medical assistance to individuals up to 133 percent of the poverty line if that provision was effective before January 1, 2014. This requirement will not apply to states who certify that the budget has a deficit or is projected to have a deficit. A state will not receive federal funds if it has eligibility standards, methodologies, or procedures under the state Medicaid plan that are more restrictive than those in effect on date of enactment of this

Act. States may, however, maintain less restrictive eligibility standards. There is a requirement to maintain eligibility standards until the Exchange is fully operational. This requirement will continue to apply through September 30, 2010, with respect to determining the eligibility for medical assistance of any child less than 19 years of age.

A state may provide medical assistance to individuals who beginning January 1, 2014, are under 65 years of age, are not currently described or enrolled in Medicaid, and whose income exceeds 133 percent of the poverty line but does not exceed the highest income level established under the state Medicaid plan. A state may elect to phase-in the extension of eligibility for medical assistance to individuals with incomes greater than 133 percent of the poverty line so long as state does not extend such eligibility to individuals with higher income before making individuals with lower income eligible for medical assistance. If an individual with an income greater than 133 percent is a parent of a child under 19 years of age who is eligible for medical assistance under Medicaid, the individual may not be enrolled under the state Medicaid plan unless the child is enrolled.

Benchmark or benchmark equivalent coverage is required to provide at least the essential benefits defined in this Act. Prescription drug coverage and coverage of mental health services would be added to the list of covered services for purposes of this expansion to Medicaid.

Manager's Amendment Changes

Amends the date from which states may elect to extend Medicaid eligibility from January 1, 2011 to April 1, 2010. The amendment includes inpatient hospital services in determining whether a state is an expansion state for purposes of the increased FMAP for newly eligible mandatory individuals. Newly eligible individuals will become eligible on December 1, 2009 (changed from the date of enactment of this Act) if they are not younger than 19 years of age and meet other specified eligibility requirements.

The amendment inserts the following new section:

Equitable Support for Certain States

Between 2014 and 2019, the FMAP will be increased by 2.2 percentage points for any state meeting certain requirements for amounts expended for medical assistance for individuals who are not newly eligible individuals. Eligible states will include expansion states, states the Secretary determines will not receive any payments on the basis of an increased FMAP for expenditures for medical assistance for newly eligible individuals, and have not been approved by the Secretary to divert a portion of the DSH allotment to the costs of providing medical assistance or other health benefits coverage under a waiver that is in effect on July 2009.

Between 2014 and 2016, the FMAP will be increased by 0.5 percentage point for certain states for amounts expended for medical assistance under the state plan or

waiver of that plan. Eligible states will include expansion states, states the Secretary determines will not receive any payments on the basis of an increased FMAP for expenditures for medical assistance for newly eligible individuals, and states with the highest percentage of its population insured during 2008.

Beginning January 1, 2017, the FMAP for Nebraska for newly eligible individuals will be 100 percent.

This increase in FMAP does not apply with respect to: 1) DSH payments; 2) grants to states for aid and services to needy families with children and for child welfare); 3) payments under the CHIP; and 4) payments based on the enhanced FMAP.

The amendment inserts the following new section:

Requirement for Certain States

States that require political subdivisions to contribute toward the non-federal share of expenditures are not be eligible for an increase in FMAP if it requires the subdivisions to pay a greater percentage of the non-federal share than would have been required by the state under the state plan as of December 31, 2009.

Income Eligibility for Nonelderly Determined Using Modified Gross Income

For purposes of determining income eligibility for medical assistance under the state Medicaid plan a state shall use the modified gross income for an individual or household. The Modified Gross Income eligibility test is not required for individuals who qualify for the state plan under a basis that does not require a determination of income, individuals who are 65 and older, and individuals who qualify for the state Medicaid plan on the basis of being blind or disabled.

Requirement to Offer Premium Assistance for Employer-Sponsored Insurance

A state can not require, as a condition of eligibility for Medicaid, that the individual apply for enrollment in qualified employer-sponsored coverage. However, the state may elect to offer premium assistance to pay for employer-sponsored insurance.

Medicaid Coverage for Former Foster Care Children

The state may provide medical assistance under Medicaid to children who were in foster care for more than six months (whether or not consecutive) but are no longer in such care and who are under 25 years of age effective on January 1, 2019.

Manager's Amendment Changes

Moves up the eligibility date of former foster care children to January 1, 2014. States may make medical assistance available, at their option, to individuals who are: 1) under 26 years of age; 2) are not enrolled already, but have income that exceeds the applicable level of income; 3) were in foster care on the date of turning 18 years of age or a state specified age; and 4) were enrolled in the state plan while in foster care.

Payments to Territories

Payment amount limits shall be increased by 30 percent for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. Beginning in 2014, payments made to with respect to amounts spent for medical assistance for newly eligible non-pregnant childless adults who are eligible and whose income does not exceed the income eligibility level in effect for that population under Medicaid shall not be taken into account. The FMAP shall be increased to 55 percent.

Manager's Amendment Changes

The highest income eligibility level in effect for parents under the commonwealth's or territory's state plan under Medicaid or under a waiver of the plan will not be taken into account when calculating certain specified increases.

Special Adjustments to FMAPs Determination for Certain States Recovering from a Major Disaster

Beginning January 1, 2011, the projected decreases in Medicaid funding will be reduced for states that have experienced major disasters.

Medicaid Improvement Fund Rescission

Any amounts available to the Medicaid Improvement Fund for any of the fiscal years 2104 through 2018 that are available for expenditure from the Fund and that are not obligated as of the date of enactment of this Act are rescinded.

Subtitle B – Enhanced Support for the CHIP

Additional Federal Financial Participation for CHIP

The matching rate to states for the CHIP will be increased by 23 percentage points (not to exceed 100 percent) from 2014 to 2019. A state may not impose eligibility standards that are more restrictive than those already in effect. If funding allotments are insufficient to cover all children who are eligible, a state shall establish procedures to ensure that such children are provided coverage through an Exchange. No bonus payments will be made for children enrolled after October 1, 2013. Beginning January 1, 2014, states are required to use modified gross income and household income to determine eligibility for child assistance under the state child health plan.

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Manager's Amendment Changes

The amendment makes the following changes: 1) reduces the period of increased matching percentage by changing the date from 2013 to 2015; 2) requires the continuation of eligibility standards by states for children until October 1, 2019 as a condition of receiving payments, but does not prevent states from enrolling children eligible to be targeted low-income children under the state child health plan in a qualified health plan; 3) ensures targeted low-income children, unable to be provided assistance as a result of funding shortfalls, are screened for eligibility and enrolled in state child health plans.

The amendment inserts the following new sections:

Additional Federal Financial Participation for CHIP, Maintenance of Effort

For purposes of eligibility for premium assistance for the purchase of a qualified health plan and reduced cost-sharing, certain targeted low-income children will be deemed to be ineligible for coverage under the state child health plan.

Certification of Comparability of Pediatric Coverage Offered by Qualified Health Plans

The Secretary, no later than April 1, 2015, will review benefits offered to children and the cost-sharing imposed by qualified health plans and impose cost-sharing with respect to such benefits that the Secretary determines are at least comparable to the benefits offered and cost-sharing protections provided under the state child health plan.

Technical Corrections

Provides technical corrections to CHIP Reauthorization Act (CHIPRA) and the American Reinvestment and Recovery Act (ARRA)

Manager's Amendment Changes

The amendment makes the following changes: 1) allotments under the CHIP will be made through 2015 and all dates are updated to reflect the extension of the program; 2) from amounts made available for 2013 (\$17,406,000,000) and for 2014 (\$19,147,000,000), the Secretary will compute a state allotment for each state using an increase factor. Fiscal year 2015 (changed from 2013) will now be used in calculating prorated allotments to states; 3) fiscal year 2014 (changed from 2012) and fiscal year 2015 (changed from 2013) will be used with respect to deposits and the aggregate cap on deposits made into the Child Enrollment Contingency Fund; and 4) the period during which qualifying states can receive the enhanced portion of the CHIP matching rate for Medicaid coverage of certain children is extended to 2015.

Subtitle C – Medicaid and CHIP Enrollment Simplification

Enrollment Simplification and Coordination with State Health Insurance Exchanges

States must have procedures enabling individuals to apply for coverage under Medicaid, CHIP or the Exchange through an internet website and must have procedures for conducting outreach and enrolling vulnerable and underserved populations. By 2014, individuals must be able to compare the benefits, premiums, and cost-sharing under Medicaid and CHIP to those available under a qualified health plan offered through an Exchange.

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Permitting Hospitals to Make Presumptive Eligibility Determinations for All Medicaid Eligible Populations

Any Medicaid participating hospital may elect to be a qualified entity for the purpose of determining whether an individual is eligible for medical assistance under the state Medicaid plan for purposes of providing the individual with medical assistance during a presumptive eligibility period.

Subtitle D – Improvements to Medicaid Services

Coverage for Freestanding Birth Center Services

States must cover and provide Medicaid payments to providers administering prenatal labor and delivery or postpartum care in a freestanding birth center.

Concurrent Care for Children

The voluntary election to seek hospice care by a child does not constitute a waiver of any rights of the child to be provided with Medicaid coverage for services related to the treatment of a terminal illness.

State Eligibility Option for Family Planning Services

States may offer optional coverage for family planning services for a categorically needy group. Individuals described as categorically needy are those people: 1) whose income does not exceed an eligibility level established by the state that does not exceed the highest income eligibility level established under the state plan for pregnant women; and 2) who are not pregnant. A state may include individuals who would have been eligible under a Section 1115 waiver (research and demonstration projects), had the individuals applied on or before January 1, 2007.

Clarification of Definition of Medical Assistance

Amends the definition of medical assistance to clarify that it includes both payment for services and the services themselves.

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

Community First Choice Option

Beginning October 1, 2010, a state may provide for home and community-based attendant services and supports to assist eligible individuals in activities of daily living. Services include those which would otherwise have been provided in a nursing facility, institution for mental diseases, or an intermediate care facility.

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Removal of Barriers to Providing Home and Community-Based Services

The Secretary will help states develop service systems designed to provide home and community-based services. States will be able to provide more types of services through a state plan amendment than through a waiver. States may also extend full Medicaid benefits to individuals receiving home and community-based services under a state plan

amendment. States may elect to target services to specific populations and may differ in the type, amount, duration, or scope of such services to such specific populations.

Money Follows the Person Rebalancing Demonstration

Extends the Money Follows the Person Rebalancing Demonstration to 2016 and adjusts the time periods relating to the reduction of institutional residency.

Protection for Recipients of Home and Community-Based Services Against Spousal Impoverishment

Individuals who are eligible for medical assistance for home and community-based services can be considered in the definition of institutionalized spouse in determining special treatment of income for institutional spouses for a five-year period beginning in 2014.

Funding to Expand State Aging and Disability Resource Centers

Appropriates to the Secretary \$10 million for each of fiscal years 2010 through 2014 to carry out duties relating to providing technical assistance to states and implementing State Aging and Disability Resource Centers.

Sense of the Senate Regarding Long-Term Care

Summarizes findings of the Senate regarding long-term care and states that during the 111th session, the Congress should address long-term care services and supports in a comprehensive way that guarantees elderly and disabled individuals the care they need.

Subtitle F – Medicaid Prescription Drug Coverage

Prescription Drug Rebates

The rebate for single source and innovator multiple source drugs will increase from 15.1 to 23.1 percent, except for the rebate for clotting factors and outpatient drugs approved for pediatric indications, where it will increase to 17.1 percent. The basic rebate percentage will increase from 11 to 13 percent. Each state is required to report to the Secretary on a quarterly basis the total amount of rebates in dollars received from pharmacy manufacturers for drugs provided to individuals enrolled with Medicaid managed care organizations. In no case will the rebate for a single source drug or an innovator multiple source drug for a rebate period beginning after December 31, 2009, exceed 100 percent of the average manufacturer price of the drug.

Addressed in
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Elimination of Exclusion of Coverage of Certain Drugs

Effective January 1, 2014, drugs used to promote smoking cessation, barbiturates, and benzodiazepines will not be excluded from Medicaid coverage.

Providing Adequate Pharmacy Reimbursement

The Secretary will calculate the federal upper reimbursement limit of average manufacturer price as 175 percent of the weighted average of monthly average manufacturer prices. The Secretary will implement a smoothing process for average

manufacturer prices. Manufacturers must regularly report the total number of units used to calculate the monthly average manufacturer price for each covered outpatient drug.

Subtitle G – Medicaid DSH Payments

Medicaid DSH Payments

When a state's percentage of uninsured individuals is reduced by 45 percent, the DSH allotment will be reduced by 50 percent (or 25 percent in a low DSH state). The state's reduced allotment determination will not include any portion of the allotment approved for providing medical assistance or other health benefits coverage under a waiver in effect on July 2009. DSH allotments will be reduced as the rate of uninsured individuals declines. The DSH allotment can at no time be reduced by more than 65 percent compared to its fiscal year 2012 allotment (increased by the percentage change in the consumer price index).

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Manager's Amendment Changes

The amendment adds that the DSH allotment for Hawaii for the second, third, and fourth quarters of fiscal year 2012 is \$7,500,000. For 2013 and each year thereafter, the allotment for Hawaii will be increased in the same manner as allotments for low DSH states. The Secretary can not impose a limitation on the total amount of payments made to hospitals under a Section 1115 Demonstration Project unless the limitation is necessary to ensure a hospital does not receive payments in excess of certain specified amounts or as necessary to ensure payments under the waiver do not exceed a specified amount.

The DSH minimum allotment for 2013 or any succeeding year may not be less than 50 percent (changed from 35 percent) of the allotment determined for the state for fiscal year 2012, increased by the percentage change in the consumer price index for all urban consumers for each previous fiscal year. Amendments regarding DSH payments do not apply to the allotment determined for Hawaii for 2012 and succeeding years. The applicable percentage calculation varies based on whether a state or low DSH state has spent more or less than 99.9 percent of the allotments.

Subtitle H – Improved Coordination for Dual Eligible Beneficiaries

5-Year Period for Demonstration Projects

Any waiver that provides medical assistance for dual eligible individuals may be conducted for a period of five years, and upon request of the state may be extended for additional five-year periods unless the Secretary determines that the conditions for waiver have not been met or that it would no longer be cost-effective and efficient to extend the waiver.

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Providing Federal Coverage and Payment Coordination for Dual Eligible Beneficiaries

By March 1, 2010, the Secretary will establish a Federal Coordinated Health Care Office within CMS in order to align acute care and long-term services with other services furnished under Medicare, provide support for coordination of contracting and oversight by states and CMS and to improve health outcomes and access to benefits for all dual eligible individuals.

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

Adult Health Quality Measures

By January 1, 2011, the Secretary will develop a core set of adult health quality measures for Medicaid eligible adults. Within twelve months the Secretary will establish a Medicaid Quality Measurement Program. Each state with a state Medicaid plan or waiver will annually report to the Secretary on state-specific adult health quality measures.

Addressed in
Title II of the
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Payment Adjustment for Health Care-Acquired Conditions

The Secretary will develop regulations effective July 1, 2011, prohibiting payment for health care-acquired conditions. The Secretary may exclude certain conditions identified under Medicare for non-payment under Medicaid when the Secretary finds the inclusion of such conditions to be inapplicable to Medicaid beneficiaries.

Addressed in
Title II of the
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State Option to Provide Health Homes for Enrollees with Chronic Conditions

Beginning January 1, 2011, a state may provide for medical assistance to eligible individuals with chronic conditions who select a designated provider, a team of health care professionals, or a health team, as the individual's health home for purposes of providing the individual with health home services. The Secretary may award planning grants to States for purposes of developing a state amendment plan for providing health homes for enrollees with chronic conditions. A designated provider will report to the state on all applicable measures for determining the quality of such services. When appropriate and feasible, a designated provider will use HIT in providing the state with such information.

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Demonstration Project to Evaluate Integrated Care Around a Hospitalization

The Secretary will establish a demonstration project to evaluate the use of bundled payments for the provision of integrated care for a Medicaid beneficiary with respect to an episode of care that includes hospitalization and for concurrent physician services provided during a hospitalization. The demonstration project shall operate from 2012 through 2016. The Secretary will ensure payments are properly adjusted for severity of illness and other characteristics.

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Medicaid Global Payment System Demonstration Project

The Secretary will work with the Center for Medicare and Medicaid Information to establish the Medicaid Global Payment System Demonstration Project under which a

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participating state will adjust the payments made to an eligible safety net hospital system or network from a fee-for-service payment structure to a global capitated payment model. The demonstration project shall operate during a period of fiscal years 2010 through 2012.

Pediatric Accountable Care Organization Demonstration Project

The Secretary will establish the Pediatric ACO Demonstration Project to authorize a participating state to allow pediatric medical providers that meet specified requirements to be recognized as an ACO for purposes of receiving incentive payments. The Secretary may establish an annual cap on incentive payments. The demonstration project will begin in 2012 and end in 2016.

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Medicaid Emergency Psychiatric Demonstration Project

The Secretary will establish a demonstration project under which an eligible state will provide payment under the state Medicaid plan to an institution for mental diseases that is not publicly owned and that meets certain requirements regarding the treatment of emergency medical conditions. States participating in the project may manage the provision of services for stabilization of medical emergency conditions through utilization review, authorization, or management practices, or the application of medical necessity and appropriateness criteria applicable to behavioral health. Up to eight states may participate for a three-year period.

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

MACPAC Assessment of Policies Affecting all Medicaid Beneficiaries

The Medicaid and CHIP Payment and Access Commission will review national and state-specific Medicaid and CHIP data and submit reports and recommendations to Congress, the Secretary, and states based on such reviews. In addition, the Commission will review and report on aggregate trends in spending, utilization, and financial performance under Medicaid and the private market.

Subtitle K – Protections for American Indians and Alaska Natives

Special Rules Relating to Indians

Health programs operated by the IHS, Indian tribes, tribal organizations, and Urban Indian organizations will be the payer of last resort for services provided to individuals eligible for such services. Cost-sharing is prohibited for Indians enrolled in a qualified health benefit plan in the individual market through an Exchange. Facilities operated by the IHS will be added to a list of agencies that serve as an “Express Lane” agency able to determine Medicaid and CHIP eligibility.

Addressed in
Title X of the
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Elimination of Sunset Provision for Reimbursement for all Medicare Part B Services Furnished by Certain Indian Hospitals and Clinics

Removes the sunset provision on reimbursement so that all services furnished by certain Indian hospitals and clinics can continue to be reimbursed by Medicare Part B.

Subtitle L – Maternal and Child Health Services

Maternal, Infant, and Early Childhood Home Visiting Programs

As a condition of receiving payments each state must conduct a statewide needs assessment that identifies the quality and capacity of existing programs or initiatives for early childhood home visitation in the state, and the state's capacity for providing substance abuse treatment and counseling services. The Secretary will make grants to enable eligible entities to deliver services under early childhood home visitation programs. Entities eligible for payments must establish quantifiable benchmarks such as improvements in maternal and newborn health, prevention of injuries or child abuse, emergency department visits, school readiness, crime or domestic violence and family economic self-sufficiency.

Support, Education, and Research for Postpartum Depression

The Secretary may make grants to eligible entities for the establishment, operation, and coordination of effective and cost efficient systems for the delivery of essential services to individuals with or at risk for postpartum conditions and their families.

Personal Responsibility Education

States may carry out personal responsibility education programs designed to educate adolescents on both abstinence and prevention of pregnancy as well as sexually transmitted infections. Programs must replicate evidence-based programs, be medically accurate and complete, include activities to educate youth who are sexually active, place substantial emphasis on abstinence and contraception, provide age-appropriate information and activities, and provide all information in a culturally appropriate context. Seventy-five million dollars will be allotted per year through 2014.

Manager's Amendment Changes

Changes personal responsibility education programs definition from education involving abstinence and conception to "healthy relationships, including marriage and family interactions."

Restoration of Funding for Abstinence Education

Appropriates \$50 million per year through fiscal year 2014 for abstinence education.

Inclusion of Information About the Importance of Having a Health Care Power of Attorney in Transition Planning for Children Aging out of Foster Care and Independent Living Programs

Transition planning requires states to provide information to children transitioning or aging out of the foster care system about the importance of designating another individual

to make health care treatment decisions on their behalf, such as a medical power of attorney.

Manager's Amendment Changes (apply to Title II generally)

The amendment inserts the following new sections:

Demonstration Projects

An application or renewal of any demonstration project to promote the objectives of Medicaid or the CHIP in a state that would result in an impact on eligibility, enrollment, benefits or cost-sharing will be considered by the Secretary in promulgating regulations relating to such applications or renewals. Regulations will concern a process for public notice and comment, requirements regarding the goals and expected costs of the programs, a process for the submission of reports by the Secretary regarding the implementation of the project, and a process for the periodic evaluation.

Incentives for States to Offer Home and Community-Based Services as a Long-Term Care Alternative to Nursing Homes

In the case of a balancing incentive payment state that meets certain specified standards during the incentive period, the FMAP determined for the state will be increased by an applicable percentage points with respect to eligible medical assistance expenditures. Incentive payments will rebalance state spending between nursing homes and home and community-based services.

Effective as if Included in the Enactment of the CHIPRA of 2009.

The one time appropriation is increased from \$11,706,000,000 to \$15,361,000,000 for the period beginning on October 1, 2014 and ending on March 31, 2015. States may offer the option of premium assistance subsidies only where the subsidy is cost-effective. In 2013, the allotment will be \$17,406,000,000, for 2014, \$19,147,000,000, for 2015 for purposes of making semi-annual allotments it will be \$2,850,000,000 for October 1, 2014 through March 31, 2015 and \$2,850,000,000 for April 1, 2015 through September 30, 2015. Expands the definition of a "targeted low-income child.". Extends the period during which the Secretary may award grants for outreach and enrollment through 2015 and the amount appropriated will be \$140,000,000.

Establishment of a Pregnancy Assistance Fund

The Secretary will establish a Pregnancy Assistance Fund, for the purpose of awarding competitive grants to states to assist pregnant and parenting teens and women and to increase public awareness and education. Twenty-five million dollars will be appropriated for each of fiscal years 2010 through 2019. A state may apply for a grant to carry out any activities related to pregnancy and parenting assistance. Amounts received may be used to enable institutions to establish, maintain, or operate pregnant and parenting student services.

Indian Health Care Improvement Act

S.1790 entitled "A bill to amend the Indian Health Care Improvement Act to revise and extend that Act, and for other purposes," is enacted into law in order to increase the Indian health care workforce, develop programs for innovative care delivery models, behavioral health care services, construction of Indian health facilities, and an Indian youth suicide prevention grant program.

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

Hospital Value-Based Purchasing Program

The Secretary shall establish a hospital value-based purchasing program under which value-based incentive payments are made in a fiscal year to hospitals that meet certain established performance standards over a specific period of time.

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Improvements to the Physician Quality Reporting System

Not later than January 1, 2012, the Secretary shall develop a plan to integrate reporting on quality measures with the meaningful use of EHRs reporting requirements. Such integration includes the selection of measures, the reporting of which would demonstrate both meaningful use and quality of care. The Secretary must provide feedback to eligible professionals regarding their performance with respect to satisfactorily submitting data on these quality measures. Moreover, the Secretary shall establish a review process for eligible professionals regarding an adverse data submission determination.

Improvements to the Physician Feedback Program

The Secretary shall use claims data to provide confidential reports to physicians that measure the resources involved in furnishing care to individuals. Effective 2012, these reports will compare patterns of resource use of the individual physician to such patterns of other physicians. For these reports, the Secretary must establish methodologies as appropriate, such as to attribute to physicians specific episodes of care, identify appropriate physicians for purposes of comparison, and aggregate episodes of care attributed to a physician into a composite measure per individual.

Quality Reporting for Long-term Care Hospitals, Inpatient Rehabilitation Hospitals, and Hospice Programs

For fiscal year 2014 and each year thereafter, each long-term care hospital, inpatient rehabilitation hospital, and hospice program must submit to the Secretary specific data on quality measures. The Secretary must establish procedures for making the data submitted available to the public, albeit, after the long-term care hospital, inpatient rehabilitation

hospital, or hospice program has had the opportunity to review the data prior to public release.

Quality Reporting for Prospective Payment System-Exempt Cancer Hospitals

For fiscal year 2014 and each year thereafter, each cancer hospital must submit to data on quality measures. The Secretary must establish procedures for making the data submitted available to the public, albeit after a cancer hospital has had the opportunity to review the data prior to public release.

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

The Secretary must develop a plan for a value-based purchasing program for payments under Medicare for home health agencies and skilled nursing facilities. The Secretary shall consult with relevant affected parties and consider experience with such demonstrations that the Secretary determines are relevant to the value-based purchasing program.

Manager's Amendment Changes

The amendment inserts the following new section:

Development of a Value-Based Purchasing Program for Ambulatory Surgical Centers

Not later than January 1, 2011, the Secretary shall submit a report to Congress containing a plan for developing a value-based purchasing program for payments to ambulatory surgical centers under Medicare. The Secretary shall consult with relevant stakeholders and to consider: 1) the ongoing development of measures of quality and efficiency in ambulatory surgical centers; 2) the reporting, collection, and validation of quality data; 3) the structure of value-based payment adjustments; and 4) methods for public disclosure of information on the performance of ambulatory surgical centers. In order to qualify as an ambulatory surgical center, a health care center must accept a standard overhead payment from Medicare and must meet specified health and safety standards.

