ALSTON&BIRD LLP

Health Care Public Policy Group Health Care Reform Chart

The chart below summarizes key issues addressed in the "Patient Protection and Affordable Care Act" (H.R. 3590), as passed by the Senate on December 24, 2009, and the "Health Care and Education Affordability Reconciliation Act of 2010," as released by the House Rules Committee on March 18, 2010. We anticipate that a manager's amendment to the reconciliation package will be discussed at an upcoming Rules Committee meeting. A House vote on both the Senate heath care reform bill and the reconciliation bill is currently scheduled for March 21, 2010.

Policy	Senate Bill (H.R. 3590)	Reconciliation Bill (H.R. 4872)
Health Insurance Exchange/ Pooling Mechanism	High-Risk Pools - Immediate Access to Insurance for Uninsured Individuals with a Preexisting Condition. Requires the Secretary to create a temporary insurance high-risk pool program within 90 days of enactment to provide insurance to people who have been uninsured for 6 months and have a pre-existing condition. Ensures premium rate limits for the newly insured population. Imposes sanctions on plans that encourage individuals to un-enroll in order to enter the high risk pool. Appropriates up to $5 billion for the program, which terminates in 2014 when the Exchanges are operational. Establishes a transition to the Exchanges for eligible individuals. *(Sec. 1101)* Health Insurance Consumer Information. Requires the Secretary to award grants to the States to support offices of health insurance consumer assistance or a health insurance ombudsperson to assist with filing complaints and appeals with insurers; track problems; educate and assist consumers; and resolve problems with obtaining premium tax credits. Requires state officials to report data to state and federal authorities. Appropriates $30,000,000 for the first year of the program and such sums as necessary in future years. *(Sec. 1002)* Ensuring That Consumers get Value for their Dollars. For plan years beginning in 2010, requires the Secretary and States to establish a process for annual review of increases in premiums for health insurance coverage. Requires States to provide information to the Secretary on trends in premium increases and to make recommendation to State Exchanges about whether particular insurers should be excluded from participation. Provides $250,000,000 in funding for grants to States from 2010 until 2014 to support: reviewing and, if appropriate under State law, approving premium increases for health insurance coverage; providing information and recommendations to the Secretary; and establishing academic or non-profit medical reimbursement data centers to collect medical reimbursement information from health insurers to analyze, and to make such information available to issuers, providers, researchers, policy makers, and the general public. Centers established under this section would develop fee schedules and other database tools that reflect market rates for medical services and the geographic difference in those rates and would also make information available to the public through a website that allows consumers to understand the amounts that health care providers in their area charge for a particular medical service. *(Sec. 1003)* Immediate Information that Allows Consumers to Identify Affordable Coverage Options. Requires the Secretary to establish, by July 1, 2010, an Internet portal for individuals or small businesses in any state to identify health insurance coverage options, including insurance, Medicaid, or Medicare, high-risk pools; and coverage	Payments to the Territories. Permits territories to establish Health Benefits Exchanges. Provides an additional $1 billion to be distributed to Puerto Rico, Virgin Islands, Guam, American Samoa, and the Northern Marianas Islands for purposes of establishing these exchanges. *(Sec. 1204)*

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	within the small group market, including reinsurance for retirees and tax credits. Requires development of a standardized format for information on plans, including information on the percentage of premium revenue spent on nonclinical costs; eligibility; availability; premium rates; and cost sharing. *(Sec. 1103)* Affordable Choices of Health Benefit Exchanges. Requires the Secretary to award planning and establishment grants to States within 1 year of enactment to support establishment of an American Health Benefit Exchange. Requires each State to establish an Exchange by 2014. Exchanges would: facilitate purchase of qualified health plans; provide for establishment of a Small Business Health Options Program (SHOP) to help small employers in the State; make qualified plans available to qualified individuals and employers; implement certification procedures for plans; operate a toll-free hotline to provide assistance; maintain a website for enrollees and prospective enrollees to compare plans; rate each qualified plan; use a standard format in presenting plan options; inform individuals about Medicaid, CHIP, and other program eligibility; establish an electronic "calculator" that determines the actual cost of plans after premium tax credits and cost-sharing reduction; certify certain individual as exempt from the individual responsibility requirement; provide certain information to employers; and establish a Navigator program to conduct public education activities and distribute fair and impartial information on qualified health plans. Plans offered within the Exchanges must be qualified health plans (or stand-alone dental). Requires the Secretary to: establish criteria for the certification of health plans; develop a rating system that would rate qualified health plans offered through an exchange in each benefits level on the basis of the relative quality and price; develop an enrollee satisfaction survey system that would evaluate the level of enrollee satisfaction with qualified health plans; continue to operate the internet portal developed under section 1103(a) and make available a model template for an internet portal for use by the Exchanges; and provide for enrollment periods [Added by Pryor Amendment 2939]. Allows States to require additional benefits if the State makes payments to defray the cost of any additional benefits. Requires mental health parity. *(Sec. 1311)* Regional or Interstate Exchanges. Allows States to permit Exchanges to operate in more than one State with approval from the Secretary. Allows States to create subsidiary Exchanges. *(Sec. 1311)* Rewarding Quality through Market-Based Incentives. Requires the Secretary, in consultation with stakeholders, to develop guidelines for a payment structure that provides increased reimbursement or other incentives for improving health outcomes through quality reports, case management, care coordination, chronic disease management, medication and care compliance initiatives (including medical home); activities to reduce hospital readmissions; activities to improve patient safety and reduce medical errors; wellness and health promotion activities; and activities to reduce health care disparities. *(Sec. 1311)* Certification of Qualified Health Plans. Allows Exchanges to certify a health plan as "qualified" if the plan meets certification requirements promulgated by the Secretary (sets forth minimum requirements including requirement that plans report on pediatric quality reporting measures) and if it is in the best interests of qualified individuals and employers in the State. Requires that plans seeking certification submit a justification for any premium increase prior to implementation of the increase. Requires transparency: plans seeking certification must submit to the Exchange and the Secretary and make public the following information: claims	

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	payment policies; periodic financial disclosures; enrollment and disenrollment data; data on denied claims; rating practices; cost-sharing information for out-of-network coverage; and other information, in plain language. Also requires cost sharing transparency. Requires the Secretary to harmonize rules concerning accurate and timely disclosure of terms and conditions to participants. *(Sec. 1311)* Qualified Individuals and Employers. Limits access to the Exchange to citizens and lawful residents. Individuals seeking to enroll in a qualified health plan in the individual market offered through the Exchange and residing in a State where the Exchange is established are considered eligible. Defines qualified employer as a "small" employer that elects to make all full-time employees eligible for one or more qualified health plans offered in the small group market through an Exchange. Allows States to allow large group coverage to be offered through the Exchange beginning in 2017. At such time, large employers would be considered to be qualified employers *(Sec. 1312)* Employer Size. Defines large employer as an employer who employed an average of 101 or more employees on business days during the preceding calendar year. Small employer means having employed between 1 and 100 employees on business says during the preceding calendar year. Allows the states to cap small employers at 50 employees for years prior to 2016. Allows small businesses participating in the Exchange to continue to be treated as eligible even if more employees are hired. *(Sec. 1304)* Consumer Choice. Allows a qualified individual to enroll in any qualified health plan available. Provides that employers may specify a level of coverage for employees, and that employees may select from plans that offer coverage at that level. Allows enrolled individuals to pay premiums directly to the insurer. Prohibits compelled enrollment. Requires Members of Congress and congressional staff to be offered only plans offered through an Exchange. *(Sec. 1312)* Individual and Small Group Market Risk Pools. Requires that a health insurance issuer consider all enrollees in all health plans offered by the issuer in the individual market (inside and outside of the Exchange) to be members of a single risk pool. Requires all enrollees in an insurance issuer's plans in the small group market to be considered to be in a single risk pool. *(Sec. 1312)* Financial Integrity. Requires Exchanges to submit an annual accounting on expenses and activities to the Secretary. Gives the HHS OIG authority to investigate Exchanges. Includes protections against fraud and abuse within the Exchanges. Amends 31 U.S.C. 3730(e) (relating to civil actions for false claims); requires courts to dismiss claims if substantially the same allegations or claims were publicly disclosed; defines original source. Requires a GAO study on Exchange activities within 5 years of the date when Exchanges are first permitted to operate and dictates topics to be studied. *(Sec. 1313).* State Flexibility. Requires the Secretary to set standards for establishment and operation of Exchanges, qualified health plans, and reinsurance and risk adjustment programs as soon as practicable. Requires States to apply such requirements no later than January 1, 2014. If a State fails to elect to establish an Exchange or implement requirements, requires the Secretary to establish and operate an Exchange within that States. Exchanges operating as of January 1, 2010 are presumed compliant. *(Sec. 1321)*	