Value-Based Payment Modifier under the Physician Fee Schedule

The Secretary must establish a payment modifier that provides for differential payment to a physician or a group of physicians under the fee schedule based upon the quality of care furnished, compared to cost and during a specific performance period. During the initial performance period, the Secretary shall provide information in this regard to the participating physicians and groups of physicians. The Secretary shall, as appropriate, apply the payment modifier in a manner that promotes systems-based care.

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Payment Adjustment for Conditions Acquired in Hospitals

The Secretary shall inform the public about hospital-acquired conditions of each applicable hospital, but must ensure that an applicable hospital has the opportunity to review and submit corrections prior to the information being made public. The Secretary

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also must conduct a study on expanding the healthcare-acquired conditions policy to payments made to other facilities under Medicare. Such study shall include an analysis of how such policies could impact quality of patient care, patient safety, and spending under Medicare.

PART II – National Strategy to Improve Health Care

National Strategy

The Secretary shall establish a national strategy to improve the delivery of health care services, patient health outcomes, and population health. The national strategy shall include a comprehensive strategic plan to achieve its priorities. The strategic plan shall include provisions to address strategies to align public and private payers with regard to quality and patient safety efforts.

Manager's Amendment Changes

The amendment places the following new limitations on the Secretary when identifying national priorities for quality improvement in health care: 1) the Secretary may not use any information from comparative clinical effectiveness research in a manner that treats extending the life of an elderly, disabled, or terminally ill individual as of lower value than extending the life of an individual who is younger, non-disabled, or not terminally ill; and 2) the Secretary shall not use evidence or findings from comparative clinical effectiveness research in a manner that precludes or discourages an individual from choosing health care treatment based on how the individual values the tradeoff between extending the length of their own life and the risk of disability.

Interagency Working Group on Health Care Quality

The President shall convene a working group called the Interagency Working Group on Health Care Quality. The goals of the Working Group are: 1) collaboration between federal departments and agencies with respect to developing and disseminating strategies, goals, models, and timetables consistent with national priorities; 2) avoidance of inefficient duplication of quality improvement efforts and resources in addition to a streamlined process for quality reporting and compliance requirements; and 3) assessing alignment of quality efforts in the public and private sectors.

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Quality Measure Development

The Secretary must award grants, contracts, or intergovernmental agreements to eligible entities for purposes of developing, improving, updating, or expanding quality measures. An entity that receives one of the above shall use such award to develop quality measures that: 1) support measures required to be reported under the Social Security Act and in support of gaps in existing quality measures that need improvement; 2) support measures developed under Section 1139A of the Social Security Act and the Medicaid Quality Measurement Program under Section 1139B; 3) is able to be collected using health information technologies (to the extent practicable); and 4) is free of charge to users of such measure.

Manager's Amendment Changes

The Secretary shall develop, and periodically update, provider-level outcome measures for hospitals and physicians. The Secretary must develop at least ten outcome measurements for acute and chronic diseases and at least ten outcome measurements for primary and preventative care. In developing outcome measures, the Secretary must: 1) consult with professional societies, voluntary health care organizations, and expert panels; and 2) utilize the recommendations contained within the Institute of Medicine's clinical practice guidelines. The final outcome measurements will seek to address risk adjustment, accountability and sample size, include multiple dimensions and include the full scope of services that comprise a cycle of care.

The Secretary must publicly report on measures for hospital-acquired conditions that are currently utilized by CMS for the adjustment of the amount of payment to hospitals based on rates of hospital-acquired infections.

The amendment inserts the following new section:

Clinical Practice Guidelines

After receiving the Institute of Medicine's report regarding clinical protocols, the Secretary, in consultation with professional societies, voluntary health care organizations and expert panels, must contract with the Institute no less than every three years to employ the results and the best methods identified in the study to identify new clinical practice guidelines.

Quality Measurement

The entity selected by the Secretary to develop quality measures shall convene multi-stakeholder groups to provide input on the selection of quality measures and national priorities. When convening these groups, the entity shall ensure an open and transparent process. Each year, the Secretary shall make available to the public a list of the quality measures the Secretary is considering for adoption. In selecting such measures, the Secretary shall take into consideration the input received from multi-stakeholder groups.

Manager's Amendment Changes

This provision instructs that the multi-stakeholder group created under this Act will develop efficiency measures in addition to quality measures for use in Medicare.

Data Collection; Public Reporting

In order to implement public reporting of performance, the Secretary shall collect and aggregate consistent data on quality and resource use measures and may award grants or contracts for this purpose. The Secretary shall ensure that such collection, aggregation, and analysis system spans an increasingly broad range of patient populations, providers, and geographic areas over time.

Manager's Amendment Changes

The amendment inserts the following new section:

Establishment of Strategic Framework for Performance Information Reporting

The Secretary shall establish and implement an overall strategic framework to carry out the public reporting of performance information. Performance information is information on clinical conditions that is provider-specific and sufficiently disaggregated and specific to meet the needs of patients with different clinical conditions. This strategic framework may include methods and related timelines for implementing nationally consistent data collection, data aggregation, and analysis methods.

Collection and Aggregation of Data

The Secretary shall collect and aggregate consistent data on quality and resource use measures from information systems used to support health care delivery, and may award grants or contracts for this purpose. The Secretary shall align such collection and aggregation efforts with the standards for the interoperability of HIT systems and related standards. The Secretary shall ensure that the scope of such data collection involves a wide range of patient populations, providers, and geographic areas.

PART III – Encouraging Development of New Patient Care Models

Establishment of Center for Medicare and Medicaid Innovation within the Centers for Medicare and Medicaid

By January 1, 2011, the Secretary must create a Center for Medicare and Medicaid Innovation within CMS to test various innovative payment and service delivery models to determine how these models improve the quality and efficiency of health care services provided to individuals enrolled in Medicare, Medicaid, and SCHIP. The Center shall test each of the models selected by the Secretary and will make testing results and recommendations available to the public. There shall be no administrative or judicial review of the actions of the Secretary in: 1) selecting the models for testing or expansion; 2) selecting the organizations, sites or participants to test those models selected; 3) determining the duration and scope of such testing; 4) determining the budget neutrality of such models; or 5) the decision to terminate, modify, or expand a model.

Manager's Amendment Changes

The Center for Medicare and Medicaid Innovation is designed to test innovative payment and service delivery models to improve the coordination, quality, and efficiency of health care services provided to individuals enrolled in Medicare and/or Medicaid. This provision instructs the Center to conduct a limited testing of such payment and service delivery models on certain geographic areas to determine how these models affect Medicare/Medicaid program expenditures and quality of care. The Secretary will select for testing those payment and service delivery models that utilize telehealth services: 1) in treating behavioral health issues and stroke; and 2) to improve the capacity of non-

medical providers and non-specialized medical providers to provide health services for patients with chronic complex conditions. The Secretary will prioritize selection of models operating at entities located in medically underserved areas and facilities of the IHS. The Secretary shall also select models that utilize a diverse network of providers of services and suppliers to improve care coordination for individuals with two or more chronic conditions and a history of hospitalizations. In addition, the Secretary may consider whether a particular model demonstrates effective linkage with other public sector or private sector payers.

In measuring the performance of such payment and service delivery models, the Secretary shall select measures that reflect national priorities for quality improvement and patient-centered care. The Secretary may expand the scope and duration of any model through rulemaking if: 1) the Secretary finds that such expansion will reduce spending without reducing quality of care, or improve quality of care without increasing spending; 2) the Chief Actuary of CMS certifies that such expansion would reduce program spending; and 3) the Secretary determines that such expansion would not deny or limit the coverage or provision of benefits under Medicare or Medicaid.

Medicare Shared Savings Program

Not later than January 1, 2012, the Secretary will establish a Medicare shared savings program that coordinates groups of providers and suppliers to work together through ACOs with the goal of promoting accountability, and thus better care coordination, for Medicare fee-for-service patient populations. The Secretary shall give additional payments under the Medicare shared savings program to eligible ACO professionals.

To participate, an ACO must: 1) be willing to become accountable for the quality, cost, and overall care of a defined population of Medicare fee-for-service beneficiaries; 2) agree to participate in the program for at least three years; 3) have a formal legal structure allowing it to receive and distribute payments for shared savings; 4) include enough primary care professionals to cover the Medicare beneficiaries assigned to it; 5) have in place leadership and management structures that include clinical and administrative systems; 6) define processes to promote evidence-based medicine and patient engagement; and 7) demonstrate to the Secretary that it meets patient-centeredness criteria.

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Manager's Amendment Changes

Under the Medicare Shared Savings Program, if an ACO meets a benchmark performance level, it shall be eligible to receive payment for a portion of the savings it has brought to the Medicare program. This provision gives the Secretary the option to utilize other payment models for making payments under the Medicare shared savings program, including: 1) the payment model under Section 3022 of the Act, wherein an ACO must be willing to become fully accountable for the overall care of Medicare fee-for-service beneficiaries assigned to it; or 2) a partial capitation model wherein an ACO is responsible for some, but not all, of the items and services covered under Medicare; or 3) any other payment model that the Secretary determines will improve the quality and

efficiency of items and services furnished under Medicare. The choice of any of these payment methods shall not result in additional Medicare program expenditures.

In addition to other selection criteria, the Secretary may give preference to ACOs that already participate in similar arrangements with other payers. The Secretary may also select for participation in the Medicare Shared Savings Program those ACOs participating in the physician group practice demonstration (a demonstration project to test the use of incentives to health care groups participating in the Medicare program to encourage coordination of care, investment in administrative structures and processes to ensure efficient service delivery; and reward physicians for improving health outcomes).

National Pilot Program on Payment Bundling

The Secretary shall establish a pilot program to determine the most clinically appropriate way to coordinate and pay for post-acute care that improves the coordination, quality, and efficiency of Medicare services in response to applicable conditions. The Secretary shall develop payment methods for entities participating in the pilot program. Such payment shall include payment for the furnishing of applicable services as well as other appropriate services related to treating the patient during an episode of care (such as care coordination, medication reconciliation, discharge planning, transitional care service and other patient-centered activities).

The Secretary shall select quality measures and a patient assessment instrument to evaluate the pilot program. Additionally, the Secretary shall conduct an independent evaluation of the pilot program, measuring the extent to which the pilot program has: 1) improved quality measures; 2) improved health outcomes; 3) improved applicable beneficiary access to care; and 4) reduced Medicare spending. Based on this evaluation, the Secretary shall submit an initial report to Congress within two years of the implementation of the pilot program, and a final report within three years.

Manager's Amendment Changes

The Secretary must establish a pilot program to determine the most clinically appropriate way to coordinate post-acute care after a Medicare beneficiary has suffered from an “applicable condition.” This provision modifies the program such that the Secretary may select ten conditions to be “applicable conditions” rather than only eight such conditions. Furthermore, in conducting the pilot program on post-acute care integration, the Secretary must apply the provisions of the program so as to separately pilot test the continuing care hospital model. The term “continuing care hospital” means an entity that has demonstrated the ability to meet patient care and patient safety standards while providing medical, rehabilitative, long-term care, and skilled nursing services under common management.

In addition, at any point after January 1, 2016, the Secretary may extend the duration of the pilot program on post-acute care integration if: 1) the Secretary finds that such expansion will reduce spending without reducing quality of care, or improve quality of care without increasing spending; 2) the Chief Actuary of CMS certifies that such

expansion would reduce program spending; and 3) the Secretary determines that such expansion would not deny or limit the coverage or provision of benefits under Medicare.

Independence at Home Demonstration Program

By January 2, 2012, the Secretary shall establish a demonstration program to test a payment incentive and service delivery model that utilizes physician and nurse practitioner-directed home-based primary care teams to reduce Medicare expenditures and improve health outcomes. The model to be tested is intended to provide comprehensive, coordinated, continuous and accessible at-home care to high-need populations.

The Secretary shall evaluate each at home medical practice to assess whether the practice has achieved program goals of: 1) reducing hospitalizations and readmissions; 2) reducing emergency room visits; 3) improving health outcomes commensurate with an individual's stage of chronic illness; 4) improving efficiency of care; 5) reducing costs to Medicare; and 6) improving beneficiary and caregiver satisfaction. The Secretary shall report the results of this evaluation to Congress.

Hospital Readmissions Reduction Program

The Secretary shall downwardly adjust Medicare payments to all hospitals which exhibit excess hospital readmissions for certain conditions selected by the Secretary. If the Secretary finds that a particular hospital has excess readmissions, the Secretary will reduce the payments that would otherwise be made to that hospital for such a discharge. The Secretary shall make information available to the public regarding readmission rates of each hospital in the Medicare program on the CMS Hospital Compare Internet website. Each hospital shall have an opportunity to review and submit corrections to the readmission data before it is reported to the public.

The Secretary shall make available a program for eligible hospitals to improve their readmission rates through the use of patient safety organizations. The Secretary shall utilize risk adjustment measures to identify eligible hospitals. Both the eligible hospitals and the patient safety organizations working with those hospitals shall report to the Secretary on the processes employed by the hospital to reduce readmission rates, and the impact of these efforts.

Manager's Amendment Changes

The Secretary shall downwardly adjust Medicare payments to hospitals which exhibit excess hospital readmissions. For such hospitals, the Secretary shall pay for hospital discharges under the following formula: the product of the base operating diagnosis-related group payment amount (the payment amount that would otherwise have been made to the hospital for hospital discharges) and the adjustment factor for the hospital for the fiscal year. These adjustments in payment will apply to discharges on or after October 1, 2012.

Community-Based Care Transitions Program

The Secretary shall establish a community-based care transitions program to fund eligible entities to help them furnish improved care transition services to high-risk Medicare beneficiaries. Eligible entities are hospitals identified by the Secretary as having high readmission rates and community-based organizations that provide care transition services through arrangements with such hospitals. In selecting entities to participate in the program, the Secretary shall give priority to those entities that: 1) participate in a program administered by the Administration on Aging to provide concurrent care transitions interventions with multiple hospitals and practitioners; or 2) serve medically underserved populations, small communities, and rural areas.

Extension of Gainsharing Demonstration

The Gainsharing Demonstration Program tests and evaluates methodologies and arrangements between hospitals and physicians regarding utilization of inpatient hospital resources. The goal of this program is to improve the quality and efficiency of care provided to Medicare beneficiaries and to develop improved operational and financial hospital performance with sharing of remuneration as specified by the program. This provision extends the Gainsharing Demonstration Program to September 30, 2011, for projects that were in operation as of October 1, 2008. All funding and reporting deadlines are extended as well.

Subtitle B—Improving Medicare for Patients and Providers

PART I – Ensuring Beneficiary Access to Physician Care and Other Services

Increase in the Physician Payment Update

Currently in Medicare, the Secretary establishes fee schedules that set payment amounts for all physicians' services under the Medicare program. This provision updates the conversion factor related to payment of physician services under Medicare to 0.5 percent for fiscal year 2010. Additionally, the Secretary shall adjust the work geographic index floor. For purposes of payment for services furnished on or after January 1, 2004, and before January 1, 2011, the Secretary shall increase the work geographic index to 1.00 for any locality for which such work geographic index is less than 1.00. Finally, the Secretary shall modify the practice expense geographic index (this reflects the relative costs of the mix of goods and services comprising practice expenses in the different fee schedule areas compared to the national average). Thus, in 2010 the employee wage and rent portions of the practice expense geographic index shall reflect $\frac{3}{4}$ of the difference between relative costs of employee wages and rents in each of the different fee schedule areas and the national average of such employee wages and rents. In 2011, the index shall reflect $\frac{1}{2}$ of this difference.

Manager's Amendment Changes

The updates to the conversion factors for payment of physician services under Medicare are repealed.

Extension of the Work Geographic Index Floor and Revisions to the Practice Expense Geographic Adjustment under the Medicare Physician Fee Schedule

The Secretary shall analyze current methods of establishing practice expense geographic adjustments. The Secretary shall evaluate: 1) the feasibility of using actual data or reliable survey data developed by medical organizations on the costs of operating a medical practice (including office rents and non-physician staff wages) in different fee schedule areas; 2) the extent to which types of office expenses are determined in local markets instead of national markets; and 3) the weights assigned to each of the categories within the practice expense geographic adjustment. As a result of this analysis, the Secretary shall make appropriate adjustments to the expense geographic index for 2012 to ensure accurate geographic adjustments across fee schedule areas.

Extension of Exceptions Process for Medicare Therapy Caps

Under Medicare, an individual may obtain an exception from the required uniform dollar limitation if the provision of such services is determined to be medically necessary. This provision extends the time period to December 31, 2010, for which expenses incurred from physical therapy, occupational therapy, and speech-language pathology services are considered for purposes of obtaining an exception from the uniform dollar limitation.

Extension of Payment for Technical Component of Certain Physician Pathology Services

This provision extends treatment and payment for certain physician pathology services under Medicare through 2010.

Extension of Ambulance Add-Ons

This provision extends the time period during which there shall be an increase pay for ground, air, and super rural ambulance services. Thus, the payment for these ambulance services will increase by three percent for any services furnished through 2011.

Manager's Amendment Changes

This provision extends the time period during which there shall be an increase pay for ground, air, and super rural ambulance services. Thus, the payment for these ambulance services will increase by three percent for any services furnished through 2011.

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

Extends the delay the Secretary is required to impose on application of the 25 percent threshold payment adjustment policy for long-term care hospital services furnished under Medicare until December 29, 2011. Upon sunset of this provision, if more than 25 percent of the discharges during a cost report period from a long-term care hospital or satellite are admitted from any acute care hospital, the payment to the long-term care hospital for that cost report period will be adjusted for all discharges.

The temporary moratorium on the certification of new long-term care hospitals and satellite facilities, and on any increase in the number of beds at such facilities, is extended through December 29, 2011.

Manager's Amendment Changes

Under the Medicare, Medicaid, and SCHIP Extension Act of 2007, the Secretary is required to delay application of the 25 percent threshold payment adjustment policy for long-term care hospital services furnished under Medicare until December 29, 2012.

The temporary moratorium on the certification of new long-term care hospitals and satellite facilities, and on any increase in the number of beds at such facilities, is extended through December 29, 2012.

Extension of Physician Fee Schedule Mental Health Add-On

Extends the physician fee schedule mental health add-on from December 31, 2009 to December 31, 2010.

Permitting Physician Assistants to Order Post-Hospital Extended Care Services

This provision permits physician assistants to order post-hospital extended care services for Medicare patients and applies to items and services furnished on or after January 1, 2011.

Exemption of Certain Pharmacies from Accreditation Requirements

A pharmacy may be exempt from the independent accreditation requirement if each of the following criteria are met: 1) total billings for such items and services are less than five percent of total pharmacy sales; 2) the pharmacy has been enrolled as a supplier of such items and services for at least five years; 3) the pharmacy submits to the Secretary an attestation that the pharmacy meets the criteria for (1) and (2); and 4) the pharmacy agrees to submit materials as requested by the Secretary to verify that the pharmacy meets this criteria. The Secretary may apply an alternative accreditation requirement for these pharmacies.

Part B Special Enrollment Period for Disabled TRICARE Beneficiaries

Establishes a special TRICARE enrollment period for those individuals who are eligible to enroll, but did not enroll, in Part B during the initial enrollment period offered to that individual, and waives the increase in premium. The Part B special enrollment period shall be the twelve month period beginning the day after the last day of the initial enrollment period, or if later, the twelve month period beginning with the month the individual is notified of enrollment under this section. An individual may only enroll during the special enrollment period one time during the individual's lifetime.

Payment for Bone Density Tests

Medicare shall reimburse for the cost of bone density scans furnished in 2010 and 2011. The payment amount shall be 70 percent of the product of: 1) the relative value of the service; 2) the conversion factor for fiscal year 2006; and 3) the geographic adjustment

factor for the service for the fee schedule area for 2010 and 2011. However, the adjustment to payment under this section may not cause the amount of expenditures under this part for the year to differ by more than \$20,000,000 from the amount of expenditures that would have been made if such adjustments had not been made.

The Secretary is authorized to contract with the Institute of Medicine to study the ramifications of Medicare payment reductions for bone density scans. Such study shall assess how payment reductions affect access to bone density testing for Medicare beneficiaries. The Institute of Medicine shall submit a report to Congress and to the Secretary on the results of the study.

Revision to the Medicare Improvement Fund

The Medicare Improvement Fund is money available to the Secretary to make improvements under the original fee-for-service program under Medicare Parts A and B. This provision reduces the monies available in 2014 for this Fund from \$2,290,000,000 to \$0.

Treatment of Certain Complex Diagnostic Laboratory Testing

The Secretary shall conduct a demonstration project wherein separate payments are made for complex diagnostic laboratory tests provided to individuals under Medicare Part B. The separate payments made to laboratories may not exceed \$100,000,000, and funding for this effort shall come from the Federal Supplemental Medical Insurance Trust Fund. Not later than two years after the completion of the demonstration project, the Secretary shall submit a report to Congress assessing the impact of the demonstration project on access to care, quality of care, health outcomes, and expenditures under Medicare.

The applicable complex diagnostic tests for the demonstration project are tests: 1) that analyze gene protein expression, topographic genotyping, or a cancer chemotherapy sensitivity assay; 2) that are determined by the Secretary to be a laboratory test for which there is not an alternative test having equivalent performance characteristics; 3) which are billed using a Health Care Procedure Coding System code (which is not a “not otherwise classified” code); 4) which are approved by the FDA or covered under Medicare; and 5) for diagnostic X-rays and diagnostic laboratory tests.

Improved Access for Certified Nurse-Midwife Services

Increases the amount Medicare will cover for certified nurse–midwife services. As of January 1, 2011, the Medicare program shall reimburse for 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary. This fee schedule for nurse midwives may now match the fee schedule provided to physicians who perform the same services (whereas before, the amount paid to midwives could not exceed 65 percent of the amount paid to physicians for the same services).

PART II – Rural Protections

Extension of Outpatient Hold Harmless Provision

For rural hospitals with fewer than 100 beds and which are not sole community hospitals, the outpatient hold harmless provision is extended to 2011. The hold harmless provision for rural hospitals that are the sole community hospital in an area shall be extended to 2011. In addition, these sole community hospitals shall not be held to a 100-bed limitation for calendar year 2010, thus permitting all sole community hospitals to be eligible for the hold harmless provisions in 2010.

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

Extends the cost reporting period to the one-year period beginning July 1, 2010. During this extended cost reporting period, a hospital with fewer than 50 beds that is located in a qualified rural area shall be reimbursed for 100 percent of the reasonable costs of providing an outpatient clinical diagnostic laboratory test covered under Medicare Part B.

Extension of the Rural Community Hospital Demonstration Program

This demonstration program is designed to test the feasibility and advisability of the establishment of rural community hospitals to furnish covered inpatient hospital services to Medicare beneficiaries. This provision extends the demonstration program for an additional one-year period, set to begin immediately following the last day of the initial five-year period. In addition, the Secretary shall expand the demonstration program to 20 states (choosing states with the lowest population density and other criteria set by the demonstration program), and shall increase the number of hospitals participating in the program to 30. The Secretary shall ensure the continued participation of rural community hospitals already included in the program.

Manager's Amendment Changes

This provision extends the rural community hospital demonstration program for an additional five-year period (as opposed the one-year extension).

Extension of the Medicare-Dependent Hospital Program

A Medicare Dependent Hospital is a rural hospital that: 1) has 100 or fewer beds; 2) is not also classified as a sole community hospital; and 3) at least 60 percent of its inpatient days or discharges during the hospital's cost reporting period were attributed to Medicare Part A beneficiaries. This provision extends the Medicare Dependent Hospital Program cost reporting period to October 1, 2012. Hospitals are also permitted to decline reclassification under this program through October 1, 2012.

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

For discharges from hospitals occurring in fiscal years 2011 and 2012, the Secretary shall set a percentage increase in reimbursement rates. The Secretary shall use a sliding scale ranging from a 25 percent increase for low-volume hospitals with 200 or fewer

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discharges of Medicare beneficiaries in the fiscal year, to 0.0 percent for low-volume hospitals with greater than 1,500 discharges of such beneficiaries in the fiscal year. For discharges prior to fiscal year 2011 and in fiscal year 2013 and beyond, the Secretary shall determine the applicable percentage increase for such hospitals based upon the relationship between the standardized cost-per-case for such low-volume hospitals, the total number of discharges of such hospitals, and the amount of the additional incremental costs (if any) that are associated with such number of discharges.

Manager's Amendment Changes

This provision slightly alters the sliding reimbursement rate scale for low-volume hospitals. The Secretary shall use a sliding scale ranging from a 25 percent increase for low-volume hospitals with 200 or fewer discharges of Medicare beneficiaries in the fiscal year to zero percent for low-volume hospitals with greater than 1,600 (as opposed to 1,500) discharges of such beneficiaries in the fiscal year.

Improvements to the Demonstration Project on Community Health Integration Models in Certain Rural Communities

This demonstration project is intended to allow states to test new ways to better coordinate hospital, nursing home, home health and other critical health care services to Medicare beneficiaries in rural areas. This provision allows participating entities to select more than six counties within a state in which to operate the demonstration program. In addition, this provision removes rural health services from being eligible under the demonstration project.

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Medicare Payment Advisory Commission Study of Medicare Payments for Health Care Providers Serving in Rural Areas

The Medicare Payment Advisory Commission shall conduct a study on the adequacy of payments under the Medicare program for items and services furnished by providers in rural areas. Such a study shall include an analysis of: 1) any adjustments in payments to such providers; 2) access of Medicare beneficiaries to items and services in rural areas; 3) the adequacy of payments to providers in rural areas; and 4) the quality of care furnished in rural areas. Not later than January 1, 2011, the Medicare Payment Advisory Commission shall submit a report to Congress containing the results of this study, complete with recommendations for legislation to modify payments to providers in rural areas.

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Technical Correction Related to Critical Access Hospital Services

The Medicare program shall reimburse for 101 percent of the reasonable costs for facility fees at critical access hospitals. In addition, Medicare shall pay 101 percent of the reasonable costs incurred by critical access hospitals in furnishing ambulance services. These payment revisions shall take effect as if these revisions were included in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Therefore, these provisions shall apply to payments for services furnished during cost reporting periods beginning on or after January 1, 2004.

Extension of and Revisions to Medicare Rural Hospital Flexibility Program

Extends the Medicare Rural Hospital Flexibility Program through October 1, 2012, and authorizes such sums as may be necessary for fiscal years 2011 and 2012. With funding under this program, states develop rural health networks and critical access hospitals. This provision also revises the program to allow the Secretary to award grants to hospitals for data system upgrades in order to assist such hospitals in participating in delivery system reforms under this Act (such as value-based purchasing programs, ACOs, payment bundling, etc.).

PART III – Improving Payment Accuracy

Payment Adjustments for Home Health Care

For 2013 and subsequent years, the Secretary shall adjust payments for home health services under the Medicare program by a percentage rate of adjustment. The Medicare Payment Advisory Commission shall conduct an evaluation of how the adjusted home health prospective payment impacts: 1) access to home health care for Medicare beneficiaries; 2) quality outcomes; 3) the number of home health agencies; and 4) rural agencies, urban agencies, for-profit agencies, and nonprofit agencies.

In addition, the Secretary shall reduce the prospective payment amount for home health services by such proportion that will result in a five percent aggregate reduction in overall payments for home health services. Currently, the one-year Medicare rural home health add-on policy dictates that in the case of home health services furnished in a rural area, the Secretary shall increase the payment amount for such services by five percent. This is now changed from a “one-year” policy to a “temporary” policy. Thus, the Secretary shall extend this program through January 1, 2016. For home health episodes of care in rural areas which end on or after April 1, 2010 and before January 1, 2016, the Secretary shall add-on three percent.

The Secretary shall conduct a study to evaluate the costs and quality of care among efficient home health agencies relative to other such agencies in providing access to care and in treating Medicare beneficiaries with varying levels of illness. Such a study shall include: 1) methods to revise home health prospective payments to more accurately account for the costs related to patient severity of illness or to improving beneficiary access to care; 2) the validity and reliability of responses on the Outcome and Assessment Data Set (a patient assessment instrument used in the home health care setting) with emphasis on questions that relate to higher payment under the home health prospective payment system; and 3) necessary revisions to the payment system to ensure higher quality of care. Not later than March 1, 2011, the Secretary shall submit a report to Congress on the outcomes of the study of prospective payments to home health care providers.

Manager’s Amendment Changes

This provision changes the date upon which the Secretary shall begin adjusting payments for home health services. For 2014 and subsequent years, the Secretary shall adjust

payments for home health services under the Medicare program by a percentage rate of adjustment. The Secretary shall provide for a four-year phase-in of this percentage adjustment, with all adjustments being fully implemented by 2017.

In an effort to reform the home health agency payment system, the Secretary shall conduct a study on costs involved in providing ongoing access to home health care to low-income and medically underserved Medicare beneficiaries. The study will examine how effective home health agencies are in treating Medicare beneficiaries with varying levels of illness. Additionally, the study will analyze operational issues involved with implementing any potential revisions to the home health payment system (including impacts for both home health agencies and administrative and systems issues for the CMS). In orchestrating this study, the Secretary shall consult with appropriate stakeholders, such as groups representing home health agencies and groups representing Medicare beneficiaries.

Such a study shall include an analysis of methods to revise home health prospective payments to more accurately account for the costs related to patient severity of illness or to improving beneficiary access to care. The Secretary may consider whether the following factors should be used as part of the study to measure patient severity of illness and access to care: 1) population density and relative patient access to care; 2) variations in service costs for providing care to individuals who are dually eligible under the Medicare and Medicaid Programs; 3) the presence of severe or chronic diseases, as evidenced by multiple, discontinuous home health episodes of care; and 4) poverty status. Not later than March 1, 2014, the Secretary shall submit a report to Congress on the outcomes of the home health agency payment reform analysis and make recommendations for legislation and administrative action as appropriate.

Based on the results of the home health agency payment reform analysis, the Secretary may provide for a four-year demonstration project to test whether making payment adjustments for home health services under the Medicare program would substantially improve access to care for patients with high severity levels of illness or for low-income or underserved Medicare beneficiaries. The Secretary shall not reduce standard prospective payments made to home health agencies to offset any increase in payments made for home health services under the demonstration project. The Secretary shall evaluate and report to Congress the results of any such demonstration program. Funding of up to \$500,000,000 shall come from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund for fiscal years 2015 through 2018.

Hospice Reform

By January 1, 2011, the Secretary shall collect information as necessary to revise payments for hospice care, and not earlier than October 1, 2013, the Secretary shall implement revisions to the methodology for determining hospice payment rates based on this study, ensuring that any revisions in payment result in the same aggregate

expenditures for hospice care under Medicare. The Secretary shall consult with hospice programs and the Medicare Payment Advisory Commission regarding payment revisions.

Following the Medicare Payment Advisory Commission's recommendations for Hospice program eligibility, payment for hospice services furnished to Medicare beneficiaries may only be made to a hospice physician or nurse practitioner who has a face-to-face encounter with the individual patient to determine continued eligibility of the individual for hospice care prior to the 180th-day recertification. In the case of hospice care provided for longer than 180 days, the Secretary shall medically review such hospice care when the hospice provider sees more than a certain percentage of beneficiaries (as set by the Secretary) for such lengthy hospice care. These provisions apply to hospice care furnished on or after January 1, 2011.

Improvement to Medicare DSH Payments

For fiscal year 2015 and thereafter, the Secretary shall pay to certain disproportionate share hospitals an additional amount that is 25 percent of what the additional amount would have otherwise been. Hospitals eligible for this payment adjustment are those that that: 1) serve a significantly disproportionate number of low-income patients; or 2) are located in an urban area, having 100 or more beds, and can demonstrate that inpatient care revenues from state and local government sources exceed 30 percent of total revenues.

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The Secretary shall pay such hospitals an additional amount equal to the product of the following three factors: 1) a factor equal to the difference between the amount of payments that would have been made to such hospitals and the amount that will now be made to such hospitals under changed regulations; 2) a factor related to the amount of individuals under the age of 65 who are uninsured; and 3) a factor equal to the percent for each hospital that represents the quotient of the amount of uncompensated care for each hospital and the aggregate amount of uncompensated care for all hospitals.

Manager's Amendment Changes

This provision alters the way that the Secretary shall calculate additional payments made to hospitals. The Secretary uses three factors to calculate such payments. One of the factors relates to the number of individuals who are uninsured. This revised provision states that in 2015, 2016 and 2017 this factor shall equal one minus the percent change in the percent of individuals under the age of 65 who are uninsured in 2013 (as compared to the year for which the most recent data is available) minus 1.5 percentage points. In 2018 and all subsequent fiscal years, this factor shall equal one minus the percent change in the percent of all individuals who are uninsured in 2013 (as compared to the year for which the most recent data is available) minus 1.5 percentage points.

Misvalued Codes under the Physician Fee Schedule

The Secretary shall identify misvalued codes under the physician fee schedule and make appropriate adjustments. To review and make appropriate adjustments to these misvalued codes, the Secretary may: 1) use existing processes to receive

recommendations; 2) conduct surveys, other data collection activities, studies, or other analyses; 3) use analytic contractors to identify services, conduct surveys or collect data; 4) coordinate the review and adjustment with the periodic review required under the Social Security Act; and 5) make appropriate coding revisions which may include consolidation of individual services into bundled codes for payment under the fee schedule.

The Secretary shall establish a process to validate relative value units under the physician fee schedule. This process may include validation of work elements involved with furnishing a service and may include validation of the pre, post, and intra-service components of work. The Secretary shall make appropriate adjustments to the work relative value units under the fee schedule. However, the limitations on annual Medicare adjustments are applicable, and therefore adjustments in the fee schedule for a given year may not cause the amount of expenditures to differ by more than \$20,000,000 from the amount of expenditures that would have been made if such adjustments had not been made.

Modification of Equipment Utilization Factor for Advanced Imaging Services

With respect to payment for physicians' services under Medicare, the Secretary shall adjust the practice expense relative value units related to imaging and computer-assisted imaging services to reflect higher presumed utilization. For such services furnished on or after January 1, 2010 and before January 1, 2013, the Secretary shall presume a 65 percent (rather than 50 percent) rate of utilization of imaging equipment; for services furnished between January 1, 2013 and January 1, 2014, a 70 percent utilization rate; and for services furnished on or after January 1, 2014, a 75 percent utilization rate. In addition, the Secretary shall adjust the "discount" on single-session imaging to consecutive body parts. For imaging services furnished on or after July 1, 2010, the Secretary shall increase the reduction in payments attributable to the multiple procedure payment reduction from 25 percent to 50 percent.

Revision of Payment for Power-Driven Wheelchairs

Medicare shall pay for the rental of power-driven wheelchairs on a monthly basis. Medicare shall pay fifteen percent of the purchase price of such wheelchair for the first three months of a rental period and six percent for the remaining months. This provision applies to power-driven wheelchairs supplied after January 1, 2011. This provision shall not apply to wheelchairs furnished pursuant to contracts under competitive acquisition programs for competitively priced items and services.

Hospital Wage Index Improvement

Extends the reclassification of the hospital wage index through September 30, 2010. Not later than December 31, 2011, the Secretary shall submit to Congress a report that includes a plan to reform the hospital wage index system. The Secretary shall take into account the goals for reforming such a system set forth in the Medicare Payment Advisory Commission June 2007 report entitled "Report to Congress: Promoting Greater Efficiency in Medicare." These goals include establishing a new hospital compensation

system that: 1) uses Bureau of Labor Statistics data or other methodologies to calculate relative wages for each geographical area involved; 2) minimizes wage index adjustments between and within metropolitan areas and statewide rural areas; 3) includes methods to minimize the volatility of wage index adjustments that result from implementation policies; 4) takes into account the effect that implementation of the system would have on health care providers; 5) addresses issues related to occupational mix, such as staffing practices and ratios, and any evidence on the effect on equality of care or patient safety as a result.

Manager's Amendment Changes

Beginning April 1, 2010, the Secretary shall include average hourly wage data in the calculation of the hospital wage index, but only if doing so would result in a higher wage index.

Treatment of Certain Cancer Hospitals

The Secretary shall conduct a study to determine if certain cancer hospitals (including a hospital that has been recognized as a comprehensive cancer center or clinical cancer research center by the National Cancer Institutes of Health) incur greater costs than those incurred by other hospitals furnishing similar services. In conducting this study, the Secretary shall take into consideration the cost of drugs and biological incurred by such cancer hospitals. Insofar as the Secretary determines that such hospital incurs costs greater than other similar hospitals, the Secretary shall provide for an appropriate adjustment to such hospital reimbursement to reflect those higher costs. These provisions apply to services furnished on or after January 1, 2011.

Payment for Biosimilar Biological Products

Medicare shall pay for biosimilar biological products used in health care. A biosimilar biological product means a biological product approved under an abbreviated application for a license of a biological product that relies in part on information in an application for another biological product. Medicare shall reimburse for such biological products in an amount that is the sum of: 1) the average sales price for the biosimilar biological product; and 2) six percent of the average sales price for the reference biological product (meaning the biological product which is already licensed and upon which this biosimilar biological product is relying in its application). This provision shall apply to payments for biosimilar biological products beginning in the second calendar quarter following the enactment of this Act.

Medicare Hospice Concurrent Care Demonstration Program

The Secretary shall establish such a demonstration program at participating hospice programs. The demonstration program shall work to improve services when Medicare beneficiaries receive hospice care and other items and services under the Medicare program concurrently. The demonstration program shall be conducted for a three-year period and shall be furnished in a way so as to ensure budget neutrality. Up to fifteen hospice programs (located in both urban and rural areas) shall participate in the demonstration program. The Secretary shall provide for an independent evaluation for

the demonstration program, and shall report to Congress the results of the evaluation. This evaluation shall determine whether the demonstration program has improved patient care, quality of life, and cost-effectiveness for Medicare beneficiaries.

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

In the case of hospital discharges occurring on or after October 1, 2010, the Secretary shall adjust the area wage index for hospitals and federal rates for inpatient hospital operating costs in the same manner as these were adjusted in fiscal year 2008. Therefore, the Secretary shall employ a uniform, national adjustment to the area wage index (establishing a rural floor by requiring that the wage index for a hospital in an urban area of a state cannot be less than the area wage index determined for that state's rural area). Additionally, the Secretary shall make adjustments to federal rates for inpatient hospital operating costs in a budget neutral fashion (for example any changes to diagnosis-related group classifications should be made in a manner so that aggregate payments to hospitals are not affected).

Health and Human Services Study on Urban Medicare-Dependent Hospitals

The Secretary shall conduct a study on the need for an additional payment for urban Medicare-dependent hospitals for inpatient hospital services. The study shall include an analysis of: 1) the Medicare inpatient margins of urban Medicare-dependent hospitals, as compared to other hospitals which receive one or more additional payments or adjustments under Medicare; and 2) whether the additional payments to Medicare-dependent, small rural hospitals should be applied to urban Medicare-dependent hospitals. Not later than nine months after the date of enactment of this Act, the Secretary shall submit to Congress a report containing the results of the study on the need for an additional payment for urban Medicare-dependent hospitals for inpatient hospital services. The Secretary shall also make recommendations for legislation and administrative action as appropriate.

Subtitle C – Provisions Relating to Part C

Medicare Advantage Payment

Medicare Advantage payments will be based on the average of the bids from Medicare Advantage plans in a particular service area. Competitive benchmarks will be set for each area equal to the weighted average of all plan bids, and the benchmarks will be capped. Average per capita savings (if any) will be returned to enrollees in the form of monthly rebates. Performance bonus payments will be based on a plan's level of care coordination and management performance. Coordination and management programs should focus on patient education and self-management, transitional care interventions, patient safety, financial policies that promote systematic coordination of care by primary care physicians, health care disparities, medication therapy management, and HIT.

Beginning in 2012, each Medicare Advantage organization offering a Medicare Advantage local plan in an area identified by the Secretary may elect to provide rebates

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to grandfathered enrollees. The Secretary will also provide transitional rebates for the provision of extra benefits to certain enrollees. Eligible enrollees include individuals who enroll in a Medicare Advantage plan in an applicable area and experience a significant reduction in extra benefits as a result of competitive bidding. The Secretary may transfer up to \$5,000,000,000 from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust to provide these extra benefits from 2012 through 2019.

With respect to the Program of All-Inclusive Care for the Elderly (PACE) program, the following provisions and regulations relating to those provisions, will not apply: 1) the Medicare Advantage area-specific non-drug monthly benchmark amount based on competitive bidding; 2) the establishment of Medicare Advantage local plan service areas; 3) performance bonuses; 4) the grandfathering of supplemental benefits for current enrollees after implementation of competitive bidding; and 5) transitional extra benefits.

Manager's Amendment Changes

Beginning April 1, 2010, the Secretary shall include average hourly wage data in the calculation of the hospital wage index, but only if doing so would result in a higher wage index.

Benefit Protection and Simplification

Cost-sharing for services may not exceed the cost-sharing required for those services under the traditional fee-for-service program, Medicare Parts A and B. Services include chemotherapy administration services, renal dialysis services, skilled nursing care, and any other services that the Secretary determines appropriate. However, for related services with no cost-sharing required under Parts A and B, cost-sharing may now be required.

Beginning in 2012, plans that provide extra benefits are required to first give priority to cost-sharing reductions, then to prevention and wellness care, and last, to benefits not covered under the original Medicare fee-for-service program, such as eye examinations and dental coverage.

Application of Coding Intensity Adjustment During Medicare Advantage Payment Transition

In order to ensure payment accuracy, the Secretary will be given new authority to adjust risk scores in Medicare Advantage. The Secretary will conduct an analysis of differences in coding patterns compared to the fee-for-service program and will ensure the results of such analysis are incorporated into the risk scores for 2011 and subsequent years.

Simplification of Annual Beneficiary Election Periods

Beginning in 2011, there will be a 45-day period during which enrollees can disenroll from Medicare Advantage and switch over to the traditional fee-for-service program under Medicare Parts A and B, where they may elect qualified prescription drug coverage.

Extension for Specialized Medicare Advantage Plans for Special Needs Individuals

The Special Needs Plan program authority will be extended from 2011 through 2014. Beginning in 2011, the Secretary may apply the payment rules under the Program of All-Inclusive Care for the Elderly (PACE) to the extent necessary to reflect the costs of treating high concentrations of frail individuals. The Secretary will establish procedures for the transition of applicable individuals to a Medicare Advantage plan that is not a specialized Medicare Advantage plan for special needs individuals or the original Medicare fee-for-service program under Medicare Parts A and B. This transition must take place by January 1, 2013.

The authority of specialized Medicare Advantage plans to target enrollment to certain populations will be extended from December 31, 2010 to December 31, 2012. Beginning in 2011, the Secretary will use a risk score that reflects the known underlying risk profile and chronic health status of similar individuals which will be used for new enrollees in Medicare Advantage plans that are not specialized Medicare Advantage plans for special needs individuals. The risk adjustment must be evaluated and revised periodically in order to account for higher medical and care coordination costs associated with frailty, individuals with multiple co-morbid chronic conditions, and individuals with a diagnosis of mental illness, and also to account for costs that may be associated with higher concentrations of beneficiaries with those conditions.

Extension of Reasonable Cost Contracts

The period of reasonable cost contracts will be extended from January 1, 2010 to January 1, 2013.

Technical Correction to Medicare Advantage Private Fee-For-Service Plans

Beginning in 2011, to the extent that the Secretary is applying the 2008 service area extension waiver policy to Medicare Advantage coordinated plans, the Secretary shall extend the application of the waiver to employers who contract directly as Medicare Advantage private fee-for-service plans.

Making Senior Housing Facility Demonstration Permanent

The service area of a Medicare Advantage senior housing facility plan will be limited to a senior housing facility in a geographic area. These senior housing facility plans are Medicare Advantage plans that restrict enrollment to individuals who reside in a continuing care retirement community, provide primary care services onsite, have adequate ratios of accessible physicians to beneficiaries, provide transportation services to specialty providers, and have participated in a demonstration project for one year or more.

Authority to Deny Plan Bids

Beginning in 2011, the Secretary has the authority to deny bids submitted by Medicare Advantage organizations and prescription drug plans if they propose significant increases in cost sharing or decreases in benefits offered under their plans.

Development of New Standards for Certain Medigap Plans

The Secretary will be required to have the National Association of Insurance Commissioners (NAIC) review and revise standards for benefit packages classified as “C” and “F” based on evidence published in peer-reviewed journals or current examples used by integrated delivery systems.

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

Medicare Coverage Gap Discount Program

For coverage to be available for covered Part D drugs of a manufacturer, the manufacturer must: 1) participate in the Medicare coverage gap discount program; 2) have entered into an agreement with the Secretary; and 3) have entered into a contract with a third party that the Secretary has also entered into a contract with. Coverage will apply to drugs dispensed on or after July 1, 2010. Manufacturer requirements will not apply if the Secretary determines the availability of the drug is essential to health beneficiaries or if there are extenuating circumstances.

The Secretary must establish and monitor a Medicare coverage gap discount program by July 1, 2010 and enter into agreements with manufacturers that require them to provide beneficiaries access to discounted prices. Manufacturers with agreements in effect must collect and have available appropriate data to ensure compliance. Agreements will be effective for 18 months and will be automatically renewed. The Secretary may terminate the agreement for certain specified violations and manufacturers may terminate agreements for any reason. A civil money penalty will be imposed on those who fail to provide discounts for applicable drugs in accordance with the agreement. Beneficiaries will not be prevented from purchasing a covered Part D drug that is not an applicable drug (including a generic drug or drug that is not the formulary of their prescription drug plan).

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

Beginning in 2011, rebates and bonus payments will not be used in calculating Medicare Part D low-income benchmark premiums.

Voluntary de minimus Policy for Subsidy Eligible Individuals under Prescription Drug Plans and MA-PD Plans

Beginning in 2011, the Secretary will allow a prescription drug plan or a MA-PD plan to waive the monthly beneficiary premium if the amount of the premium is nominal. The Secretary will be authorized to auto-enroll subsidy eligible individuals in plans that waive nominal premiums. If there is more than one plan available, the Secretary will randomly assign individuals to various participating plans in the region. Individuals may decline or change their enrollment.

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

Beginning in 2011, if an individual's spouse dies during the determination or redetermination period for low-income assistance, the period will be extended for one year.

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

Beginning in 2011, the Secretary must provide subsidy eligible individuals (enrolled in a prescription drug plan and automatically reassigned to a new Part D low-income subsidy plan) with: 1) information on formulary differences between the two plans; and 2) a description of: i) their right to request a coverage determination; ii) their right to reconsideration; iii) how to bring an appeal; and iv) how to resolve a grievance.

Funding Outreach and Assistance for Low-Income Programs

Additional funding will be provided for outreach and assistance for low-income programs including funding for the CMS Program Management Account, for Area Agencies on Aging through the Administration on Aging, and funding for Aging and Disability Resource Centers. The Secretary may request that an entity awarded a grant to support the conduct of outreach activities aimed at preventing disease and promoting wellness.

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

Beginning in 2011, prescription drug plan sponsors will be required to include all covered Part D drugs in the categories and classes identified by the Secretary, with certain exceptions. The Secretary will establish criteria and exceptions through the promulgation of a regulation which includes a public notice and comment period. Until criteria are established, the following categories will be used: anticonvulsants, antidepressants, antineoplastics, antipsychotics, antiretrovirals, and immunosuppressants for the treatment of transplant rejection.

Reducing Part D Premium Subsidy for High-Income Beneficiaries

For individuals with modified adjusted gross income exceeding the applicable threshold amount, the monthly amount of the beneficiary will be increased by a specified adjustment amount. This adjustment amount will be the product of the quotient of the applicable percentage (reduced by 25.5 percent) and 25.5 percent, and the base beneficiary premium. In carrying out their duties, officers, employees, and contractors of the Social Security Administration will be allowed to disclose taxpayer identity information, the amount of the premium subsidy adjustment or premium increase, and tax return information to certain federal agencies including the Centers for Medicare and Medicaid Services, the Office of Personnel Management and the Railroad Retirement Board, Health and Human Services, and the Department of Justice.

Elimination of Cost Sharing for Certain Dual Eligible Individuals

Cost sharing will be eliminated for certain dual eligible individuals receiving care under a home and community-based waiver program and who would otherwise require institutional care.

Reducing Wasteful Dispensing of Out-Patient Prescription Drugs in Long-Term Care Facilities under Prescription Drug Plans and MA-PD Plans

Part D prescription drug plans will be required to use uniform dispensing techniques when dispensing covered drugs to enrollees who reside in a long-term care facility in order to reduce waste associated with 30-day refills.

Improved Medicare Prescription Drug Plan and MA-PD Plan Complaint System

The Secretary is required to develop and maintain a complaint system that is easy to use to collect and maintain information on all prescription drug plan complaints, to report and initiate appropriate interventions, and to guide quality improvement.

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

Part D drug plans must use a single, uniform exceptions and appeals process with respect to the determination of prescription drug coverage for an enrollee under the plan. They must also provide instant access to this process through a toll-free number and a website.

Office of the Inspector General Studies and Reports

The OIG must conduct a study of the extent to which formularies used by prescription drug plans and MA-PD plans under Part D include drugs commonly used by full-benefit dual eligibles. A report of these findings together with recommendations must be reported to Congress each year beginning with 2011.

The OIG must also conduct a study on prices for covered Part D drugs: 1) comparing prescription drug prices paid under the Medicare Part D program to those paid under State Medicaid programs; and 2) assessing the financial impact of any discrepancies in prices on the federal government and the financial impact of any discrepancies on enrollees under Part D or individuals eligible for Medicaid. Prices will include any rebate or discount. The Inspector General has authority to collect information related to prices of Part D drugs under Medicare and covered outpatient drugs under Medicaid. The OIG must submit a report to Congress with the results of the study along with recommendations for legislative and administrative action.

Including Costs Incurred By AIDS Drug Assistance Programs and Indian Health Service in Providing Prescription Drugs toward the Annual Out-of-Pocket Threshold under Part D

Beginning in 2011, costs associated with prescription drugs dispensed to low-income individuals under a State Pharmaceutical Assistance Program, by an Indian health organization, or under the AIDS Drug Assistance Program will be used when calculating the annual out-of-pocket threshold.