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	Definitions. Defines "educated health care consumers," who are required to be consulted by the Exchanges under Sec. 1311(d)(6). *(Sec. 1304)*.	
Medicaid	Medicaid Coverage for the Lowest Income Populations. As of January 2014, expands Medicaid eligibility to "newly-eligible" individuals with income at or below 133 percent of the Federal Poverty Level (FPL). Newly-eligible individuals include individuals under 65, who are not pregnant and not entitled to Medicare. Medicaid eligibility for children ages 6 to 19 also increases to 133 percent of the FPL as of January 1, 2014. States have the option to provide this expanded coverage on or after April 1, 2010 and may also extend coverage to these non-elderly, non-pregnant individuals above 133 percent of FPL through a State plan amendment. States may provide for a presumptive eligibility period. Newly eligible individuals are defined as individuals who are not under 19 years of age and who are not eligible for Medicaid or under a waiver for benefits as of December 1, 2009. *(Sec. 2001)* For the period of January 1, 2014 through September 30, 2019, provides an increased Federal medical assistance percentage (FMAP) of 2.2 percent for states that have already undertaken a Medicaid expansion (i.e., an "Expansion State"), will not receive any payments for newly eligible individuals, and have not been approved by the Secretary to divert DSH payments to the costs of providing medical assistance or other health benefits under a waiver in effect as of July 2009. *(Sec. 2001)* For the period of January 1, 2014 through December 31, 2016, provides an increased FMAP of .5 percent for a state that is an "expansion state," will not receive any payments for newly eligible individuals, and has the highest percentage of its population insured during 2008. *(Sec. 2001)* Provides for a 100 percent FMAP for Nebraska in 2017 and thereafter. *(Sec. 2001)* Medicaid coverage under the expansion must consist of benchmark coverage described in section 1937 of the SSA or benchmark-equivalent coverage. Benchmark coverage must consist of coverage for the essential health benefits, prescription drugs, and mental health services. *(Sec. 2001)* From 2014 through 2016, the Federal government will pay 100 percent of the cost of covering newly-eligible individuals. In 2017 and 2018, States that initially covered less of the newly-eligible population (called "Other States") would receive more assistance than those States that covered at least some non-elderly, non-pregnant individuals ("Expansion States") but must also cover inpatient hospital services. Other States would receive a Federal Medical Assistance Percentage (FMAP) increase for services provided to newly-eligible individuals of 34.3 and 33.3 percentage points in 2017 and 2018, respectively. Expansion States would receive 30.3 and 31.3 percentage points in 2017 and 2018, respectively. Beginning in 2019 and thereafter, all States would receive an FMAP increase of 32.3 percentage points for such services. *(Sec. 2001)* Maintenance of Income Eligibility. States would be required to maintain the same income eligibility levels through December 31, 2013 for all adults. This "maintenance of effort" (MOE) requirement would be extended through September 30, 2019 for all children currently covered in Medicaid or CHIP. Between January 1, 2011 and January 1, 2014, a State would be exempt from the MOE requirement for optional, non-pregnant, non-disabled, adult populations whose family income is above 133 percent of FPL, if the State certifies to the Secretary that the State is currently experiencing a budget deficit or projects to have a budget deficit in the following State fiscal year. *(Sec. 2001)*	Federal Funding for States. Eliminates the provision providing for a 100 percent FMAP for Nebraska in 2017 and thereafter. (*Sec. 1201)* Increases federal support for the Medicaid expansion by requiring the Federal government to pay 100 percent of the cost of covering newly-eligible individuals in 2014, 2015, and 2016; 95 percent in 2017; 94 percent in 2018; 93 percent in 2019; and 90 percent in 2020 and years thereafter. (*Sec. 1201)* Changes the date through which states that have already undertaken a Medicaid expansion (i.e., an "expansion state"), will not receive any payments for newly eligible individuals, and have not been approved by the Secretary to divert DSH payments to the costs of providing medical assistance or other health benefits under a waiver in effect as of July 2009, will receive an increased FMAP of 2.2 percent from September 30, 2019 to December 31, 2015. Changes the formula for calculating the increased FMAP for expansion states. The expansion state share of the costs of covering nonpregnant childless adults would be reduced by 50 percent in 2014; 60 percent in 2015; 70 percent in 2016; 80 percent in 2017; and 90 percent in 2018. In 2019 and years thereafter, expansion states would bear the same costs of covering nonpregnant, childless adults as non-expansion states. (*Sec. 1201)* Payments to Primary Care Physicians. Requires Medicaid payment for primary care services (including payments