Immediate Reduction in Coverage Gap in 2010

Beginning in 2010 and thereafter, the initial coverage limit in the standard Part D benefit will be increased by \$500. Prescription drug sponsors will be fully reimbursed for the reduction in beneficiary cost sharing. The Secretary will develop an estimate of additional increased costs attributable to increased drug utilization, financing and administrative costs which will be used to adjust payments to plan sponsors.

Subtitle E – Ensuring Medicare Sustainability

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

A new productivity adjustment will be used when calculating the market basket update for inpatient hospitals, home health providers, nursing homes, hospice providers, inpatient psychiatric facilities, long-term care hospitals and inpatient rehabilitation facilities. The productivity adjustment will also be applied to payment updates for outpatient providers under Part B who do not already have this adjustment. Additional market basket reductions will be implemented for ambulance services, ambulatory surgical center services, laboratory services, certain durable medical equipment, prosthetic devices, orthotics, and prosthetics.

Manager's Amendment Changes

The amendment makes the following changes regarding market basket updates.

Revision to Medicare Percentage Payment Increases to Hospitals

After determining the applicable percentage payment increase to hospitals for inpatient discharges occurring in a fiscal year (as outlined in Section 1886(b)(3) of the Social Security Act), the Secretary shall then reduce such percentage increases by 0.25 percentage point in fiscal years 2010 and 2011; by 0.1 percentage point for fiscal years 2012 and 2013; and by 0.2 percentage point for each of fiscal years 2014 through 2019.

Revision to Prospective Payment for Long-Term Care Hospitals

Currently, under the Social Security Act, the Secretary determines the prospective payment under Medicare for inpatient hospital services furnished by a long-term care hospital. This provision adds that the Secretary shall reduce any annual update to the standard federal rate for discharges in by an additional 0.25 percentage point in fiscal year 2010; by 0.50 percentage point in fiscal year 2011; by 0.1 percentage point in 2012 and 2013; and by 0.2 percentage point for years 2014 through 2019.

Revision to Prospective Payment for Inpatient Rehabilitative Services

Currently, the Secretary determines a prospective payment rate for rehabilitative services under Medicare. The Secretary shall establish an increase factor based on an appropriate percentage increase in a market basket of goods and services comprising services for which payment is made under Medicare. This provision adds that the

Secretary shall reduce this increase factor by 0.25 percentage point in fiscal years 2010 and 2011; by 0.1 percentage point in 2012 and 2013; and by 0.2 percentage point for years 2014 through 2019.

Revision to Prospective Payment for Home Health Agencies

Currently, the Secretary establishes a prospective payment rate for home health agencies under Medicare in part by determining a home health market basket percentage increase. This provision instructs the Secretary to reduce this percentage increase by one percentage point for fiscal years 2011 through 2013.

Revision to Prospective Payment for Psychiatric Hospitals

Currently, the Secretary is tasked with determining a prospective payment rate for psychiatric hospitals under Medicare. This provision instructs the Secretary to reduce any update to a base rate for days for a psychiatric hospital by 0.25 percentage point in fiscal years 2010 and 2011; by 0.1 percentage point in 2012 and 2013; and by 0.2 percentage point for years 2014 through 2019.

Revision to Payment for Hospice Care

Currently, the Secretary establishes a payment rate for hospice care services furnished under Medicare. With respect to routine home care and other services included in hospice care, the payment rates for such care and services shall be the payment rates in effect during the previous fiscal year increased by the market basket percentage increase. This provision instructs the Secretary to reduce the market basket percentage increase by 0.3 percentage point for fiscal years 2013 through 2019.

Revision to Prospective Payment for Outpatient Hospitals

Currently, the Secretary determines a prospective payment rate for outpatient hospital services furnished under Medicare, in part by determining an outpatient department fee schedule increase factor. This provision instructs the Secretary to reduce the outpatient department fee schedule increase factor by 0.25 percentage point in fiscal years 2010 and 2011; by 0.1 percentage point in 2012 and 2013; and by 0.2 percentage point for years 2014 through 2019.

The amendment inserts the following new section:

Reduction in Update for Failure to Report:

Annually, beginning in 2014, each psychiatric hospital and psychiatric unit must submit certain quality data measures to the Secretary. The Secretary will select measures for inclusion in this quality reporting initiative, generally selecting only those quality measures that have been endorsed by the National Quality Forum (or whichever consensus-based entity is currently contracting with the HHS to establish and maintain data measurements). Participating psychiatric hospitals and psychiatric units must be notified of the selected measures by October 1, 2012, and the Secretary shall establish procedures to ensure that these providers have an opportunity to review the quality measures prior submitting them. Once

the reporting period begins, if a psychiatric entity fails to submit quality data in a given year, the Medicare program will penalize that provider by reducing the prospective payment made to that entity for the year by two percentage points. Any reduction in payment in a given year shall not impact prospective payments made in subsequent years.

Temporary Adjustment to the Calculation of Part B Premiums

Between 2011 and 2019 the threshold amount will be equal to the amount for 2010, and the dollar amounts for the applicable percentage will be equal to the dollar amounts for 2010.

Independent Medicare Advisory Board

The Independent Medicare Advisory Board (“Board”) is established to reduce the per capita growth rate of growth in Medicare spending. The Board will be required to submit actuarial sound proposals to Congress that recommend ways to: 1) extend Medicare solvency; 2) improve the health care delivery system and health outcomes; 3) reduce excess cost growth; 4) monitor the effects on Medicare beneficiaries of changes in payments to providers; 5) monitor the effects of the recommendations on providers and suppliers; and 6) consider the unique needs of dual-eligible beneficiaries. The Board will be composed of fifteen members appointed by the President with the advice and consent of the Senate. Members must include those with national recognition for expertise in certain specified areas of health and finance. A Chairperson will be appointed and will be governed by the general policies established by the Board.

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Each year beginning in 2013, the Chief Actuary of CMS will determine whether the projected Medicare per capita growth rate exceeds the projected Medicare per capita target growth rate. If it does, the Chief Actuary will establish an applicable savings target. Beginning in 2018, the Chief Actuary will also calculate the projected five-year average percentage increase in national health expenditures. The Comptroller General of the United States will conduct a study on changes to payment, rate and coverage policies and methodologies under Medicare as a result of the recommendations contained in the proposals the Board. The results must be submitted to Congress by 2015 along with recommendations for legislative and administrative action.

Manager’s Amendment Changes

The amendment changes the name of the Board to the “Independent Payment Advisory Board.” The Board will work to reduce the per capita rate of growth in Medicare spending. This provision instructs the Board to submit to Congress and the President yearly legislative proposals related to the Medicare program. Such proposals must pinpoint specific legislative action that will reduce growth rates in Medicare spending while maintaining or enhancing beneficiary access to quality care. As appropriate, the proposals should include recommendations to reduce payments under Medicare Parts C and D, but any such recommendation shall not affect the full premium income-related subsidies for individuals with income up to 150 percent of poverty line.

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The Board does not have to submit proposals in years where the Medicare per capita growth rate for a given year does not exceed the projected Medicare per capita target growth rate. The Chief Actuary of CMS is responsible for determining the projected Medicare per capita growth rate. In years where the Board does not submit legislative proposals, it shall still issue an advisory report to Congress on matters related to the Medicare program. Proposals submitted by the Board are to be introduced to the House and Senate by the House and Senate majority leader respectively on the day of submission to Congress and the Secretary will implement them once approved by Congress. However, this provision instructs the Secretary to not implement these recommendations if CMS determines the Medicare growth rate exceeds the projected target growth rate.

The Board must produce an annual public report containing standardized information on system-wide health care costs, patient access to care, utilization, and quality of care that allows for comparison by region, types of services, types of providers, and both private payers and the Medicare program. The Board will take the findings into account when developing legislative proposals. Every two years, the Board must submit to Congress and the President recommendations on how to slow the growth in national health expenditures while preserving or enhancing quality of care. Recommendations must be made available to the public.

Subtitle F - Health Care Quality Improvements

Establishment of Center to Research Health Care Quality Practices

The Director of AHRQ will establish a new Center to implement better system-wide practices for improving the quality, safety and value of health care service delivery. This new Center will operate under the Center for Quality Improvement and Patient Safety (which is part of AHRQ). The Center is tasked with integrating proven processes (found through evaluative research from a variety of disciplines) into the health care system that result in better patient outcomes, more consistent care, higher patient safety, and the overall reduction of medical errors. In addition, the Center will identify those health care providers that deliver high-quality and efficient services, and implement ways to bring such good practices to other health care institutions. Finally, the Center shall foster education, training and mentoring programs at the local level so that providers can learn from one another on how best to improve the quality of their practices.

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Quality Improvement Network Research Program

The Center for Quality Improvement and Patient Safety will create a "Quality Improvement Network Research Program." This research program will conduct research on health care quality, paying special attention to improving care in hospital intensive care units, preventing infections acquired in the health care setting, developing methods for reducing preventable hospital admissions, and using HIT to improve health outcomes for children. The Director of AHRQ will continually identify new tasks and priorities for the research program, taking into account: 1) the cost to federal health programs; 2) consumer and provider needs; 3) the potential impact of research programs on health

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status and function of patients, including vulnerable populations; 4) areas where there are gaps in knowledge concerning quality and patient safety; and 5) health information technology.

The Center shall coordinate all of its activities with the activities conducted by the Center for Medicare and Medicaid Innovation (a center which tests innovative payment and service delivery models to improve the coordination, quality, and efficiency of health care services provided to individuals enrolled in Medicare and/or Medicaid and established by Section 3021 of this Act). The Center for Quality Improvement and Patient Safety shall be funded with \$20,000,000 for fiscal years 2010 through 2014.

Quality Improvement Technical Assistance Grant Program

The Center for Quality Improvement and Patient Safety, under AHRQ, shall award grants to entities that can assist health care providers in adopting and implementing higher quality health care practices. To be eligible for such a grant, an entity must demonstrate prior expertise in providing technical support to health care providers regarding quality improvement. Grant awardees must disseminate information on quality improvement, system delivery reform and best medical practices. In bringing this information to health care providers, the grantee must coordinate with HIT regional extension centers and primary care extension programs. The Director of AHRQ shall evaluate the performance of the entities participating in the quality improvement technical assistance grant program in order to determine whether to renew a grant. The Director will evaluate: 1) how successful the entity has been in helping area health care providers to implement the higher quality health care practices advocated by the Center for Quality Improvement and Patient Safety; 2) how area health care institutions and providers perceive the value of the entity's assistance; and 3) whether the entity's actions have resulted in better patient health outcomes and lower costs.

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

The Secretary shall award grants to states, state-designated entities, and Indian tribes for the purpose of establishing community health teams to support area primary care providers. To be eligible for the grant, the proposed health team must be interdisciplinary and inter-professional, and must incorporate elements of community-based prevention initiatives and patient education into the delivery of health care. Once awarded the grant, the health team shall establish contractual agreements with area primary care providers to perform support services. The health teams will make it possible for primary care providers to better address disease prevention and chronic disease management by facilitating collaboration between these providers and existing community-based health resources. With a goal of creating more patient-centered medical homes and integrated health care, the health team will connect primary care providers with: 1) preventive and health promotion services; 2) specialty care and inpatient services; 3) pharmacist-delivered medication management services; and 4) complimentary and alternative medical services. The health team will also give providers the tools to develop a focused identification and referral system for children at risk for behavioral problems, as well as a

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support system for patients who are transitioning from one medical setting to another (such as discharge from a hospital to a nursing home). Finally, the health teams will collect and report data on the success of the collaborative effort on patient health outcomes and on patient experience of care.

Manager's Amendment Changes

Under the Act, the Secretary shall provide grants to entities for the purpose of establishing community health teams. Among other things, these health teams will support patient-centered medical homes. This provision amends the Act by including within the definition of "patient-centered medical homes" all primary care providers (as opposed to just physicians).

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Medication Management Services in Treatment of Chronic Disease

By May 1, 2010, the Secretary shall establish a grant program with the purpose of aiding pharmacists in implementing medication management services for the treatment of chronic diseases. Eligible pharmacists will be those that can provide an appropriate medical setting for medication management, and those that coordinate medication management services through local community health teams. Participating pharmacists will use grant monies to provide patients with medication management services including: 1) assessments of health and functional status; 2) medication treatment plans; 3) medication therapy; 4) evaluations of the safety and efficacy of medication therapy; 5) initial and ongoing comprehensive medication reviews to identify, resolve and prevent adverse drug events; 6) communication of medical review findings to other appropriate health care providers; 7) patient and care-giver education and training on appropriate medication use; 8) additional support services designed to enhance patient adherence to therapeutic regimens; 9) coordination of medication management services within the broader health needs of the patient; and 10) such other patient care services allowed by other federal programs that have implemented medication management services. These pharmacist-delivered medication management services are intended for individual patients who: 1) take four or more prescribed medications (including over-the-counter medications and dietary supplements); 2) take any "high risk" medications; 3) have two or more chronic diseases; or 4) have undergone a transition of care, or exhibit other factors that are likely to create a high risk of medication-related problems.

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The Secretary shall measure the clinical effectiveness of the medication management program, evaluating: 1) whether patient enrollees maintained better health with fewer hospitalizations and emergency room visits; 2) whether patients changed their overall health care resource use; 3) patient and provider satisfaction with the program; 4) the impact of patient-cost sharing requirements on medication adherence; 5) clinical, economic and demographic factors that impact medication management; and 6) the extent to which participating pharmacists who maintain a dispensing role have a conflict of interest in the provision of medication management services. The Secretary may also award grants or contracts to entities for the purpose of funding the development of better performance measures to evaluate the medication management program.

Design and Implementation of Regionalized Systems for Emergency Care

The Secretary, acting through the Assistant Secretary for Preparedness and Response, shall award grants to states and Indian tribes for projects that design, implement and evaluate innovative models for comprehensive emergency care and trauma systems. The Secretary will award grants to projects that: 1) create collaboration between public health and safety services, emergency medical services, medical facilities and trauma centers to increase emergency medical access; 2) utilize transport communication systems that ensure that patients are taken to medically appropriate facilities; 3) track available regional hospital resources (i.e. Inpatient bed capacity, emergency department capacity, on-call specialist coverage, and ambulance diversion status) and use this information to make determinations on which hospital is best suited to handle a given emergency; and 4) utilize region-wide data management systems which submit data to the National Emergency Medical Service Information System, the National Trauma Data Bank and to other state and federal databanks and registries. Projects that serve medically underserved populations shall be given priority for grant awards.

Eligible entities must seek non-federal matching contributions. In addition, these entities must make an evaluation of their pilot project, identifying: 1) the impact on patient health outcomes (i.e. Trauma, stroke, cardiac emergencies, neurological emergencies, and pediatric emergencies); 2) the key characteristics of the emergency care system in the region that contribute to effective emergency care; 3) strategies for assuring long-term sustainability of the region's emergency care system, including state and local legislation necessary to maintain the system; and 4) barriers to developing a quality emergency medical system and methods for overcoming these barriers.

Support for Emergency Medicine Research

The Secretary shall support federal programs administered by NIH, AHRQ, HRSA, the CDC, and other agencies invested in improving the emergency care system. The Secretary shall foster programs that: 1) research the basic science of emergency medicine; 2) design ways to use scientific research to enhance patient outcomes; 3) investigate the economic impact of implementing new emergency system policies; and 4) address the pediatric emergency care system.

Grants for Trauma Care Centers: The “Substantial Uncompensated Care” Grants Program

The Secretary shall establish the “substantial uncompensated care” grants program to offer aid to trauma centers that are struggling financially because of unpaid patient bills. To qualify for these grants, the trauma center must demonstrate a continued commitment to serving trauma patients regardless of ability to pay. Additionally, the trauma center must have policies in place, such as a sliding fee scale, to assist patients who cannot pay for part or all of the care they receive. The Secretary shall award grants to those trauma centers that fall into one of the following categories: Category A: the center receives at least 40 percent of patients from charity or self-pay sources, and at least 50 percent of total visits to the center are from Medicaid, charity, and self-pay patients combined; Category B: at least 35 percent are charity or self-pay patients, and at least 50 percent of

total visits are Medicaid, charity, and self-pay combined; Category C: at least 20 percent are charity or self-pay, and at least 30 percent are Medicaid, charity, or self-pay combined. The Secretary shall award enough funding to cover 100 percent of the uncompensated costs to trauma centers that qualify for Category A. The Secretary shall award not more than 75 percent of uncompensated care costs to Category B trauma centers, and not more than 50 percent of uncompensated care costs to Category C trauma centers.

Grants for Trauma Care Centers: The “Core Mission” Grant Program

The Secretary shall establish “core mission” grants, intended to help trauma centers carry out their health care mission (be that to provide education and outreach programs or to coordinate with regional trauma systems etc.). The Secretary shall reserve 25 percent of available core mission awards for Level III and IV trauma centers. (Level III trauma centers do not have a full availability of specialists, but do have resources for emergency and surgical care for most trauma patients; Level IV trauma centers only have resources to provide initial evaluation and stabilization.) The Secretary shall reserve another 25 percent of awards for large urban Level I and II trauma centers that offer a graduate medical education fellowship in trauma care. (Level I and Level II trauma centers provide the highest level of surgical care to trauma patients, and have a full range of specialists and equipment available 24 hours a day. In addition, Level I centers have an education program, and preventive and outreach programs.)

Grants for Trauma Care Centers: The “Emergency” Grant Program

The Secretary shall establish the “emergency” grant program which will provide emergency relief to trauma facilities to ensure the future availability of trauma services. These grants are available to qualified public, nonprofit IHS, Indian tribal and urban Indian trauma centers. The Secretary shall give preference to trauma centers that operate in geographic regions where the availability of trauma care in the region would decrease significantly if the center were forced to close or downgrade because of a lack of funding or demand for trauma services in the region exceeds capacity.

Trauma Care Registry Reporting

The Secretary may require trauma centers receiving grants from the above trauma care grant programs to provide data to a national and centralized registry of trauma cases.

Grants to States for Improving State-Wide Trauma Centers

The Secretary shall provide funding to states to improve trauma care. The states are tasked with awarding these grants to public or nonprofit trauma centers, or to hospitals in underserved areas where trauma services are needed. States shall award grants to recipients with the goal of accomplishing one or more of the following activities: 1) providing funding to physicians in trauma-related physician specialties; 2) providing for the fiscal stability of safety net trauma centers; 3) reducing trauma center overcrowding; 4) establishing new trauma services in underserved areas; 5) enhancing collaboration between trauma centers and other hospitals and emergency services; 6) making capital improvements to trauma centers to increase access and expedite care (i.e. Building a

helipad); 7) enhancing trauma surge capacity at specific trauma centers; 8) expediting the transfer of patients between the trauma center and air and ground transport; 9) enhancing interstate trauma center collaboration. The state shall award at least 40 percent of the federal funding to safety net trauma centers, defined as centers that provide care for those who are not eligible for health insurance and cannot afford to pay for health care services. When awarding grants, the Secretary shall prioritize states with Category A trauma centers.

Program to Facilitate Shared Decision-Making

The Secretary, acting through the Director of AHRQ, shall contract with entities to develop patient decision aids. These decision aids are a technique to engage patients in decision-making by encouraging patients to determine their own values with regard to health care. Using these decision aids as a tool, health care providers will be able to assist patients in weighing treatment options and can design medical plans that are better suited to a patient's personal preferences. The contract recipient shall develop such patient decision aids, educate providers on proper use, and providing technical assistance to providers on implementation of decision aids. The aids must be in a form that is adaptable for patients of different ages and varying cultural and educational backgrounds.

Presentation of Prescription Drug Benefit and Risk Information

The Secretary, acting through the FDA Commissioner, shall make a determination as to whether consumers would benefit from additional quantitative summaries on the drug label concerning a drug's benefits and risks. To make such a determination, the Secretary shall review all available research on the social and cognitive psychology of consumer decision-making. The Secretary shall consult with drug manufacturers, clinicians, patients, experts in health literacy, representatives of racial and ethnic minorities, and experts in women's and pediatric health. If the Secretary determines that additional drug information on the drug label would improve health care decision-making for patients and clinicians, the Secretary shall have the authority to promulgate proposed regulations to implement new drug labeling requirements.

Demonstration Projects on Health Professional Education Curriculum

The Secretary may award grants to entities to carry out demonstration projects to integrate quality improvement and patient safety curriculum into the clinical education of health professionals. Eligible entities include health professions schools, schools of public health, schools of social work, schools of nursing, schools of pharmacy, institutions with graduate medical education programs, and schools of health care administration. Eligible entities must seek non-federal matching contributions in an amount equal to \$1 for every \$5 of federal funds provided under the grant. After evaluating these funded projects, the Secretary will disseminate results to the public and make a detailed report to Congress with recommendations on health professional education nation-wide.

Office of Women’s Health within HHS

This provision creates an Office of Women’s Health within HHS. All functions currently exercised by the Office on Women’s Health of the Public Health Service shall be transferred to the new Office of Women’s Health within the Department. This Office is tasked with coordinating activities within the Department that relate to disease prevention, health promotion, service delivery, research, and professional education for issues of particular concern to women. In addition, the Office will provide expert advice to the Secretary concerning scientific, legal, ethical, and policy issues relating to women’s health. Finally, the Office shall establish a National Women’s Health Information Center to facilitate the exchange of information regarding matters relating to health information, health promotion, preventive health services, research advances, and education in the appropriate use of health care.

Office of Women’s Health within the CDC

A new Office of Women’s Health is established within the CDC. The Office shall report to the Director of the CDC on the current level of the Centers’ activity regarding women’s health conditions in all aspects of the Centers’ work. In this context, the term “women’s health conditions” means any disease, disorder or condition that is unique to, significantly more serious for, or significantly more prevalent in women. This term shall also include those diseases, disorders or conditions for which the factors or medical risk or type of medical intervention are different for women. The Office will consult with health professionals in an effort to identify projects that should be conducted or supported by the Centers to address these women’s health conditions. In addition, the Office will serve as a member of HHS Coordinating Committee on Women’s Health.

Office of Women’s Health Research

Currently, there already is an Office of Research on Women’s Health at NIH. This provision instructs that this Office shall report directly to the Director of NIH.

Office of Women’s Health within the Substance Abuse and Mental Health Administration

Currently, there already is an Administrator for Women’s Services at the Substance Abuse and Mental Health Administration. This provision allows the Administrator to appoint an Associate Administrator for Women’s Services who shall report directly to the Administrator. In addition, the Secretary may establish an Office of Women’s Health within the Substance Abuse and Mental Health Administration.

Office of Women’s Health within AHRQ

Creates a new Office of Women’s Health and Gender-Based Research within AHRQ. This Office will advise the Director of the agency on the current level of agency activity regarding women’s health. After consulting health professionals on agency policy, the Office will establish short-range and long-range goals and objectives within the Agency for research important to women’s health and identify projects in women’s health that should be conducted or supported by the Agency. Finally, the Office will serve as a member of HHS Coordinating Committee on Women’s Health.

Office of Women’s Health within the HRSA

A new Office of Women’s Health is established within HRSA. This Office will advise the Administrator of the agency on the current level of agency activity regarding women’s health. After consulting health professionals on agency policy, the Office will establish short-range and long-range goals and objectives within the Agency for research important to women’s health and identify projects in women’s health that should be conducted or supported by the Agency. In addition, the Office will serve as a member of HHS Coordinating Committee on Women’s Health. The Director of the Office shall assume the authority for the development, implementation, administration, and evaluation of any projects carried out through HRSA relating to women’s health.

Office of Women’s Health within the FDA

This provision creates a new Office of Women’s Health within the FDA. Using available data by sex in the testing of drugs, medical devices, and biological products, the Office shall apprise the Commissioner on current participation by women in the FDA’s clinical trials. In consultation with manufacturers, health professionals, and consumer organizations with expertise in women’s issues, the Office will establish short-range and long-range goals and objectives within the Administration for issues of particular concern to women’s health. The Office will make annual estimates of funds needed to monitor clinical trials and analysis of data by sex in accordance with goals that are identified. In addition, the Office will provide information to women and health care providers on those areas in which differences between men and women exist in terms of all aspects of clinical testing. Finally, the Office will serve as a member of HHS Coordinating Committee on Women’s Health.

Non-Termination of Current Women’s Health Offices

The new Offices of Women’s Health created with HHS, the CDC, AHRQ, HRSA, and the FDA are not intended to replace, terminate or modify existing agencies/offices that are currently working on women’s health issues (including the Office of Research on Women’s Health of NIH and the Associate Administrator for Women’s Services under the Substance Abuse and Mental Health Administration). Also, provisions that create these new Offices are not intended to give the Secretary or any other agency new regulatory authority, nor do these sections modify any existing regulatory authority.

Extension of Patient Navigator Program

The Secretary may continue to award grants for demonstration programs to provide patient navigator services (whereas these programs would have expired on September 30, 2010). Such programs connect patients with “patient navigators” who assist patients in coordinating health care services needed for the diagnosis and treatment of chronic disease. These programs also facilitate the involvement of community organizations in assisting individuals who are at risk for or who have cancer or other chronic diseases to receive better access to high-quality health care services (such as by creating partnerships with patient advocacy groups, charities, health care centers, community hospice centers, other health care providers, or other organizations in the targeted community).

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Manager’s Amendment Changes (applies to Title III, Subtitle F):

The amendment inserts the following new section:

Government Accountability Office Study and Report on Causes of Action

The Comptroller General of the United States shall conduct a study of whether the development, recognition, or implementation of any guideline or other standards that may result in the establishment of a new cause of action or claim and must report to Congress within two years on the findings of this study.

Manager’s Amendment Changes (apply to Title III generally):

The amendment inserts the following new sections:

Medicare Coverage for Individuals Exposed to Environmental Health Hazards

Under this provision, eligible individuals who are affected by environmental exposures will become entitled to benefits under Medicare Part A and eligible to enroll in Medicare Part B. The Secretary shall determine which individuals are eligible “environmental exposure affected individuals.” This term refers to any person who has been diagnosed with one or more conditions including: 1) asbestosis, pleural thickening or pleural plaques; 2) mesothelioma, or malignancies of the lung, colon, rectum, larynx, stomach, esophagus, pharynx or ovary; or 3) any other diagnosis the Secretary determines is an asbestos-related condition. Such an individual must have been present for an aggregate total of six months in a geographic area subject to an emergency declaration (defined under the Comprehensive Environmental Response, Compensation, and Liability Act of 1980), during a time period ending not less than ten years prior to diagnosis of the asbestos-related condition and prior to completion of the remedial asbestos removal actions in that region. An individual not meeting the preceding criteria may still qualify as an environmental exposure affected individual if they have been diagnosed with a medical condition caused by the exposure to a public health hazard.

Pilot Program for Care of Environmental Exposure Affected Individuals

The Secretary shall establish a pilot program to provide innovative approaches to furnishing comprehensive, coordinated, and cost-effective health care to environmental exposure affected individuals. The Secretary may also establish a separate pilot program which respect to each geographic area subject to emergency declaration in order to offer care to environmentally exposed persons therein (excluding the disaster declaration of June 17, 2009, related to severe storms and flooding in the states of Arkansas and South Dakota). These pilot programs are permitted to provide for the furnishing of benefits, items, or services not otherwise covered or authorized under Medicare.

In addition, the Secretary shall develop and implement innovative methodologies to reimburse providers who provide benefits, items and services to environmental

exposure affected individuals under this pilot program. However, the Secretary shall not make payments under the pilot program for any services provided to environmental exposure affected individuals who are otherwise provided for under any other public or private benefits plan. This pilot program does not have to be budget neutral and funding will be provided under the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund.

Program for Early Detection of Certain Medical Conditions Related to Environmental Health Hazards

The Secretary shall establish a program to provide competitive grants to eligible entities for the purpose of screening “at-risk” individuals for early detection of “environmental health conditions.” An awarded entity shall screen all at-risk individuals and develop and disseminate public information concerning the general availability of environmental health screening and the detection, prevention, and treatment of environmental health conditions. These entities shall also report on the availability of Medicare benefits for certain individuals diagnosed with environmental health conditions. The program will be funded by with: 1) \$23,000,000 for fiscal years 2010 through 2014; and 2) \$20,000,000 for each 5-year fiscal period thereafter.

Definition of Frontier State

A “frontier” state means a state in which at least 50 percent of the counties in the state are “frontier counties” (meaning a low-density county in which the population per square mile is less than six). The following provisions related to payment in frontier states do not apply to any hospital or other health care provider located in a state that receives a non-labor related share adjustment under the Social Security Act (under that section, the Secretary may make payment adjustments to providers located in Alaska and Hawaii as appropriate to take into account the unique circumstances of these states).

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Floor Area Wage Index for Hospitals in Frontier States

The current provision instructs the Secretary to determine a national adjusted prospective payment rate for inpatient hospital services. The Secretary shall adjust this rate for different geographical areas. This new provision states that for hospital discharges occurring on or after October 1, 2010, the area wage index applicable to hospitals located in a frontier state may not be less than 1.00. These provisions do not need to meet budget neutrality.

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Floor Area Wage Adjustment Factor for Hospital Outpatient Department Services in Frontier States:

The current provision instructs the Secretary to implement a prospective payment system for hospital outpatient department services. This new provision states that with respect to covered outpatient department services furnished on or after

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January 1, 2011, the area wage adjustment factor applicable to hospitals located in a frontier state may not be less than 1.00.

Practice Expense Index for Physician's Services Furnished in Frontier States

The current provision instructs the Secretary to implement a payment system for physician services under Medicare. As part of this payment calculation, the Secretary shall establish an index which reflects the relative costs of the mix of goods and services comprising practice expenses for physicians. This new provision states that with respect to such services furnished in a frontier state on or after January 1, 2011, the Secretary shall increase any such index to 1.00 (if such index would otherwise be less than 1.00). This provision does not have to be applied in a budget neutral manner.

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Revision to Skilled Nursing Facility Prospective Payment System

Resource Utilization Groups under Medicare use a case-mix classification system to assign a nursing home resident to a category based on his or her medical conditions and the resources needed to provide care. Each category is tied to a Medicare payment rate under the skilled nursing facility prospective payment system. This provision calls for a temporary delay in implementing Version 4 of the Resource Utilization Groups (published in August 2009, this version, among other things, increases the number of Resource Utilization Group categories from 53 to 66). The Secretary shall not implement Version 4 prior to October 1, 2011. However, beginning October 1, 2010, the Secretary shall implement those provisions of Version 4 that relate to rehabilitative therapy and changes to the lookback period. This is in effort to ensure that only those services furnished after admission to a skilled nursing facility are used as factors in determining a case mix classification for payment under the skilled nursing facility prospective payment system. Nothing in this provision shall be construed as delaying the implementation of version 3.0 of the Minimum Data Sets.

Pilot Testing Pay-For-Performance Programs for Certain Medicare Providers

By January 1, 2016, the Secretary shall put into operation a pilot program to test value-based purchasing programs for payments under Medicare. The Secretary may, at any point after January 1, 2018, expand the duration and scope of the pilot program for value-based purchasing if: 1) the Secretary determines that such expansion would reduce Medicare spending without reducing the quality of care or improve the quality of care without reducing spending; 2) the Chief Actuary of CMS certifies that such expansion would reduce program spending under Medicare; and 3) the Secretary determines that such expansion would not deny or limit the coverage or provision of benefits under Medicare for Medicare beneficiaries.

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Providers eligible for this pilot program include: 1) psychiatric hospitals and psychiatric units; 2) long-term care hospitals; 3) rehabilitation hospitals; 4) prospective payment system exempt cancer hospitals; and 5) hospice programs.

Payments under the pilot program for value-based purchasing shall be established in a budget neutral manner (such that spending under the value-based purchasing program for a given year does not exceed what otherwise would have been expended if the program were not implemented).

Additional Incentive Payments for Physician Participation in Quality Reporting

Certain health care professionals have the opportunity to receive an additional incentive payment for quality reporting in years 2011 through 2014. This incentive payment would mean an increase of an additional 0.5 percent on top of any already applicable quality percent increase payment for the year. In order to qualify for this additional incentive payment, a health care professional must ensure that Maintenance Certificate Program submits on his or her behalf all required quality measurement data for the year. In addition, the professional must participate in, and successfully complete, a Maintenance Certificate Program for that year. In year 2015 and beyond, the Secretary may incorporate participation in a Maintenance of Certificate Program into the composite of measures of quality of care under the physician fee schedule payment modifier. Under the Medicare program, this payment modifier provides for differential payment to a physician or a group of physicians based upon the quality of care furnished compared to cost during a performance period. A Maintenance Certificate Program is continuous assessment program (such as qualified American Board of Medical Specialties Maintenance of Certification Program) that advances quality and the lifelong learning and self-assessment of board certified specialty physicians by focusing on the competencies of patient care, medical knowledge, practice-based learning, interpersonal and communication skills and professionalism.

Elimination of Medicare Advantage Regional Plan Stabilization Fund

Any amount contained in the Medicare Advantage Regional Plan Stabilization Fund as of the date of the enactment of this Act shall be transferred to the Federal Supplementary Medical Insurance Trust Fund.

Improvement in Medicare Part D Medication Therapy Management Programs

Two years after the date of enactment of this Act, prescription drug sponsors shall begin to offer medication therapy management services to targeted beneficiaries with the goal of increasing patient adherence to prescription medications. Under this program, the prescription drug plan sponsor shall ensure that licensed pharmacists conduct annual comprehensive medication reviews of the medications taken by beneficiaries participating in the medication therapy management program. As a result of the review, the pharmacist may create a medication action plan for the beneficiary. These medication reviews may be furnished person-to-person or using telehealth technologies and the pharmacist will make all follow-up interventions warranted by the review.

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The prescription drug plan sponsor shall have in place a process to automatically enroll targeted beneficiaries in the medication therapy management program (with protocols to allow such beneficiaries to opt-out of enrollment). Additionally, the plan sponsor must have in place a process to assess, at least on a quarterly basis, the medication use of individuals who are at risk but not enrolled in the medication therapy management program, including individuals who have experienced a transition in care. The Secretary shall have authority to modify or broaden the requirements for a medication therapy management program under Medicare Part D, and may study new models for medication therapy management through the Center for Medicare and Medicaid Innovation.

Developing Methodology to Assess Health Plan Value

Development of Methodology to Assess Health Plan Value: The Secretary, in consultation with relevant stakeholders (including health insurers, health care consumers, employers, and health care providers), shall develop a methodology to measure health plan value. Such methodology shall take into consideration: 1) the overall cost to enrollees under the plan; 2) the quality of the care provided for under the plan; 3) the efficiency of the plan in providing care; 4) the relative risk of the plan's enrollees as compared to other plans; and 5) the actuarial value or other comparative measure of the benefits covered under the plan. The Secretary shall submit a report to Congress concerning this methodology not later than 18 months after the date of enactment of this Act.

Modernizing Computer and Data Systems of the Centers for Medicare and Medicaid Services to Support Improvements in Care Delivery

Not later than nine months after the date of enactment of this act, the Secretary shall develop a plan to modernize the computer and data systems of CMS. In developing this plan, the Secretary shall consider how such a modernized computer system could make data available in a reliable and timely manner to providers of services and suppliers to support their efforts to better manage and coordinate care furnished to beneficiaries of Centers for Medicare and Medicaid Services programs (all in accordance with the regulations of HIPAA). Additionally, the Secretary shall support consistent evaluations of payment and delivery system reforms under Centers for Medicare and Medicaid Services programs.

Physician Compare Website; Public Reporting of Performance Information

The Secretary is tasked with developing a Physician Compare website database containing comprehensive information on physicians enrolled in the Medicare program by 2011. The goal of this website is to assist patients in comparing available "physicians" to improve health care decision-making. The website will provide information for the public on quality and patient experience measures with respect to physicians enrolled in the Medicare program, including: 1) measures collected under the Physician Quality Reporting Initiative; 2) an assessment of patient health outcomes and functional status of patients; 3) an

assessment of the continuity and coordination of care and care transitions, including episodes of care and risk-adjusted resource use; 4) an assessment of efficiency; 5) an assessment of patient experience; and 6) an assessment of the safety, effectiveness and timeliness of care. In this context, the term “physician” means a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor.

In developing and implementing this “Physician Compare” website and related public reporting of information on physician performance, the Secretary shall include: 1) processes to assure that data made public is statistically valid and reliable; 2) processes by which a physician or other eligible professional whose performance on measures is being publicly reported has a reasonable opportunity to review individual results before they are made public; 3) processes to assure that the implementation of the plan and the data made available provide a robust and accurate portrayal of a physician’s performance; 4) data that reflects the care provided to all patients seen by physicians, under both the Medicare program and other payers, to the extent that such information would provide a more accurate portrayal of physician performance; 5) processes to ensure appropriate attribution of care when multiple physicians and other providers are involved in the care of patient; 6) processes to ensure timely statistical performance feedback is provided to physicians; 7) processes to ensure that all patient data pertaining to the website remains private; and 8) implementation of computer and data systems of CMS that support valid, reliable, and accurate public reporting activities. The Secretary shall consult with multi-stakeholder groups as part of this effort and shall consider how the website fits together with the plan to transition to a value-based purchasing program for physicians under the Medicare Improvements for Patients and Providers Act of 2008.

Financial Incentives to Encourage Consumers to Choose High Quality Providers

Not later than January 1, 2019, the Secretary may establish a demonstration program to provide financial incentives to Medicare beneficiaries who receive health care services from high quality physicians. In no case may Medicare beneficiaries be required to pay increased premiums or cost sharing or be subject to a reduction in Medicare benefits as a result of this demonstration program. The Secretary shall ensure that any such demonstration program does not disadvantage those beneficiaries without reasonable access to high performing physicians.

Provision of Medicare Data for Performance Measurements

After January 1, 2012, qualified entities are permitted to request Medicare claims data from the Secretary. Upon such request, the Secretary shall provide standardized extracts of claims data for items and services furnished under Medicare A, B and D for one or more specified geographic areas and time

periods (taking action to protect the identity of persons enrolled in Medicare). The Secretary will charge a fee to the requesting entity for receipt of claims data. Entities permitted to receive such information are those public and private entities qualified to use claims data to evaluate the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness and resource use. The Secretary shall not make claims data available unless a qualified entity agrees to subsequently release its evaluation of providers of services and suppliers.

Community-Based Collaborative Care Networks

In fiscal years 2011 through 2015, the Secretary may award grants to eligible entities to support community-based collaborative care networks. A community-based collaborative care network is a consortium of health care providers with joint governance structure that provides comprehensive coordinated and integrated health care services for low-income populations. These networks include disproportionate share hospitals and all federally qualified rural health clinics. In awarding grants, the Secretary shall give priority to those networks that have: 1) the capability to provide the broadest range of services to low-income individuals; 2) the broadest range of providers that serve a high volume of low-income individuals; and 3) a county or municipal department of health.

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Office of Minority Health

The Office of Minority Health will be transferred from the Office of Public Health and Science to the Office of the Secretary. This transferred Office shall be headed by the Deputy Assistant Secretary for Minority Health, who shall report directly to the Secretary and shall work to strengthen the capacity of the Office to improve minority health and the quality of health care minorities receive, eliminating racial and ethnic disparities.

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Grants for Improving Minority Health

The Secretary, acting through the Deputy Assistant Secretary for Minority Health, will award grants to public and nonprofit private entities in communities of color to assure improved health status of racial and ethnic minorities. The Secretary shall also develop measures to evaluate the effectiveness of activities aimed at reducing health disparities and supporting the local community. Such measures shall evaluate community outreach activities, language services, and workforce cultural competence.

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Establishment of Individual Offices of Minority Health Within HHS

The head of each of the following agencies shall establish an Office of Minority Health within the agency: CDC, HRSA, SAMHSA, AHRQ, the FDA, and CMS. The head of each agency shall appoint a director with documented experience in minority health services. Any federal office with responsibility over minority health issues that is already in existence as of the date of enactment of this Act shall not be terminated, reorganized, or have any of its powers or duties

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transferred or modified. Any reference in federal law to an “Office of Minority Health” is deemed to be a reference to the Office of Minority Health within the Office of the Secretary.

Redesignation of National Center on Minority Health and Health Disparities
Renames the “National Center on Minority Health and Health Disparities” as the “National Institute on Minority Health and Health Disparities.” In addition, this provision amends instructs that the Director of the National Institute on Minority Health and Health Disparities shall be responsible for coordinating all research and activities conducted or supported by the Institute on minority health and health disparities. The Director shall also plan, coordinate, review and evaluate research and other activities conducted or supported by the Institutes and Centers of NIH.

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Amendment to the Hospital Value-Based Purchasing Program
The Secretary will select measures other than measures of hospital readmission for the purposes of evaluating the hospital value-based purchasing program.

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GAO Study on Medicare Beneficiary Access to High-Quality Dialysis Services
The Comptroller General of the United States will conduct a study and report to Congress on the impact of Medicare beneficiary access to high-quality dialysis services, including specified oral drugs (for which there is no injectable equivalent) that are furnished to such beneficiaries for the treatment of end stage renal disease under the bundled prospective payment system.

TITLE IV – PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH

Subtitle A - Modernizing Disease Prevention and Public Health Systems

National Prevention, Health Promotion and Public Health Council

The President of the United States is charged with establishing an interagency council within HHS known as the National Prevention, Health Promotion and Public Health Council. The Surgeon General will serve as the chairperson and representatives from agencies interacting with national health and safety policy will serve as the members.

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The Council shall provide coordination and leadership to all federal departments and agencies with respect to disease prevention, wellness and health promotion, and integrative health care. The Council shall develop a national prevention, health promotion, public health and integrative health care strategy that incorporates the most effective and achievable means of improving the health status of Americans and reducing the incidence of preventable illness and disability. Findings and recommendations as to

the best practices and priorities supporting the national wellness strategy shall be reported annually to Congress and the President.

Advisory Group on Prevention, Health Promotion and Integrative and Public Health

The President of the United States shall establish an Advisory Group comprised of no more than 25 health care professionals with expertise on chronic disease management and prevention to support the efforts of the National Prevention, Health Promotion and Public Health Council.

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Prevention and Public Health Fund

The Secretary shall establish a Prevention and Public Health Fund within HHS. The Fund will expand national investment in prevention and public health programs authorized by the Public Health Service Act and thereby help restrain health care costs in the private and public sector. The Fund is appropriated \$500 million for fiscal year 2010 and may increase \$250 million annually until 2015 and thereafter when the amount is not to exceed \$1 billion.

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Clinical and Community Preventative Services

The Director of AHRQ shall establish and provide ongoing administrative support to an independent Preventive Services Task Force. This Task Force will review the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of clinical preventive services for the purpose of developing recommendations for the health care community. The Task Force shall coordinate its work with the Community Preventive Service Task Force and the Advisory Committee on Immunization Practices, and will examine how its recommendations interact with the recommendations of these other task forces. All recommendations are to be published in a Guide to Clinical Preventive Services, which must be revised every five years. The Task Force shall also provide technical assistance to those health care entities that request help in implementing the Guide recommendations.

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Establishment of an Independent Community Preventive Service Task Force

The Director of the CDC shall establish and provide ongoing administrative support to an independent Community Preventive Service Task Force. The Task Force is charged with responsibilities and goals similar to those of the Preventative Services Task Force. Funds appropriate for the activities of the Task Force will be appropriated annually.

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Education and Outreach Campaign Regarding Preventive Benefits

The Secretary shall implement a national public-private partnership for a disease prevention and health promotion outreach. The campaign is intended to raise public awareness of health improvement and shall disseminate public information that informs, educates, and encourages the use of preventative services and healthy behaviors linked to the prevention of chronic disease. The Institute of Medicine will provide ongoing advice on evidence-based scientific information to the Secretary for use in coordinating this educational campaign.

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Within one year of the enactment of this Act, the Secretary, acting through the Director of the CDC, shall establish a science-based media campaign on health promotion and disease prevention and maintain an internet website designed to address proper nutrition, regular exercise, smoking cessation, obesity reduction, the five leading disease killers in the United States, and disease screening. The campaign will be subject to an independent evaluation every two years, and the Secretary shall report to Congress every two years on its effectiveness.

The federal Internet website for personalized prevention planning will serve as a tool for the public to gain access to the most up-to-date scientific evidence relating to disease prevention. The website shall contain a component that enables an individual to determine their disease risk (based on personal and family history, and body mass index etc.) for the five leading diseases in the United States, and obtain personalized suggestions for preventing such diseases. The Secretary shall establish an Internet portal that provides tools for the public to assess their health risks. This portal shall be developed and maintained by private and academic entities.

The Secretary shall provide guidance and relevant information to states and health care providers regarding preventive and obesity-related services that are available to Medicaid enrollees. Each state shall design a public awareness campaign to educate Medicaid enrollees on preventive and obesity-related services. The Secretary shall report to Congress by January 1, 2011 (and every three years thereafter until January 1, 2017) on the status and effectiveness of the public awareness campaigns.

Manager's Amendment Changes (applies to Title IV, Subtitle A generally):

The report submitted by the National Prevention and Health Promotion Council must submit science-based initiatives measuring the goals of Healthy People 2020 (changed from 2010), and establish plans for consolidating federal health programs and centers in order to meet priority goals of Healthy People 2020 (changed from 2010).

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The amendment also broadens the allowable uses for prevention and public health funding by adding "initiatives" to the list of uses. It also edits the name of the program from the Education and Outreach Campaign for Preventive Benefits to the Education and Outreach Campaign Regarding Preventive Benefits. The amendment also changes the term "Gateway" to "Exchange".

Subtitle B—Increasing Access to Clinical Preventive Services

School-Based Health Centers

The Secretary will implement a school-based health center program to award grants for initiatives supporting school-based health centers. To be eligible for a grant, an entity must: 1) be a school-based health center, defined as a health center located in or adjacent to a school facility and administered by a sponsoring facility; 2) provide comprehensive primary health services during school hours to children and adolescents by licensed

health professionals; and 3) pledge not to perform abortion services. Preference for funding will be given to school-based health centers serving a significant Medicaid or CHIP eligible population. A school-based health center receiving funds under this section shall not provide health care services to minors without the consent of a parent or legal guardian.

Funds awarded under the grant program may be used for: 1) acquiring and leasing equipment; 2) training related to the provision of comprehensive primary health services; 3) management and operation of clinic programs; and 4) payment of salaries for health professionals and other appropriate clinic personnel. Funds may not be used to provide abortions. The Secretary may also award funds to pay for the costs of expanding and modernizing existing buildings for use as a school-based health center.

Oral Healthcare Prevention Activities

The Secretary, in collaboration with the Director of the Centers for Disease Control, shall promote preventive oral healthcare with particular emphasis on children and pregnant women. Activities include providing demonstration grants to community-based dental providers dedicated to dental disease management and entering into cooperative agreements with states and tribal organizations to streamline preventive dental care. Information gained from these targeted activities will serve as the foundation for a national oral health public education campaign. Surveillance of preventive oral health practice will be improved by the inclusion of oral health components in the National Health and Nutrition Examination Survey.

Medicare Coverage of Annual Wellness Visit Providing a Personalized Prevention Plan

This section includes personalized prevention plan services to the list of “medical and other health services” provided to Medicare beneficiaries. Medicare beneficiaries will be eligible to receive an initial preventive physical examination within twelve months of the start of coverage and every twelve months thereafter. These new prevention plan services will enable a Medicare beneficiary to have a health risk assessment prior to or during a visit with a health professional. The health risk assessment may include the following elements: 1) establishing or updating an individual’s medical and family history; 2) creating a list of all current health providers; 3) measuring height, weight, body mass index, blood pressure, and other routine measurements; 4) detecting cognitive impairments; 5) establishing or updating a personalized screening schedule; 6) performing a health risk assessment; and 7) furnishing appropriate referrals.

The Secretary shall establish public guidelines for health risk assessment, make patients and providers aware that a health risk assessment is a required part of the personalized prevention plan under Medicare, and encourage the use of HIT.

With respect to personalized prevention plan services, the Federal Supplementary Medical Insurance Trust Fund (which reimburses health care providers for Medicare

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services) shall reimburse the lesser of the actual charge for the service or the amount determined under the physician fee schedule. Any personalized prevention plan services furnished by a hospital outpatient department shall be reimbursed at this same rate, rather than under the prospective payment system for outpatient departments.

In addition, Medicare will waive the annual Medicare Part B deductible for personalized prevention plan services. Typically, Medicare beneficiaries have to pay for health care services up to a minimum deductible before Medicare begins to pay its share (in 2010 that deductible is \$155). Under this provision, this minimum deductible will not apply to personalized prevention plan services. However, Medicare will not pay for personalized prevention plan services that occur more frequently than once per year.

Removal of Barriers to Preventive Services in Medicare

Starting January 1, 2011, with respect to preventive services, Medicare shall reimburse the lesser of the actual charge for the service or the amount determined under a fee schedule established by the Secretary, if the services rendered are recommended with a grade of A or B by the United States Preventive Task Force. Any preventive services furnished by an outpatient department of a hospital shall be reimbursed at this same rate, rather than under the prospective payment system for outpatient departments. “Preventive Services” are defined as: 1) screening and preventive services including: pneumococcal, influenza, and hepatitis B vaccines, screening mammography, screening pap smear and pelvic exams, prostate and colorectal cancer screening tests, bone mass measurements, glaucoma screening, medical nutrition therapy services, cardiovascular screening blood tests, diabetes screening tests and outpatient self-management training services, and ultrasound screenings for abdominal aortic aneurysm; 2) an initial preventive physical examination; and 3) personalized prevention plan services.

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In addition, Medicare will waive the annual Medicare Part B deductible for preventive services. Typically, Medicare beneficiaries have to pay for health care services up to a minimum deductible before Medicare begins to pay its share (in 2010 that deductible is \$155). Under this provision, this minimum deductible will not apply to personalized prevention plan services. Additionally, the deductible does not apply to colorectal cancer screening tests regardless of the methods used to diagnose (example: regardless of whether or not tissue is removed or other procedures are utilized in connection with the screening test).

Manager’s Amendment Changes:

Payment and Elimination of Coinsurance in All Settings: Adds that nutrition therapy services will be covered at 100 percent if they are services recommended with a grade of A or B by the United States Preventive Services Task Force. Reimbursement for clinical diagnostic laboratory tests is increased from 80 percent to 100 percent. Extended care in religious nonmedical health care institutions will be paid for at 100 percent of a specified amount, with certain exceptions.

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Evidence-Based Coverage of Preventive Services in Medicare

Effective beginning January 1, 2010, the Secretary may: 1) modify the coverage of any preventive service offered to Medicare beneficiaries following recommendations made by the United States Preventive Services Task Force (this Task Force reviews the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of clinical preventive services and develops recommendations for the health care community); 2) modify the services included in the initial preventive physical examination (including the health risk assessment); and 3) provide that no payment shall be made for preventive services rendered that do not meet Task Force recommendations.

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Improving Access to Preventive Services for Eligible Adults in Medicaid

The definition of "medical assistance" covered by Medicaid shall include: 1) all clinical preventive services assigned a grade of A or B by the United States Preventive Services Task Force; 2) all approved adult vaccinations recommended by the Advisory Committee on Immunization; and 3) all medical and remedial services recommended by a physician for the maximum reduction of physical or mental disability. This provision shall be effective January 1, 2013.

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The FMAP (the percentage of federal matching funds for state expenditures on Medicaid services) shall increase by one percentage point for states that provide: 1) clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force; and 2) approved adult vaccinations recommended by the Advisory Committee on Immunization Practices. This provision shall be effective January 1, 2013.

Coverage of Comprehensive Tobacco Cessation Services for Pregnant Women in Medicaid

Counseling and pharmacotherapy services to help pregnant women quit smoking shall be included within the list of "medical assistance" services covered by Medicaid. Medicaid will reimburse for those counseling and pharmacotherapy services that are: 1) performed under the supervision of a physician (or any other health care professional qualified to perform such services under state law); and 2) recommended with respect to pregnant women in "Treating Tobacco Use and Dependence: 2008 Update: A Clinical Practice Guidelines," published by the Public Health Service.

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Pharmacotherapy services under this section include prescription and nonprescription tobacco cessation drugs approved by the FDA, but shall not include coverage for drugs or biologicals not otherwise covered under Medicaid. This provision shall be effective October 1, 2010.

Coverage shall be available for prescription vitamins and mineral products that are recommended for tobacco cessation use in pregnant women. There shall be no cost-sharing, deduction, or other similar charge for counseling, pharmacotherapy services, or covered outpatient services.

Incentive Program for Prevention of Chronic Diseases in Medicaid

The Secretary shall award grants to states to carry out initiatives to provide incentives for Medicaid beneficiaries to participate in behavior modification programs aimed at: 1) tobacco cessation; 2) controlling or reducing weight; 3) lowering cholesterol; 4) lowering blood pressure; 5) avoiding the onset of diabetes, or in the case of a diabetic, improving the management of that condition; and 6) addressing co-morbidities, including depression. Any incentives provided to a Medicaid beneficiary to participate in behavior modification programs shall not be taken into account for purposes of determining the beneficiary's eligibility for benefits under the Medicaid program generally.

The Secretary will award three-year grants to states beginning January 1, 2011, and shall conduct an outreach and education campaign to make states aware of the availability of such grants. A state awarded a grant shall conduct its own outreach and education campaign to make Medicaid beneficiaries and providers aware of the state initiatives under the program. States awarded grants must: 1) track Medicaid beneficiary participation in the program; 2) evaluate changes in health risk and outcomes for program participants, including participant adoption and maintenance of new health behaviors; 3) establish standards and health status targets for program participants; 4) evaluate the overall effectiveness of the program; 5) report to the Secretary on processes that have been developed and lessons learned; and 6) require Medicaid managed care programs to report on preventive services rendered as part of their reporting on quality measures. A state may carry out these programs in partnership with Medicaid providers, community-based organizations, faith-based organizations, Indian tribes, or other similar entities. Normally, the Social Security Act requires that states provide Medicaid programs across the whole state, but the Secretary may waive this requirement.

Manager's Amendment Changes (applies to Title IV, Subtitle B):

The amendment includes vision services in the definition of comprehensive primary health services provided during physicals of school children in school-based health centers. The amendment also clarifies that a beneficiary is eligible to receive an initial preventive physical examination during the 12-month period after the date coverage under Medicare Part B; thereafter, a preventive physical examination will be covered on an annual basis, so long as the exam was not received within the preceding twelve-month period.

Subtitle C—Creating Healthier Communities

Community Transformation Grants

A "Community Transformation Grants" program will be established wherein HHS and the CDC shall award grants to state and local governmental agencies and community-based organizations for the implementation, evaluation, and dissemination of evidence-based community preventive health activities in order to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming. Eligibility, training, dissemination of information, and use-of-funds requirements are delineated under the

grant program. Funds awarded under the program shall not be used to create video games or to carry out any other activities that may lead to higher rates of obesity or inactivity.

Healthy Aging, Living Well; Evaluation of Community-Based Prevention and Wellness Programs for Medicare Beneficiaries

The “Healthy Aging, Living Well” grant program will award grants to state or local health departments and Indian tribes to carry out five-year pilot programs to provide public health community interventions, screenings, and where necessary, clinical referrals for individuals who are between 55 and 64 years of age. The eligibility, training, dissemination of information and use-of-funds requirements under the grant program include a mandate that any grant recipient conduct ongoing health screening to identify risk factors for cardiovascular disease, cancer, stroke, and diabetes among individuals in both urban and rural areas. Moreover, the Secretary shall conduct an evaluation of community-based prevention and wellness programs and develop a plan for promoting healthy lifestyles and chronic disease self-management.

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Removing Barriers and Improving Access to Wellness fro Individuals with Disabilities

The Architectural and Transportation Barriers Compliance Board and the FDA are charged with promulgating regulatory standards setting forth the minimum technical criteria for medical diagnostic equipment used in physician’s offices, clinics, emergency rooms, hospitals, and other medical settings. The standards must ensure that such equipment is accessible to, and usable by individuals with accessibility needs.

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Immunizations

The Secretary has the authority to negotiate and enter into contracts with the manufacturers of adult vaccines for purchase and delivery, subject to other sections of the bill. States may obtain additional quantities of such adult vaccines through the purchase of vaccines from manufacturers at the applicable price negotiated by the Secretary. In addition, the Secretary and the CDC has the authority to establish a demonstration program to award grants to states to improve the provision of recommended immunizations for children, adolescents, and adults through the use of evidence-based and population-based interventions. Additionally, the Comptroller General is required to conduct a study on the ability of Medicare beneficiaries aged 65 and older to access routinely recommended vaccines covered under the Medicare drug benefit. Finally, funding for the program offering state immunization grants under Section 317 of the Public Health Services Act is reauthorized by removing the funding date restrictions.

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Nutrition Labeling of Standard Menu Items at Chain Restaurants

Standard menu items of restaurant chains with twenty or more locations must now display a nutrient and caloric content disclosure adjacent to the name of the menu item and a statement concerning suggested daily caloric intake. Drive-through boards are also included in this requirement, but daily specials, temporary items, custom orders, and items that are part of a customary market test are not included. Additionally, there are

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specific requirements for operators of twenty or more vending machines. A sign listing product nutritional values shall be posted next to the machine if product labels are not visible to the consumer.

Demonstration Project Concerning Individualized Wellness Plan

A pilot program will be established to test the impact of providing at-risk populations treated at community health centers with an individualized wellness plan designed to reduce risk factors for preventable conditions.

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Reasonable Break Time for Nursing Mothers

Employers are required to provide a reasonable break time for nursing mothers to express milk in a shielded, private place other than a bathroom. The break time is uncompensated time and employers with less than 50 employees are not subject to these requirements if it would cause undue hardship.

Manager's Amendment Changes (applies to Title IV, Subtitle C generally):

No less than 20 percent of community transformation grants must be awarded to rural and frontier areas. The amendment adds "frontier areas" as areas which may receive funds.

Addressed in
Title IV of the
President's
Proposal

Subtitle D – Support for Prevention and Public Health Innovation

Research on Optimizing the Delivery of Public Health Services

The Secretary and the CDC shall make funds available for research to optimize the delivery of public health services, including 1) examining evidence-based prevention practices, with a particular focus on high priority areas identified by the National Prevention Strategy or Healthy People 2020; 2) analyzing the translation of interventions from academic settings to real world settings; and 3) identifying effective strategies for organizing, financing, or delivering public health services in real world community settings.

Addressed in
Title IV of the
President's
Proposal

Understanding Health Disparities: Data Collection and Analysis

The Secretary must ensure that any federally conducted or supported health care or public health program, activity, or survey collects and reports 1) data on race, ethnicity, sex, primary language, and disability status for applicants, recipients, or participants; 2) data at the smallest geographic level if such data can be aggregated; 3) sufficient data to generate statistically reliable estimates according to targeted categories; and 4) any other demographic data as deemed appropriate by the Secretary regarding health disparities. All of these data collection activities are subject to the privacy protections established by HIPAA. The Secretary must also survey providers to assess access to care and treatment for individuals with disabilities. The bill then details the data management, reporting, and dissemination requirements under these new data collection provisions. The bill also makes clear that these new data collection requirements will apply to data collection activities at the state level for Medicaid and CHIP.

Addressed in
Title IV of the
President's
Proposal

CDC and Employer Based Wellness Programs

The CDC must provide technical assistance, evaluation resources, trainings, etc., to workplace staff in order to generate and disseminate data as to the effectiveness of employer-based wellness programs.

Addressed in Title IV of the President's Proposal

Epidemiology-Laboratory Capacity

The Epidemiology and Laboratory Capacity Grant Program will award grants to state and local health departments and tribal jurisdictions that meet certain criteria. Under the program, grants will be awarded to assist public health agencies in improving surveillance for, and response to, infectious diseases by 1) strengthening epidemiologic capacity; 2) enhancing laboratory practice and systems to report test orders and results electronically; 3) improving information systems by developing an information exchange based on national guidelines; and 4) implementing prevention and control strategies.

Addressed in Title IV of the President's Proposal

Advancing Research and Treatment for Pain Care Management

The Secretary is required to enter into an agreement with the Institute of Medicine to convene a Conference on Pain, the purpose of which is to increase recognition of pain as a significant public health problem, and evaluate the adequacy of assessment, diagnosis, treatment, and management of acute and chronic pain in the general and at risk populations.

Addressed in Title IV of the President's Proposal

Pain Research

The Director of NIH is required to continue and expand an aggressive research program, coordinated with the Pain Consortium, on the causes of and treatments for pain.

Addressed in Title IV of the President's Proposal

Program for Education and Training in Pain Care

The Interagency Pain Research Coordinating Committee is established to coordinate all efforts within HHS and other federal agencies that relate to pain research. The Secretary has the authority to award grants, enter into cooperative agreements, and make contracts with relevant public and private entities to educate and train health care professionals in pain care.

Addressed in Title IV of the President's Proposal

Subtitle E – Miscellaneous Provisions

Sense of the Senate Concerning CBO Scoring

The Senate finds that the costs of prevention programs are difficult to estimate due in part because prevention initiatives are hard to measure and results may occur outside the five and ten year budget windows. Also, it is the sense of the Senate that Congress should work with the Congressional Budget Office to develop better methodologies for scoring progress to be made in prevention and wellness programs.

Effectiveness of Federal Health and Wellness Initiatives

The Secretary is required to conduct an evaluation of health and wellness programs as related to changes in the health status of the American public and the federal workforce. Markers of interest include absenteeism, productivity, rate of workplace injury, medical

Addressed in Title IV of the President's Proposal

costs incurred by employees, prevalence of health conditions, workplace fitness and nutrition, and incentives in the Federal Employee Health Benefits Program. Findings shall be reported to Congress.

Manager's Amendment Changes (applies to Title IV, Subtitle E):

The amendment strikes the provision regarding the sense of the Senate concerning the Congressional Budget Office Scoring.

Manager's Amendment Changes (apply to Title IV generally):

The amendment inserts the following new sections:

Catalyst to Better Diabetes Care Act of 2009

This Section may be cited as the "Catalyst to Better Diabetes Care Act of 2009." The Secretary will prepare on a biennial basis a national diabetes report card for each state, and make each report card publicly available on the internet. Each report card must include aggregate health outcomes related to individuals diagnosed with diabetes and prediabetes and will include trend analysis for the nation in order to track progress and inform policy and program development. The Secretary will promote the education and training of physicians on the importance of birth and death certificate data, encourage state adoption of the latest standard revisions of birth and death certificates, and work with states to re-engineer their vital statistics systems.

Addressed in Title IV of the President's Proposal

Workplace Wellness Program

The Secretary will award grants to eligible small business employers to provide their employees with access to comprehensive workplace wellness programs over a five-year period. Eligible employers will have less than 100 employees who work more than 25 hours per week and do not currently provide similar wellness programs. The Secretary will develop program criteria for these programs to be made available to employers. Employers interested in participating must submit proposals to the Secretary that meet the specified criteria.

Addressed in Title IV of the President's Proposal

Cures Acceleration Network

The Cures Acceleration Network is established within the Office of the Director of NIH. The network will conduct and support revolutionary advances in basic research, award grants to eligible entities to accelerate the development of high need cures, and provide resources to government agencies and appropriate institutions to develop high need cures. The network will also reduce barriers between laboratory discoveries and clinical trials for new therapies and facilitate review in the FDA for the high need cures funded by the network.

Addressed in Title IV of the President's Proposal

A Board of twenty-four members will advise the Director of NIH on network's activity and report to the Secretary on barriers, policies, programs, and recommendations for improvement.

The Director of NIH shall award competitive contracts, grants, or cooperative agreements to specified entities to promote innovation in technologies that support advanced research and accelerated development of high need cures. Entities must be a research or academic institution, medical center, biotechnology or pharmaceutical company, or disease or patient advocacy organization.

Centers of Excellence for Depression

This section may be cited as the "Establishing a Network of Health-Advancing National Centers of Excellence for Depression Act of 2009" or the "ENHANCED Act of 2009." The Secretary will award five-year renewable grants on a competitive basis to eligible entities to establish national centers of excellence for depression. Each center must integrate basic services and evidence-based interventions, involve a broad cross-section of stakeholders, provide training and technical assistance to mental health professionals, and educate policy makers, employers, and community leaders. Centers must also demonstrate effective use of partnerships, expand interdisciplinary and patient-oriented research, and coordinate with academic programs.

Addressed in
Title IV of the
President's
Proposal

The Secretary shall establish performance standards for each center and the network of centers as a whole, and will rate the performance of each center within three years. Based upon the report cards, the Secretary will make recommendations to the centers regarding improvements and recommendations to Congress for expanding the centers to serve individuals with other types of mental disorders. A third party will annually review and evaluate the network of centers to ensure they are meeting the goals of this section.

Programs Relating to Congenital Heart Disease

The purpose of the Congenital Heart Disease Surveillance System shall be to facilitate further research into the types of health services patients use and to identify possible areas for educational outreach and prevention in accordance with standard practices of the CDC. The Secretary, acting through the CDC, may enhance and expand infrastructure to track the epidemiology of congenital heart disease and to organize such information into a nationally-representative, population-based surveillance system that compiles data concerning actual occurrences of congenital heart disease.

Addressed in
Title IV of the
President's
Proposal

The surveillance system may include information concerning the incidence and prevalence of congenital heart disease, may be used to collect and store data on congenital heart disease, and may ensure the collection and analysis of longitudinal data related to individuals of all ages with congenital heart disease. The surveillance system will be made available to the public and comply with all privacy regulations.

Addressed in
Title IV of the
President's
Proposal

Automated Defibrillation in Adam's Memory Act

Amends the Automated Defibrillation in Adam's Memory Act so that it is administered by an organization that has substantial expertise in pediatric education, pediatric medicine, electrophysiology and sudden death, and changes the years from 2003 to "2003 through 2014."

Young Women's Breast Health Awareness and Support of Young Women Diagnosed with Breast Cancer

The Secretary shall conduct a national evidence-based educational campaign to increase awareness of young women's knowledge regarding breast health. The campaign shall provide age-appropriate messages and materials as developed by the CDC. The Secretary will also conduct an education campaign among physicians and other health care professionals to increase awareness of breast health and comprehensive treatment of breast cancer.

Addressed in
Title IV of the
President's
Proposal

The Secretary shall award grants to entities to establish national multimedia campaigns oriented to young women and will establish an advisory committee to assist in creating these educational campaigns. Grants will be awarded to organizations and institutions to provide health information from credible sources and substantive assistance directed to young women diagnosed with breast cancer and pre-neoplastic breast diseases.

The Secretary will conduct prevention research on breast cancer in young women, and the Director of NIH shall conduct research to develop and validate new screening tests and methods for prevention and early detection of breast cancer in young women. The Secretary shall measure: 1) young women's awareness regarding breast health; 2) the number or percentage of young women utilizing information regarding lifestyle interventions that foster healthy behaviors; 3) the number or percentage of young women receiving regular clinical breast exams; and 4) the number or percentage of young women who perform breast self exams, and the frequency of such exams, before the implementation of this Act. The Secretary must measure the impact of these activities no less than every three years and must submit reports to Congress on the results of these measurements. The term "young women" means women 15 to 44 years of age. There are authorized to be appropriated \$9,000,000 for each of the fiscal years 2010 through 2014 to carry out these activities.

Title V – HEALTH CARE WORKFORCE

Subtitle A – Purpose

Purpose

The purpose of this title is to improve access to and the delivery of health care services for all individuals, particularly low-income, underserved, and uninsured populations by:
1) gathering and assessing relevant data to streamline efforts; 2) increasing the supply of

a qualified health workforce to improve access to needed services; 3) enhancing workforce education and training; and 4) providing support to the existing workforce.

Subtitle B – Innovations in the Health Care Workforce

National Health Care Workforce Commission

The National Health Care Workforce Commission is established to serve as a national resource for Congress, the President, states, and localities. The Commission will evaluate education and training activities in relation to the demand for health care workers, and identify barriers to improved coordination at the federal, state, and local levels.

Addressed in Title V of the President's Proposal

State Health Care Workforce Development Grants

Competitive health care workforce development grant program established to encourage state partnerships for comprehensive health care workforce development at the local level.

Addressed in Title V of the President's Proposal

Health Care Workforce Assessment

The National Center for Health Workforce Analysis is established to work with the National Health Care Workforce Commission and relevant regional and state centers and agencies to gather information and conduct studies relevant to the health care workforce.

Addressed in Title V of the President's Proposal

Manager's Amendment Changes (applies to Title V, Subtitle B generally)

The amendment inserts the following new section:

Interagency Task Force to Assess and Improve Access to Health Care in the State of Alaska

Establishes the Interagency Access to Health Care in Alaska Task Force to analyze deficiencies in access for beneficiaries of Federal health care systems and develop federal-based strategies for improvement. Task Force members will represent the Departments of Health and Human Services, Defense, Army, Air Force, Veterans Affairs, Homeland Security, and the IHS.

Subtitle C – Increasing the Supply of the Health Care Workforce

Federally-supported Student Loan Funds

The federally-supported medical student loan program is modified. The most important change requires a participating student to practice in primary care for ten years (including residency training in primary health care) or through the date on which the loan is repaid in full, whichever occurs first.

Addressed in Title V of the President's Proposal

Nursing Student Loan Program

The annual allowance for federal nursing student loans is increased from \$30,000 to \$35,500 for fiscal years 2010 and 2011, and to increase accordingly thereafter for cost of attendance.

Addressed in Title V of the President's Proposal

Health Care Workforce Loan Repayment Program

Under the Pediatric Specialty Loan Repayment Program, eligible individuals agree to be employed full-time for a specified period (which shall not be less than two years) in a pediatric medical or surgical subspecialty or child and adolescent mental and behavioral health.

Addressed in Title V of the President’s Proposal

Public Health Workforce Recruitment and Retention Programs

The initiative seeks to eliminate medically underserved areas and encourage professionals to receive additional training in the field of public health. The Public Health Workforce Loan Repayment Program forgives up to \$35,000 of government and commercial student loan debt for each year of obligated service in public health. Recipients of the program must contract with the Secretary for at least three years of full-time public health service. The amount of loan forgiveness is also based on the individual’s total student debt load.

Addressed in Title V of the President’s Proposal

Allied Health Workforce Recruitment and Retention Programs

The initiative seeks to eliminate medically underserved areas and encourage professionals to receive additional training in the field of allied health.

Addressed in Title V of the President’s Proposal

Funding for National Health Service Corps

Eliminates the federal cap on individuals in the Commissioned Corps and establishes a commissioned Regular Corps and a Ready Reserve Corps for service in time of national emergency. The bill then details the differences between the two and discusses how they will be established and administered. Additionally, a grant program is established to promote nurse-managed health clinics for medically underserved populations.

Addressed in Title V of the President’s Proposal

Subtitle D - Enhancing Health Care Workforce Education and Training

Training In Family Medicine, General Internal Medicine, General Pediatrics, And Physician Assistantship

Establishes grants to accredited hospitals, schools of medicine, and certain affiliated physician assistant training programs to plan, develop, operate, or participate in an accredited professional training program in the fields of family medicine, general internal medicine, or general pediatrics. The training programs are available to medical students, interns, residents, or practicing physicians. Institutions may also use an award to operate joint degree programs in public health or to develop a physician assistant education program.

Addressed in Title V of the President’s Proposal

Grants shall also be distributed to provide need-based financial assistance to medical students, interns, residents, practicing physicians, or other medical personnel wishing to practice in such areas. Physicians planning to teach in one of these disciplines, either at the program site or in a community-based setting, may also be eligible for a grant.

Assistance in the form of grants may also establish a demonstration program to train providers in new competencies, including the patient-centered medical home model for primary care physicians.

Training Opportunities for Direct Care Workers

A grant program is created to offer training opportunities to direct care workers in long-term care settings. To be eligible for such assistance, an individual must be enrolled in courses provided by an academic institution that is partnered with a long-term care entity, and must maintain satisfactory academic progress in such courses. Following completion of the program, the individual must agree work in the field of geriatrics, disability services, long-term services and supports, or chronic care management for a minimum of two years.

Addressed in Title V of the President's Proposal

Training in General, Pediatric, and Public Health Dentistry.

Schools of Dentistry, hospitals, and certain other entities may receive grants to plan, develop, operate or participate in approved professional training programs in the field of general, pediatric, or public health dentistry. Such grants may be used to provide financial assistance to participating dental students, residents, or practicing dentists who plan to practice in the targeted areas, and to oral health care providers wishing to teach in one of those fields.

Addressed in Title V of the President's Proposal

Such entities may also use an awarded grant to establish faculty loan repayment programs, whereby the individual agrees to serve full-time as a faculty member and the program agrees to pay the principal and interest on the outstanding student loans. Upon completion by the faculty member of each of the first, second, third, fourth, and fifth years of service, the program shall pay an amount equal to 10, 15, 20, 25, and 30 percent, respectively, of the individual's student loan balance.

Alternative Dental Health Care Providers Demonstration Project

Fifteen grants shall be awarded to accredited programs to establish demonstration programs to train or employ alternative dental health care providers in order to increase access to services in rural and other underserved communities. Following the demonstration program, the Secretary and the Director of the Institute of Medicine shall evaluate access to dental health care in the United States.

Addressed in Title V of the President's Proposal

Geriatric Education and Training; Career Awards; Comprehensive Geriatric Education

Grants or contracts may be awarded to existing geriatric education centers to offer fellowships in the form of short-term intensive courses that focus on geriatrics, chronic care management, and long-term care in order to provide supplemental training for faculty members in medical schools and other health professions. Such fellowships shall be open to current faculty, appropriately credentialed volunteer faculty, and practitioners who do not have formal training in geriatrics. These courses will count towards an individual's continuing health profession education requirements.

Addressed in Title V of the President's Proposal

A geriatric education center that receives an award must also use such funds to carry out one of the following two activities. First, it may offer at least two courses each year, at no charge or nominal cost, to family caregivers and direct care providers that are

designed to provide practical training for supporting frail elders and individuals with disabilities. Such programs shall include instruction on the management of psychological and behavioral aspects of dementia, communication techniques for working with individuals who have dementia, and the appropriate use of medications for older adults. Second, it may develop and include material on depression and other mental disorders common among older adults, medication safety issues, and management of the psychological and behavioral aspects of dementia and communication techniques with individuals who have dementia in all training courses, where appropriate.

Grants shall also be awarded to individuals to foster greater interest among a variety of health professionals to enter the field of geriatrics, long-term care, and chronic care management. The individual must be an advanced practice nurse, a clinical social worker, a pharmacist, or student of psychology pursuing a doctorate or other advanced degree in geriatrics or related fields. In return, the individual shall agree to teach or practice in the field of geriatrics, long-term care, or chronic care management for a minimum of five years.

Mental and Behavioral Health Education and Training Grants

Grants are available to institutions of higher education to support the recruitment and education of students in: 1) programs of social work; 2) masters, doctoral, internship, and post-doctoral residency programs of behavioral and mental health psychology; and 3) accredited institutions of higher education offering multidisciplinary internships in child and adolescent mental health. Licensed mental health organizations are also eligible for funding to pay for training of paraprofessional child and adolescent mental health workers. At least four of the grant recipients must be historically black colleges or universities or other minority-serving institutions.

Addressed in
Title V of the
President's
Proposal

Cultural Competency, Prevention and Public Health, and Individuals with Disabilities Training

Establishes grants to entities for the development, evaluation, and dissemination of research and model curricula for working with disabled individuals. The Secretary shall evaluate the implementation of the curricula and include these competency measures in quality measurement systems as appropriate.

Addressed in
Title V of the
President's
Proposal

Advanced Nursing Education Grants

The Secretary may award grants to entities to enhance the nursing workforce by initiating and maintaining nurse retention programs. The grants may be used to: 1) promote career advancement for licensed nurses; 2) develop and implement internship and residency programs to encourage mentoring and the development of specialties; 3) assist individuals in entering and advancing through the nursing profession; or 4) improve the retention of nurses and enhance patient care that is directly related to nursing activities.

Addressed in
Title V of the
President's
Proposal

Nurse Faculty Loan Program

Eligible faculty at accredited schools of nursing may be eligible for education loan repayment assistance through the Secretary. Recipients must serve as a full-time faculty

Addressed in
Title V of the
President's
Proposal

member for at least four of the first six years after the individual either receives a masters or doctorate in nursing or signs an agreement with the Secretary. If the individual does not fulfill the requirements of the agreement, then he or she will be held liable to the federal government for the total amount paid by the Secretary.

Grants to Promote the Community Health Workforce

Grants are available to community health workers to promote positive health behaviors and outcomes for populations in medically underserved communities. Such grants shall be used to educate, guide, and provide: 1) outreach for health problems prevalent in medically underserved communities; 2) guidance regarding effective strategies to improve health and discourage risky health behaviors; 3) outreach regarding enrollment in health insurance including CHIP, Medicare and Medicaid; 4) enrollment of underserved populations to appropriate healthcare agencies and community-based programs to increase access and to eliminate duplicative care; or 5) home visitation services regarding maternal health and prenatal care.

Addressed in
Title V of the
President's
Proposal

Fellowship Training in Public Health

The Secretary may carry out activities to address documented workforce shortages in state and local health departments in the critical areas of applied public health epidemiology and public health laboratory science and informatics. The Secretary may also expand the Epidemic Intelligence Service and existing fellowship programs operated through the Centers for Disease Control and Prevention.

Addressed in
Title V of the
President's
Proposal

United States Public Health Sciences Track

A United States Public Health Sciences Track will be established at certain accredited academic health professional schools to grant appropriate advanced degrees that uniquely emphasize team based service, public health, epidemiology, and emergency preparedness and response. The Surgeon General shall promulgate policies and procedures for selecting which students will be admitted to the Track, though priority shall be given to students from rural communities and underrepresented minorities. In return for tuition and stipends, students agree to serve in the Commissioned Corps of the Public Health Service two years for every one year enrolled in school. Time reductions may be made if the student agrees to practice in a high-needs specialty residency or in a Federal medical facility located in a health shortage area. Finally, the Surgeon General shall develop criteria for the appointment of highly qualified Track faculty, students, and graduates to elite federal disaster preparedness teams.

Addressed in
Title V of the
President's
Proposal

Manager's Amendment Changes (applies to Title V, Subtitle D):

The amendment inserts the following new section:

Demonstration Grants for Family Nurse Practitioner Training Programs

The Secretary shall establish a training demonstration program for family nurse practitioners in FQHCs and nurse-managed health clinics. Eligible nurses must be appropriately licensed or eligible for licensure and demonstrate commitment to this career path.

Addressed in
Title V of the
President's
Proposal

The purpose of the program is to enable recipients to serve as primary care providers in medically underserved areas and to create a model for FQHCs and nurse-managed health clinics that may be replicated nationwide.

Subtitle E - Supporting the Existing Health Care Workforce

Health Care Professionals Training for Diversity Scholarships and Loan Repayments

The amount of appropriated funds for Diversity Scholarships, which are granted to full-time health students facing severe financial hardship for tuition and other reasonable expenses, is increased from \$37,000,000 to \$54,000,000 a year. The amount of federal reimbursement under the Faculty Loan Repayment Program has increased from \$20,000 to \$30,000.

Addressed in Title V of the President's Proposal

Interdisciplinary, Community-Based Linkages

Schools of medicine, and in certain situations, schools of nursing, are eligible to receive grants to establish area health education centers. The award may be used to create or improve an existing health education center program. A health education center must be independently operated and located in a medically underserved area that is distanced from the granting academic institution. Services offered at the center must focus on primary care and provide robust access to education through distance learning and continuing education.

Addressed in Title V of the President's Proposal

Workforce Diversity Grants

Grant funding is made available to individuals from disadvantaged backgrounds to pursue careers in nursing.

Addressed in Title V of the President's Proposal

Primary Care Extension Program

The Secretary, together with the Director of AHRQ, shall establish a Primary Care Extension Program. The program shall support primary care providers in the areas of preventive medicine, health promotion, chronic disease management, and mental and behavioral health services.

Addressed in Title V of the President's Proposal

States may also receive grants for the establishment of state or multistate Primary Care Extension Program State Hubs. At a minimum, the Hub shall consist of the state health department, the state Medicaid agency, and the department of one or more health professional schools that train primary care providers. The Hub shall create a Primary Care Extension Agency that will be responsible for: 1) assisting primary care providers with the medical home model; 2) enhancing the dissemination of research findings for evidence-based practice; and 3) developing a plan for private contributions to sustain the program and to reduce Federal funds.

Subtitle F - Strengthening Primary Care and Other Workforce Improvements

Expanding Access to Primary Care Services and General Surgery Services

From 2011 to 2016, primary care services rendered to Medicare beneficiaries shall be reimbursed at the standardized rate plus ten percent of that amount. To qualify as a primary care practitioner, the individual must be either a physician who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; a nurse practitioner, clinical nurse specialist, or physician assistant; and for whom primary care services account for at least 60 percent of the allowed charges.

Addressed in
Title V of the
President's
Proposal

From 2011 to 2016, major surgical procedures performed on Medicare beneficiaries in a health professional shortage area shall be reimbursed at the standardized rate plus ten percent of that amount. Major surgical procedures are those for which a 10-day or 90-day global period is used for payment under the fee schedule.

Medicare Federally Qualified Health Center Improvements

The Secretary shall develop a prospective payment system for services rendered at FQHCs.

Distribution of Additional Residence Positions

After July 1, 2011, if a hospital's reference resident level, defined as the highest resident level for any of the three most recent cost reporting periods, is less than the otherwise applicable resident limit, the otherwise applicable resident limit shall be reduced by 65 percent of the difference between the otherwise applicable resident limit and the reference resident level. The reduction in limits shall not apply to a hospital located in a rural area with fewer than 250 acute care inpatient beds, or to a hospital with an approved voluntary residency reduction plan if a specified plan is in place for filling the unused positions within two years. The Secretary may take the number of reductions in residents and apply those positions elsewhere at hospitals where they may be needed.

Addressed in
Title V of the
President's
Proposal

Addressed in
Title V of the
President's
Proposal

Counting Resident Time in Non-Provider Settings

Effective for cost reporting periods beginning July 1, 2010, all the time spent by a resident shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed. This modification is applicable only if a hospital incurs the costs of the stipends and fringe benefits of the resident during the time the resident spends in that setting. If more than one hospital incurs these costs, either directly or indirectly, such hospitals shall count a proportional share of the time as determined by written agreement between the hospitals. Any hospital claiming time spent in a non-provider setting shall record the information in a manner specified by the Secretary.

Rules for Counting Resident Time for Didactic and Scholarly Activities and Other Activities

Hospitals may count resident time spent in didactic conferences toward the determination of full-time equivalency. In determining the hospital's number of full-time equivalent residents, all of the time that is spent by an intern or resident in an approved medical residency training program on vacation, sick leave, or other approved leave, and that does not prolong the total time the resident is participating in the approved program beyond the normal duration of the program shall be counted toward the determination of full-time equivalency.

Preservation of Resident Cap Positions from Closed Hospitals

In the case where a hospital with an approved medical residency program closes, the Secretary must establish a process to increase the otherwise applicable resident limit for other hospitals. The Secretary may only increase the otherwise applicable residency limit of a hospital under such process if the hospital may likely fill the positions within three years.

Demonstration Projects to Address Health Professions Workforce Needs; Extension of Family to Family Health Information Centers

The Secretary, in consultation with the Secretary of Labor, shall award grants to states, Indian tribes, higher education institutes, and other entities to conduct demonstration projects that are designed to provide individuals receiving assistance under the state Temporary Assistance for Needy Families program with the opportunity to obtain education and training for occupations in the health care field that pay well and are expected to either experience labor shortages or be in high demand. If appropriate, such a demonstration will provide eligible individuals participating in the project with financial aid, childcare, case management, and other supportive services. An entity applying for a grant to carry out a demonstration project shall demonstrate that the entity has consulted with the state agency responsible for administering the state Temporary Assistance for Needy Families program, the local workforce investment board, the state workforce investment board, and the state Apprentice Agency, and that the project will be carried out in coordination with such entities.

Addressed in
Title V of the
President's
Proposal

Grants will also be awarded to up to six states to conduct demonstration projects in order to develop core training competencies and certification programs for personal or home care aides.

Increasing Teaching Capacity

The Secretary will make \$25 million in grants available to teaching health centers to establish new accredited or expanded primary care residency programs and to provide technical assistance for 2010 (\$50 million for fiscal years 2011 and 2012). Preference will be given to centers documenting an existing affiliation agreement with an area health education center program. The Secretary will make payments for direct and indirect expenses of \$230 million to qualified teaching health centers for the expansion of existing or establishment of new approved graduate medical residency training programs.

Addressed in
Title V of the
President's
Proposal

Graduate Nurse Education Demonstration

Establishes a graduate nurse education demonstration program under Medicare where an eligible hospital may receive payment for the hospital's reasonable costs for the provision of qualified clinical training to advance practice nurses. \$50 million is appropriated from the Medicare Hospital Insurance Trust Fund for fiscal years 2012 through 2015.

Addressed in
Title V of the
President's
Proposal

Subtitle G - Improving Access to Health Care Services

Spending for Federally Qualified Health Centers

The following amounts are authorized to be appropriated for FQHCs: 1) for 2010, \$2.98 billion; 2) for 2011, \$3.86 billion; 3) for 2012, \$4.99 billion; 4) for 2013, \$6.44 billion; 5) for 2014, \$7.33 billion; and 6) for 2015, \$8.33 billion. Fiscal year 2016 and succeeding years will be calculated using the preceding year amount and adjusting for percentage changes in costs incurred per patient and for the total number of patients served.

Addressed in
Title V of the
President's
Proposal

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

Using a negotiated rulemaking process, the Secretary will establish a comprehensive methodology for designating medically underserved populations and health professions shortage areas. In establishing the methodology and criteria for establishment, the Secretary will consult with relevant stakeholders who will be significantly affected by a rule and must take into account the timely availability and appropriateness of data used to determine a designation to potential applicants for such designations and the different impacts on communities of various types.

Addressed in
Title II of the
President's
Proposal

Reauthorization of the Wakefield Emergency Medical Services for Children Program

The Wakefield Emergency Medical Services for Children Program, which awards grants to expand and improve emergency medical services for children, is extended for an additional year. Funding for the program is now approved through 2014.

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

\$50 million in grants and cooperative agreements will be awarded by the Secretary to eligible entities to establish demonstration projects for the provision of coordinated and integrated services to special populations through the co-location of primary and specialty care services in community-based mental and behavioral health settings.

Key National Indicators

A Commission on Key National Indicators is established to conduct comprehensive oversight of a newly established key national indicators system, make recommendations on how to improve the system, coordinate with Federal government users and information providers to assure access to relevant and quality data, and enter into

contracts with the National Academy of Sciences. The National Academy of Sciences is responsible for creating the key national indicators system.

Manager's Amendment Changes

The amendment inserts the following new sections:

National Diabetes Prevention Program

A national diabetes prevention program targeted at adults at high risk for diabetes shall be established by the Secretary and the Director of the CDC in order to eliminate the preventable burden of diabetes. The program will include a grant program for community-based diabetes prevention program model sites, a program within the CDC to determine eligibility of entities to deliver community-based diabetes prevention services, training and outreach programs and evaluation, monitoring and technical assistance.

Budget Neutrality for Primary Care Bonuses

The amendment removes the budget-neutrality adjustment that offsets the primary care and general surgery bonuses.

Development and Implementation of Prospective Payment System for FOHCs

The Secretary will develop a prospective payment system for payment for services furnished by FQHCs. The system will take into account the type, intensity, and duration of services furnished by FQHCs, and may include adjustments.

State Grants to Health Care Providers Who Provide Service to a Higher Percentage of Medically Underserved Populations or Other Special Populations

A state may award grants to health care providers who treat a high percentage of medically underserved populations or other special populations in such state.

Addressed in Title V of the President's Proposal

Rural Physician Training Grants

The Secretary, acting through the Administrator of the HRSA, will establish a grant program to assist eligible entities in recruiting students most likely to practice medicine in underserved rural communities, providing rural-focused training and experience, and increasing the number of recent allopathic and osteopathic medical school graduates who practice in underserved rural communities. Students must receive didactic coursework and clinical experience applicable to medical practice in underserved rural communities, including clinical rotations and participation in group activities designed to develop, maintain, and reinforce their commitment to practice in these communities.

Addressed in Title V of the President's Proposal

Preventive Medicine and Public Health Training Grant Program

The amendment reauthorizes the Preventive Health Residency Program under the Public Health Service Act. Grants will be awarded to eligible entities to provide training to graduate medical residents in preventive medicine specialties.

Addressed in Title V of the President's Proposal

Infrastructure to Expand Access to Care

HHS is appropriated \$100,000,000 for fiscal year 2010 to be used for debt service on, or direct construction or renovation of, a health care facility that provides research, inpatient tertiary care, or outpatient clinical services.

Community Health Centers and the National Health Service Corps Fund

A Community Health Center Fund is established within HHS to provide for expanded and sustained national investment in community health centers and the National Health Services Corps. The Secretary will transfer amounts from the Fund to accounts within HHS to increase funding for community health centers, the National Health Service Corps, and for the construction and renovation of new community health centers.

Addressed in
Title V of the
President's
Proposal

Demonstration Project to Provide Access to Affordable Care

The Secretary, acting through HRSA, must establish a three year demonstration project in up to ten states to provide access to comprehensive health care services to the uninsured at reduced fees. Eligible entities must be a state-based nonprofit, public-private partnership that provides access to comprehensive health care services to the uninsured at reduced fees. Each participating state will receive no more than \$2 million to establish and carry out the project for the demonstration period.

TITLE VI – TRANSPARENCY AND PROGRAM INTEGRITY

Subtitle A – Physician Ownership and Other Transparency

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

Physician-owned hospitals are prohibited from participating in Medicare if they do not have a provider agreement prior to February 1, 2010. Hospitals with agreements by this date must meet other requirements addressing conflict of interest, bona fide investments and patient safety.

Transparency Reports and Reporting of Physician Ownership or Investment Interests

All drug, device, biological and medical supply manufacturers are required to report to the Secretary all transfers of value to providers and hospitals. Penalties will be assessed for noncompliance. Federal laws relating to this section will preempt duplicative state and local laws.

Addressed in
Title VI of the
President's
Proposal

Disclosure Requirements for In-Office Ancillary Services Exception to the Prohibition on Physician Self-Referral for Certain Imaging Services

With respect to magnetic resonance imaging, computed tomography, positron emission tomography, and any other designated health services, the referring physician is required to inform the individual in writing at the time of the referral where the individual may

Addressed in
Title VI of the
President's
Proposal

obtain the services for which the individual is being referred and provide such individual with a written list of suppliers who furnish such services in the area in which the individual resides.

Prescription Drug Sample Transparency

Manufacturers and authorized distributors of applicable drugs that makes distributions by mail must submit an annual report to the Secretary with the identity and quantity of drug samples requested (as required under the Federal Food, Drug and Cosmetic Act).

Addressed in
Title VI of the
President's
Proposal

Pharmacy Benefit Managers Transparency Requirements

A health benefits plan or any entity that provides pharmacy benefits management services on behalf of a health benefits plan that manages prescription drug coverage under Medicare or the Exchange must provide the following to the Secretary: 1) the percentage of all prescriptions provided through retail pharmacies compared to mail order; 2) the amount and type of rebates, discounts or price concessions attributable to patient utilization; and 3) the difference between the amount the health benefits plan pays the pharmacy benefits manager and the amount that the pharmacy benefits manager pays retail pharmacies and the number of prescriptions dispensed.

Addressed in
Title VI of the
President's
Proposal

Subtitle B – Nursing Home Transparency and Improvement

Required Disclosure of Ownership and Additional Disclosable Parties Information

Nursing homes (skilled nursing facilities under Medicare and nursing facilities under Medicaid) must make the following information available to the Secretary: 1) the identity and information of each member of the governing body of the facility; 2) the identity of each officer, director, member, partner, trustee, or managing employee; 3) any additional disclosable party of the facility; and 4) the organizational structure of each facility.

Addressed in
Title VI of the
President's
Proposal

Accountability Requirements for Skilled Nursing Facilities and Nursing Facilities

Skilled nursing facilities must have a compliance and ethics program effective in preventing and detecting criminal, civil, and administrative violations within 36 months of enactment.

Addressed in
Title VI of the
President's
Proposal

Nursing Home Compare Medicare Website

The Secretary must publish the following information on the Nursing Home Compare Website: 1) staffing data for each facility; 2) links to state websites regarding state survey and certification programs and state inspection reports; 3) the standardized complaint form; 4) summary information on substantiated complaints; and 5) the number of adjudicated instances of serious crimes by facility employees. In addition, there shall be a consumer rights information page.

Addressed in
Title VI of the
President's
Proposal

Reporting of Expenditures

Skilled nursing facilities are responsible for submitting reports detailing expenditures, including information on direct and indirect care services, assets and administrative costs.

Addressed in
Title VI of the
President's
Proposal

The Secretary will establish procedures to make this information readily available upon request.

Standardized Complaint Form

The Secretary will develop a standardized complaint form for use by a resident in filing a complaint with a state survey and certification agency and a state long-term care ombudsman program with respect to a facility. The state must make the form available upon request to residents of the facility and any person acting on the resident's behalf. The state must also establish a complaint resolution process to ensure the legal representative of a resident is not denied access to such resident or otherwise retaliated against if they have made a complaint.

Addressed in
Title VI of the
President's
Proposal

Ensuring Staffing Accountability

The Secretary will develop a program for nursing home facilities to report direct care staffing information that includes: 1) the category of work a certified employee performs; 2) resident census and case mix data; 3) a regular reporting schedule; and 4) information on employee turnover and tenure and on the hours of care provided per resident per day.

Addressed in
Title VI of the
President's
Proposal

GAO Study and Report on Five-Star Quality Rating System

The Comptroller General will conduct a study on the Five-Star Quality Rating System for nursing homes regarding implementation, any problems and potential improvements.

Addressed in
Title VI of the
President's
Proposal

Civil Money Penalties

Skilled nursing facilities and nursing homes are subject to the imposition of civil money penalties by the Secretary for any deficiencies found. The Secretary may adjust or reduce the amount of civil money penalties, depending upon the circumstances of self-reporting and correction of the deficiency.

Addressed in
Title VI of the
President's
Proposal

National Independent Monitor Demonstration Project

The Secretary, in consultation with the OIG of HHS, shall conduct 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. Such demonstration shall last for a two-year period.

Addressed in
Title VI of the
President's
Proposal

Notification of Facility Closure

An administrator of a skilled nursing facility must submit to the Secretary, state long-term care ombudsman, residents of the facility, and the legal representatives or other responsible parties, written notification of an impending closure. Administrators must also ensure that the facility does not admit any new residents on or after the date of notification and must include in the notice a plan for transfer and adequate relocation of the residents by a date prior to closure that has been approved by the state. The state will ensure that, before a facility closes, all residents have been successfully relocated to another facility or alternative home or community-based setting. Sanctions may apply to administrators of facilities that fail to comply with this section.

Addressed in
Title VI of the
President's
Proposal

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

The Secretary shall conduct two demonstration projects - one for the development of best practices in skilled nursing facilities and nursing facilities that are involved in the culture change movement, and another for the development of best practices in skilled nursing facilities and nursing facilities for the use of information technology to improve resident care. Each demonstration project shall take into consideration the special needs of residents of skilled nursing facilities and nursing facilities who have cognitive impairments, including dementia. The demonstration projects shall each be conducted for a period not to exceed three years.

Addressed in Title VI of the President's Proposal

Dementia and Abuse Prevention Training

Facilities are required to include dementia management and abuse prevention training as part of pre-employment training for permanent and contract or agency staff.

Addressed in Title VI of the President's Proposal

Subtitle C – Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-Term Care Facilities and Providers

Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-Term Care Facilities and Providers

The Secretary must establish a program to identify efficient, effective, and economical procedures for long term care facilities to conduct background checks on prospective direct patient access employees on a nationwide basis. Procedures established will require the long-term care facility to obtain state and national criminal history background checks. This program is based on the background check pilot program in the Medicare Modernization Act.

Addressed in Title VI of the President's Proposal

Subtitle D – Patient-Centered Outcomes Research

Patient-Centered Outcomes Research

A nonprofit entity known as the 'Patient-Centered Outcomes Research Institute' is established to assist patients, clinicians, purchasers, and policy-makers 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 sub-populations. Research findings will be disseminated by AHRQ.

Addressed in Title VI of the President's Proposal

Federal Coordinating Council for Comparative Effectiveness Research

Specifies that the Federal Coordinating Council for Comparative Effectiveness Research established under Section 804 of Division A of the American Recovery and Reinvestment Act of 2009 (42 U.S.C. 299b-8) shall terminate on the date of the enactment of this Act.

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

Provider Screening and Other Enrollment Requirements Under Medicare, Medicaid and CHIP

The Secretary will establish a process for the enrollment of providers and suppliers under Medicare. The process will include 1) screening of providers and suppliers; 2) a provisional enhanced-oversight period; 3) disclosure requirements; 4) temporary enrollment moratoria; and 5) compliance programs. A state plan for Medicaid medical assistance must provide that the state will comply with these new enrollment requirements. The state may provide for more stringent enrollment requirements. The Administrator of CMS will provide states will provider and supplier information necessary to comply with these new requirements.

Addressed in
Title VI of the
President's
Proposal

Within 180 days of enactment, the Secretary will establish a provider and supplier screening process for Medicare, Medicaid, and CHIP enrollment and reenrollment. The screening will include a licensure check and may include a criminal background check, fingerprinting, unannounced site visits, database checks, and other screening. The Secretary will impose a screening fee. For 2010, the fee will be \$200 for individual providers and \$500 for institutional providers. For subsequent years, the fee will be increased by the consumer price index. The Secretary may exempt a provider from the fee for hardship.

The Secretary will establish a provisional period during which new providers and suppliers will be subject to enhanced oversight. In addition, the Secretary may make any necessary adjustments to payments to applicable providers and suppliers to satisfy past-due amounts of obligated providers or suppliers.

Enhanced Medicare and Medicaid Program Integrity Provisions

The Integrated Data Repository of CMS will include claims and payment data from Medicare, Medicaid, CHIP, IHS, and health-related VA and DOD programs. Inclusion of Medicare and Medicaid data will be a priority.

Addressed in
Title VI of the
President's
Proposal

The Secretary will enter into agreements with the administrators of these programs to ensure data sharing. The OIG will have access to claims and payment data of HHS and its contractors related to Medicare, Medicaid, and CHIP. This access will subject to applicable privacy, security, and disclosure laws. The Inspector General may also obtain information from providers or suppliers. The Commissioner of the Social Security Administration will enter into an agreement with OIG that ensures access to Social Security Administration records and safeguards confidentiality.

If an entity has received an overpayment under Medicare or Medicaid, the person must: 1) report and return the overpayment to the Secretary, the state, or an intermediary; and 2) notify the Secretary, state or intermediary in writing of the reason for the overpayment. The overpayment must be reported and returned.

The Secretary will issue a regulation mandating that all Medicare, Medicaid and CHIP providers include their National Provider Identifier on enrollment applications.

The Secretary will impose an administrative penalty on an individual guilty of federal healthcare fraud. If an individual or entity knowingly makes any misrepresentation in any document as a provider or supplier they may be excluded from participation in any federal healthcare program. The Secretary may also subject such an individual or entity to civil money penalties if they know of an overpayment and do not report it. In addition, the Secretary can require certain providers and suppliers, either guilty of fraud, or found to be at risk to provide surety bonds, not less than \$50,000, commensurate with the volume of billing. The Secretary also has subpoena authority relating to matters under investigation or in question by the Secretary.

The Secretary may withhold from matching payments any amounts expended for medical assistance for individuals for whom the state does not report enrollee encounter data in a timely manner to the Medicaid Management Information System (MMIS).

The Secretary would have the authority to suspend payments to a provider or supplier pending a fraud investigation, except when there is not good cause. The Secretary would be required to consult with the OIG in determining whether there is a credible allegation of fraud.

Elimination of Duplication Between Healthcare Integrity and Protection Databank (HIPDB) and the National Practitioner Databank (NPDB)

The Secretary will create a National Practitioner Databank to collect information on national health care fraud and abuse. The Secretary will establish a process to terminate the HIPDB immediately upon enactment of this legislation and will ensure that the information formerly collected in the HIPDB is transferred to the NPDB. The types of agencies and entities with access to the NPDB are expanded to include federal and state health care programs, licensing authorities, Medicare Quality Improvement Organizations, State Medicaid Fraud Control Units, hospitals and other health care entities, law enforcement officials, and the Government Accountability Office.

Addressed in
Title VI of the
President's
Proposal

Maximum Period for Submission of Medicare Claims Reduced to Not More Than 12 Months

The time period for filing a written request for payment is reduced from three years to one year for services provided under Medicare Parts A and B, with certain limited exceptions.

Physicians Who Order Items or Services Required To Be Medicare Enrolled Physicians or Eligible Professionals

For written orders and certifications made on or after July 1, 2010, physicians or eligible professionals who order DME or home health services are required to enroll in the Medicare program. The Secretary has authority to extend these requirements to physicians and eligible professionals that order other categories of Medicare items and

services, including covered Part D drugs, if the Secretary determines that it would help reduce fraud, waste, and abuse.

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

The Secretary has authority to disenroll (for up to one year) a Medicare-enrolled physician or supplier that fails to maintain and provide access to written orders or requests for payment for DME, certification for home health services, or referrals for other items and services to the Secretary. Medicare providers are required to maintain and provide access to documentation relating to these written orders or requests for payment. The provision also extends the OIG's permissive exclusion authority to include individuals or entities that order, refer, or certify the need for services that fail to provide adequate documentation to the Secretary to verify payment.

Face To Face Encounter with Patient Required Before Physicians May Certify Eligibility for Home Health Services or DME under Medicare

Physicians (or in the case of DME, authorized eligible healthcare professionals) must have a face-to-face encounters (including telehealth) with the individual before issuing a certification or re-certification for home health services or DME as a condition for payment under Medicare Parts A and B. This applies to physicians making home health certifications in Medicaid and CHIP and written orders for DME. The Secretary is authorized to apply this requirement to other Medicare items and services based upon a finding that doing so would reduce the risk of waste, fraud, and abuse.

Addressed in
Title VI of the
President's
Proposal

Manager's Amendment Changes

The amendment expands criteria for professionals who can have face-to-face encounters with patients for home health services to include nurse practitioners and clinical nurse specialists.

Enhanced Penalties

Civil money penalties will be imposed on individuals who knowingly make, use, or cause to be made or used any false statement or record material to a false or fraudulent claim submitted for payment to a federal health care program for violations committed on or after January 1, 2010. These persons will be subject to a civil monetary penalty of \$50,000 for each false record or statement. The violations that could be subject to the imposition of sanctions and civil monetary penalties by the Secretary will include Medicare Advantage or Part D plans that: 1) enroll individuals without prior consent of the individual or designee (except Part D dual-eligibles); 2) transfer an individual from one plan to another solely for the purpose of earning a commission; 3) fail to comply with marketing requirements; or 4) employ or contract with an individual or entity that engages in such conduct. Penalties for plans that misrepresent or falsify information will be increased up to three times the amount claimed by the plan based on the misrepresentation or falsified information.

Addressed in
Title VI of the
President's
Proposal

Medicare Self-Referral Disclosure Protocol

The Secretary, in cooperation with the OIG, must establish a protocol for allowing healthcare providers and suppliers to disclose actual and potential violations of the Stark law within six months from the date of enactment.

Addressed in Title IV of the President's Proposal

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

The number of areas included in the competitive bidding program is expanded from 79 to 100 of the largest metropolitan statistical areas. The Secretary would extend the program, or apply competitively bid rates, to remaining areas by 2016.

Expansion of the Recovery Audit Contractor (RAC) Program

The Recovery Audit Contractor program is expanded. States must establish contracts with one or more Recovery Audit Contractors to ensure each Medicare Advantage or Prescription Drug Plan has in place an anti-fraud plan, to identify underpayments and to recoup overpayments made for services provided under state Medicaid plans and waivers. The Secretary is also required to expand the Recovery Audit Contractor program to Medicare Parts C and D.

Addressed in Title II of the President's Proposal

Subtitle F – Additional Medicaid Program Integrity Provisions

Termination of Provider Participation under Medicaid If Terminated Under Medicare or other State Plan

States are required to terminate individuals or entities from their Medicaid programs if the individuals or entities were terminated from Medicare or another state's Medicaid program.

Addressed in Title VI of the President's Proposal

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

Medicaid agencies are required to exclude individuals or entities from participating in Medicaid for a specified period of time if the entity or individual owns, controls, or manages an entity that: 1) has failed to repay overpayments during the period as determined by the Secretary; 2) is suspended, excluded, or terminated from participation in any Medicaid program; or 3) is affiliated with an individual or entity that has been suspended, excluded, or terminated from Medicaid participation.

Addressed in Title VI of the President's Proposal

Billing Agents, Clearinghouses, or Other Alternate Payees Required To Register Under Medicaid

Agents, clearinghouses, or other alternate payees that submit claims on behalf of healthcare providers are required to register with the state and the Secretary.

Addressed in Title VI of the President's Proposal

Requirement to Report Expanded Set of Data Elements under the Medicaid Statistical Information System (MSIS) to Detect Fraud and Abuse

States and Medicaid managed care entities are required to submit data elements from MSIS as determined necessary by the Secretary for program integrity, program oversight,

Addressed in Title IV of the President's Proposal

and administration. This requirement applies to contract years beginning after January 1, 2010.

Prohibition on Payments to Institutions or Entities Located Outside the United States

States are prohibited from making any payments for items or services provided under a Medicaid state plan or waiver to any financial institution or entity located outside of the United States.

Overpayments

The period for states to repay overpayments is extended to one year when a final determination of the amount of the overpayment has not been determined due to an ongoing judicial or administrative process. When overpayments due to fraud are pending, state repayments of the federal portion would not be due until 30 days after the date of the final judgment.

Mandatory State Use of National Correct Coding Initiative

States are required to make their Medicaid Statistical Information System methodologies compatible with Medicare's national correct coding initiative that promotes correct coding and controls improper coding. By September 1, 2010, the Secretary will identify those methodologies and notify the states on how to incorporate them.

General Effective Dates

States must implement fraud, waste and abuse programs before January 1, 2011.

Subtitle G – Additional Program Integrity Provisions

Multiple Employer Welfare Arrangements (MEWA)

Individuals in connection with MEWAs are prohibited from knowingly making false statements or representations in connection with the marketing or sale of the plan, subject to criminal penalties. MEWAs would be required to register with the Secretary of Labor before operating in a state. The Secretary of Labor would have the authority to adopt regulatory standards or issue orders that a person engaged in the business of providing insurance through a MEWA is subject to the laws of the state in which such person operates. The Secretary of Labor would be authorized to issue cease-and-desist orders against certain MEWAs if it appears that the alleged conduct of the MEWA is fraudulent, creates an immediate danger to the public safety or welfare, or is causing or can be reasonably expected to cause significant, imminent, and irreparable public injury.

Subtitle H – Elder Justice Act

Elder Justice

An Elder Justice Coordinating Council will be created within the Office of the Secretary of HHS along with an Advisory Board on Elder Abuse, Neglect, and Exploitation. The Board will make recommendations to the Elder Justice Coordinating Council relating to

Addressed in
Title VI of the
President's
Proposal

improving the quality of long-term care, implementing best practices, coordinating the activities of relevant agencies, and modifying federal, state, and local laws. The Secretary will award grants and carry out activities that provide greater protection to individuals seeking care in facilities that provide long-term care services and supports. Incentives will be given for individuals to train and seek employment at these facilities. Owners, operators and employees are required to report suspected crimes. Owners are also required to provide the Secretary with notice prior to closure of a facility so that relocation and transfer preparations can be made for residents.

National Training Institute for Surveyors

Improvements will be made with respect to the training of surveyors who are investigating allegations of abuse, neglect and misappropriation of property in programs and long-term care facilities that receive payments under Medicare and/or Medicaid. In addition, the Secretary will make grants available to state agencies that perform surveys on nursing facilities to design and implement compliant investigation systems.

Addressed in
Title VI of the
President's
Proposal

Subtitle I – Sense of the Senate Regarding Medical Malpractice

Sense of the Senate Regarding Medical Malpractice

The Senate believes: 1) healthcare reform presents an opportunity to reform medical malpractice and medical liability insurance; 2) states should be encouraged to develop and test litigation alternatives; and 3) Congress should consider establishing a state demonstration program to evaluate the alternatives.

Manager's Amendment Changes (applies to Title VI generally):

The amendment inserts the following new sections:

Health Care Fraud Enforcement

The United States Sentencing Commission will review and amend the Federal Sentencing Guidelines and policy statements applicable to persons convicted of federal health care offenses. The Commission will ensure that the guidelines and policy statements reflect the serious harms associated with health care fraud and the need for aggressive and appropriate law enforcement action to prevent such fraud.

Subpoenas under the Civil Rights of Institutionalized Persons Act

The Attorney General may require by subpoena access to any institution that is the subject of an investigation under the Civil Rights of Institutionalized Persons Act and to any document, record, material, file, report, memorandum, policy, procedure, investigation, video or audio recording, or quality assurance report relating to any institution that is the subject of an investigation under such Act to determine whether there are conditions which deprive persons residing in or confined to the institutions of any rights, privileges, or immunities secured or protected by the Constitution or laws of the United States. .

State Demonstration Programs to Evaluate Alternatives to Current Medical Tort Litigation

The Secretary is authorized to award demonstration grants to states for the development, implementation, and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations. Each state desiring a grant must develop an alternative to current tort litigation that allows for the resolution of disputes over injuries allegedly caused by health care providers or health care organizations, and that promotes a reduction of health care errors by encouraging the collection and analysis of patient safety data related to disputes resolved above by organizations that engage in efforts to improve patient safety and the quality of health care.

Addressed in
Title VI of the
President's
Proposal

Extension of Medical Malpractice Coverage to Free Clinics

The protections from liability contained in the Federal Torts Claims Act are extended to include free clinics.

Drug Labeling Changes

If the proposed labeling of a drug that is the subject of an application differs from the listed drug due to a labeling revision, the drug will be eligible for approval and will not be considered misbranded if several criteria are met. If, after a labeling revision, the Secretary determines that the continued presence of the labeling of the drug adversely impacts the safe use of the drug, no application will be eligible for approval with such labeling.

TITLE VII – IMPROVING ACCESS TO INNOVATIVE MEDICAL THERAPIES

Subtitle A – Biologics Price Competition and Innovation

Approval Pathway for Biosimilar Biological Products

The Secretary, under a new approval process, is required to license a biological product that is shown to be biosimilar to or interchangeable with a reference product (another licensed biological product). Approval of an application is prohibited until 12 years from the date on which the reference product is first approved. If the FDA approves a biological product because it is interchangeable with a reference product, the Secretary is prohibited from making a determination that a second or subsequent biological product is interchangeable with that same reference product until one year after the first commercial marketing of the first interchangeable product.

The Secretary is authorized to issue guidance for the licensure of biological products under this new pathway, and includes provisions governing patent-infringement concerns such as the protection of information, good-faith negotiations, and initiation of infringement actions. Risk-evaluation and -mitigation provisions of the Food, Drug, and Cosmetic Act will be applied to this new biosimilar-biologics approval process.

Savings

The Secretaries of the Treasury and of HHS will annually determine the amount of federal government savings generated by this subtitle regarding biologics price competition and innovation. Any savings must be used for deficit reduction.

Addressed in
Title VII of the
President's
Proposal

Subtitle B – More Affordable Medicines for Children and Underserved Communities

Expanded Participation in 340B Program

The 340B program is extended to pharmaceutical discounts on inpatient drugs and extends participation to certain children's hospitals, cancer hospitals, critical access and sole community hospitals, and rural referral centers. These hospitals would be prohibited from obtaining drugs through a group purchasing organization or arrangement. The Secretary would be authorized to exempt hospitals from this prohibition if: 1) there is a shortage; 2) a generic drug is available at a lower price; or 3) it would reduce administrative burdens.

Addressed in
Title VII of the
President's
Proposal

Improvements to 340B Program Integrity

New auditing, reporting, and other compliance requirements are established for the Secretary, and for pharmaceutical manufacturers and 340B-covered entities. These include a price-ceiling calculation and comparison system, more frequent updating of relevant parts of HHS's website, selective auditing of manufacturers and wholesalers, and a standardize covered-entity identification system. Violations would be subject to a \$5,000 per-instance fine, and, for knowing violations, additional sanctions such as removal from the program.

Addressed in
Title VII of the
President's
Proposal

Government Accountability Office (GAO) Study to Make Recommendations on Improving the 340B Program

The Comptroller General is required to submit a report to Congress within 18 months of enactment containing recommendations for improvements to the 340B program.

TITLE VIII – CLASS ACT

Establishment of National Voluntary Insurance Program for Purchasing Community Living Assistance Services and Support

A national, voluntary, long-term care insurance program is established. The Secretary will develop three actuarially sound benefit plans, ensuring 75-year solvency of the plans. Premiums will be lower for those with incomes below the poverty line or who are full-time students. Employers would be authorized to automatically enroll employees and deduct premiums from wages. Underwriting is prohibited. Plan benefits are subject to a five-year vesting period. The benefits will: 1) provide at least \$50 per day; 2) vary by the beneficiary's functional ability; 3) be paid at least weekly; and 4) not be subject to any lifetime or aggregate limit. Benefits triggers include being unable to perform daily-living activities or requiring substantial supervision.

Addressed in
Title VIII of the
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No taxpayer funds will be used for benefits payments. Cash benefits will be paid into a Life Independence Account. Account funds will be used for home care or modifications, institutional care, or medical care. An eligible beneficiary will periodically be required to recertify benefits eligibility and to submit records of expenditures. If a beneficiary is enrolled in Medicaid and: 1) is institutionalized, then the beneficiary will receive 5% of applicable benefits, the remainder going to the institution; or 2) is receiving home or community care, then the beneficiary will receive 50% of applicable benefits, the remainder going to the state. Benefits are to supplement, not supplant, other benefits.

100% of CLASS Independent Benefit Plan premiums will be deposited into a Treasury trust fund, the CLASS Independence Fund. The amounts in the Fund will be invested on behalf of beneficiaries, and will be used to cover plan administrative costs, and to pay plan benefits. A Fund Board of Trustees will oversee the management of the Fund.

A CLASS Independence Advisory Council will represent various long-term care stakeholders and will advise the Secretary on administration of the CLASS program, including the development of the CLASS Independence Plan and its premiums

TITLE IX – REVENUE PROVISIONS

Subtitle A – Revenue Offset Provisions

Excise Tax on High-Cost Employer-Sponsored Health Coverage

An excise tax of 40% will be levied on insurance companies and plan administrators for any health coverage plan that is above the threshold of \$8,500 for single coverage and \$23,000 for family coverage. The tax will apply to self-insured plans and plans sold in the group market, but not to plans sold in the individual market (except for coverage eligible for the deduction for self-employed individuals). The tax will apply to the amount of the premium in excess of the threshold. The threshold will be indexed at a consumer price index plus one percentage point, and a transition rule would increase the threshold for the 17 highest cost states for the first three years. An additional threshold amount of \$1,350 for singles and \$3,000 for families will be available for retired individuals age 55 and older and for plans that cover employees engaged in high-risk professions.

Addressed in
Title IX of the
President's
Proposal

Manager's Amendment Changes

The amendment adds that individuals whose primary work is longshore work will be treated as employees engaged in high risk professions.

Addressed in
Title IX of the
President's
Proposal

Inclusion of Cost of Employer-Sponsored Health Coverage on W-2

Employers are required to disclose the value of their contribution to the employee's health-insurance coverage on the employee's annual W-2 form.

Distributions for Medicine Qualified Only If for Prescribed Drug or Insulin

The definition of qualified medical expenses for Health Savings Accounts, Medical Savings Accounts, Flexible Spending Accounts, and Health Reimbursement Accounts to the definition used for the medical-expense itemized deduction. Over-the-counter medicine obtained with a prescription continues to qualify as a qualified medical expense.

Addressed in
Title IX of the
President's
Proposal

Increase in Additional Tax on Distributions from HSAs and Archer MSAs Not Used For Qualified Medical Expenses

The additional tax for Health Savings Account withdrawals before age 65 that are used for things other than qualified medical expenses is increased from 10% to 20%. The additional tax for Archer Medical Savings Accounts withdrawals not used for qualified medical expenses will increase from 15% to 20%.

Addressed in
Title IX of the
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Limitation on Health Flexible Spending Arrangements under Cafeteria Plans

Contributions to health Flexible Spending Accounts are limited to \$2,500 per year.

Manager's Amendment Changes

If a benefit is provided under a cafeteria plan through employer contributions to a health flexible spending arrangement, it shall not be treated as a qualified benefit unless the cafeteria plan provides that an employee may not elect for any taxable year to have salary reduction contributions in excess of \$2,500 made to such arrangement.

In the case of any taxable year beginning after December 31, 2011, the dollar amount shall be increased by an amount equal to such amount, multiplied by the cost-of-living adjustment for the calendar year in which such taxable year begins (substituting 2010 for 1992); increases shall be rounded to the next lowest multiple of \$50.

Expansion of Information Reporting Requirements

Businesses that pay any amount greater than \$600 during the year to corporate and non-corporate providers of property and services are required to file an information report with each provider and with the IRS.

Additional Requirements for Charitable Hospitals

New requirements applicable to nonprofit hospitals are established and include conducting a periodic community-needs assessment and providing emergency care despite ability to pay. A hospital that failed to meet these requirements would be subject to a \$50,000 excise tax.

Manager's Amendment Changes

The amendment changes the requirements of charges for emergency or other medically necessary care from "the lowest amounts charged" to "the amounts generally billed".

Imposition of Annual Fee on Branded Prescription Pharmaceutical Companies and Importers

Imposes an annual flat fee of \$2.3 billion on the pharmaceutical manufacturing sector beginning in 2010. This non-deductible fee would be allocated across the industry according to market share and would not apply to companies with sales of branded pharmaceuticals of \$5 million or less.

Addressed in Title IX of the President's Proposal

Imposition of Annual Fee on Medical Device Manufacturers and Importers

Imposes an annual flat fee of \$2 billion on the medical-device manufacturing sector beginning after 2009. The fee must be equal to an amount that bears the same ratio to \$2,000,000 as the covered entity's gross receipts bears to the aggregate gross receipts of all covered entities. This non-deductible fee would be allocated across the industry according to market share and would not apply to companies with sales of medical devices in the U.S. of \$5 million or less. The fee would not apply to any sale of a Class I product or any sale of a Class II product that is primarily sold to consumers at retail for not more than \$100 per unit (under the FDA product classification system). Fees will apply to medical device sales after December 31, 2008.

Addressed in Title IX of the President's Proposal

Manager's Amendment Changes

Changes the first year the fee will be imposed from the year after 2009 to the year after 2010. The amendment adds that the fee must be equal to an amount that bears the same ratio to \$3,000,000,000 as the covered entity's gross receipts to the aggregate gross receipts of all covered entities after 2017. The amendment also changes the effective date from 2008 to December 31, 2009.

Addressed in Title IX of the President's Proposal

Imposition of Annual Fee on Health Insurance Providers

A fee will be imposed in an amount that bears the same ratio to \$6.7 billion as the sum of the covered entity's net premiums plus 200 percent of their third party administration fees bears to the sum of the aggregate net premiums of all covered entities plus 200 percent of the aggregate third party administration fees of all covered entities. This non-deductible fee would be allocated across the industry according to market share and would not apply to companies whose net premiums are \$25 million or less and whose fees from administration of employer self-insured plans are \$5 million or less. The co-ops and any national plan would be subject to the insurance provider fee.

Addressed in Title IX of the President's Proposal

Manager's Amendment Changes

The amendment changes the calculation of the fee from a ratio in relation to \$6.7 billion to an amount that bears the same ratio to an applicable amount. The fee amount must bear the same ratio to the applicable amount as: 1) the covered entity's net premiums written with respect to health insurance for any health risk taken into account during the preceding calendar year; bears to 2) the aggregate net premiums written with respect to such health insurance of all covered entities taken into account during such preceding calendar year. Net premiums will be determined by the Secretary. The applicable amount will increase each fiscal year. Certain additional nonprofit entities are added to the list of those entities exempt from the annual fee on health insurance.

Addressed in Title IX of the President's Proposal

Study and Report of Effect on Veterans Health Care

The Secretary of Veterans Affairs will review and report to Congress on the effect that the fees assessed on pharmaceutical and medical-device manufacturers, and on health-insurance providers have on the cost of medical care provided to veterans, and on veterans' access to medical devices and branded drugs.

Elimination of Deduction for Expenses Allocable to Medicare Part D

The deduction for the subsidy for employers who maintain prescription drug plans for their Medicare Part D eligible retirees is eliminated.

Addressed in
Title IX of the
President's
Proposal

Modification of Section 833 Treatment of Certain Health Organizations

The adjusted-gross-income threshold for claiming the itemized deduction for medical expenses is increased from 7.5 percent to 10 percent. Individuals age 65 and older would be able to claim the itemized deduction for medical expenses at 7.5 percent of adjusted gross income through 2016.

Addressed in
Title IX of the
President's
Proposal

Limitation on Excessive Remuneration Paid by Certain Health Insurance Providers

The deductibility of executive compensation for insurance providers is limited if at least 25 percent of the insurance provider's gross premium income from health business is derived from health-insurance plans that meet the minimum essential coverage requirements in the bill. The deduction is limited to \$500,000 per taxable year and applies to all officers, employees, directors, and other workers or service providers performing services for or on behalf of a covered health insurance provider.

Addressed in
Title IX of the
President's
Proposal

Additional Hospital Insurance Tax on High-Income Taxpayers

The hospital insurance tax rate is increased by 0.5 percentage points on an individual taxpayer earning over \$200,000 (\$250,000 for married couples filing jointly).

Addressed in
Title IX of the
President's
Proposal

Manager's Amendment Changes

The amendment increases the tax rate from 0.5 to 0.9 percentage points.

Special Deduction for Blue Cross Blue Shield

Non-profit Blue Cross Blue Shield organizations must have a medical loss ratio of 85% or higher in order to take advantage of the special tax benefits provided them under Section 833 of the Internal Revenue Code, including the deduction for 25% of claims and expenses and the 100% deduction for unearned premium reserves.

Cosmetic Surgery Tax

A five percent excise tax is imposed on voluntary cosmetic surgery performed by a licensed medical professional. The tax would be collected by the medical professional at the point of service. The definition of voluntary cosmetic procedures would exclude those necessary to ameliorate a deformity arising from a congenital abnormality, a personal injury, or a disfiguring disease.

Manager’s Amendment Changes

The amendment inserts the following new section:

Imposition of Tax on Indoor Tanning Services

Beginning on July 1, 2010 a 10% excise tax will be imposed on any indoor tanning services whether paid by an individual or by insurance. Phototherapy services are excluded.

Payments under National Health Service Corps Loan Repayment Program and Certain State Loan Repayment Programs

Loan forgiveness programs intended to provide for the increased availability of health services in underserved or health professional shortage areas are added to the list of programs excluded from gross income for tax purposes.

Addressed in Title IX of the President’s Proposal

The amendment inserts the following new section:

Expansion of Adoption Credit and Adoption Assistance Programs

The dollar limitation on the adoption credit is increased from \$10,000 to \$13,170. The credit for children with special needs will be increased from \$10,000 to \$13,170 regardless of expenses. Dollar limitations will be increased annually for inflation and the income limitation will be increased annually by a cost-of-living adjustment.

Addressed in Title IX of the President’s Proposal

Subtitle B – Other Provisions

Exclusion of Health Benefits Provided By Indian Tribal Governments

Gross income does not include the value of any qualified Indian health care benefit provided by Indian Tribal governments.

Addressed in Title IX of the President’s Proposal

Establishment of Simple Cafeteria Plans for Small Businesses

A “simple cafeteria plan” employee health benefit is created for small businesses. Eligible employers maintaining a simple cafeteria plan with respect to which the requirements of this bill are met for any year will be treated as meeting any applicable nondiscrimination requirement in the bill during such year. This subtitle provides details on the establishment, definitions and guidelines as they relate to simple cafeteria plans.

Addressed in Title IX of the President’s Proposal

Qualifying Therapeutic Discovery Project Credit

The qualifying therapeutic discovery project credit for any taxable year is an amount equal to 50 percent of the qualified investment for such taxable year with respect to any qualifying therapeutic discovery project of an eligible taxpayer. Additionally, grants for therapeutic discovery projects can be awarded in lieu of the tax credit.

Addressed in Title IX of the President’s Proposal

***TITLE X – STRENGTHENING QUALITY, AFFORDABLE
HEALTH CARE FOR ALL AMERICANS***

This title, as inserted by the Manager’s Amendment, includes all amendments to Titles I through IX of the Patient Protection and Affordable Care Act.

List of Abbreviations

ACO	Accountable care organization
AHRQ	Agency for Healthcare Research and Quality
CDC	Centers for Disease Control and Prevention
CHIP	Children’s Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
DOD	Department of Defense
DME	Durable medical equipment
DSH	Disproportionate share hospital
EMTALA	Emergency Medical Treatment and Active Labor Act
EHR	Electronic health record
ERISA	Employee Retirement Income Security Act of 1974
FDA	The Food and Drug Administration
FMAP	Federal medical assistance percentage
FQHC	Federally-qualified health center
GAO	Government Accountability Office
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIT	Health information technology
HRSA	Health Resources and Services Administration
IHS	Indian Health Services
NIH	National Institutes of Health
OIG	Department of Health and Human Services Office of the Inspector General
SAMHSA	Substance Abuse and Mental Health Administration
VA	Department of Veterans Affairs