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	Income Eligibility for Non-Elderly Determined Using Modified Gross Income. As of January 1, 2014, a state would be required to determine Medicaid eligibility based on the modified gross income of an individual and the household income of a family. Eliminates the use of expense, block, or other income disregards and assets or resources tests when determining Medicaid eligibility. The new method for income determinations would not apply to: (1) individuals that are eligible for Medicaid through another program, (2) the elderly or Social Security Disability Insurance (SSDI) program beneficiaries, (3) the medically needy, (4) enrollees in a Medicare Savings Program, (5) the disabled, (6) enrollees deemed to be a child in foster care under the responsibility of the State, (7) individuals age 65 and over, and (8) eligibility determinations for prescription drug subsidies and nursing facility services. Requires that states ensure that the new eligibility determination methods do not result in previously qualified children being no longer eligible. *(Sec. 2002)* Requirement to Offer Premium Assistance for Employer-Sponsored Insurance. Effective January 1, 2014, states may offer premium assistance and subsidies to Medicaid beneficiaries who are offered employer-sponsored insurance if it is cost effective to do so, consistent with current law requirements. *(Sec. 2003)* Medicaid Coverage for Former Foster Care Children. As of January 1, 2014, requires all individuals under age 26, who have aged out of foster care as of the date of enactment, to receive Medicaid. *(Sec.2004)* Payments to Territories. Increases spending caps for the territories by 30 percent and the applicable FMAP by 5 percentage points – to 55 percent – beginning on January 1, 2011. Beginning in 2014, the cost of covering newly eligibles would not count towards the spending caps. Sets the income eligibility level for childless adults in the territories at the same level currently set for parents in the territories. *(Sec. 2005)* Special Adjustment to FMAP Determination for Certain States Recovering from a Major Disaster. Beginning January 1, 2011, the FMAP for any state that during the preceding 7 fiscal years has been declared a major disaster under section 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act will be increased by 50 percent of the number of percentage points by which the FMAP for the fiscal year is less than the FMAP for the preceding fiscal year (and 25 percent in the second and subsequent years). The percentage increases will apply only if the difference between the FMAP for the year and the preceding year is at least 3 percentage points lower. *(Sec. 2006)* Medicaid Improvement Fund Rescission. Rescinds funds available in the Medicaid Improvement Fund (appropriated in 2008) for fiscal years 2014 through 2018. *(Sec. 2007)* Enrollment Simplification and Coordination with State Health Insurance Exchanges. Requires states to establish an enrollment website by January 1, 2014 to promote seamless enrollment (including systems to ensure a secure electronic interface sufficient to allow a determination of eligibility for the appropriate program) in Medicaid, CHIP, or Exchange plans. Individuals who are ineligible for Medicaid or CHIP would be screened for eligibility for enrollment in a qualified health plan through the Exchange and for premium assistance. *(Sec. 2201 adding Sec. 1943)* Permitting Hospitals to Make Presumptive Eligibility Determinations for All Medicaid Eligible Populations. Effective January 1, 2014, permits all hospitals that participate in Medicaid to make presumptive eligibility determinations in addition to providers currently eligible to do so. Allows hospitals and other providers to	for office visits and immunizations) furnished by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine to be reimbursed at 100 percent of the payment rate that applies to such services and physician under Part B in 2013 and 2014. Provides a 100 percent FMAP to states for meeting this requirement. *(Sec. 1202)* Funding for the Territories. Changes the date on which the increased FMAP of 55 percent applies to the territories from January 1, 2011 to July 1, 2011. For territories that do not elect to establish a Health Benefits Exchange and receive a payment for this, increases the cap on federal Medicaid funding to the territories so that the additional amount equals $6.3 billion for the period of July 1, 2011 through September 30, 2019. Removes the provision in the Senate bill that would have prevented the cost of covering newly eligibles from counting towards the spending caps. *(Sec. 1204)* Income Definitions. Changes income definition from "modified gross income" to "modified adjusted gross income" for purposes of Medicaid and CHIP. *(Sec. 1004)*

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	make such determinations for all Medicaid eligible populations. The time period of presumptive eligibility would be consistent with current law. Current notification procedures would apply to all presumptive eligibility determinations. (*Sec. 2202)* Coverage for Free-Standing Birth Center Services. Requires free-standing birth center services to be covered as of the date of enactment. *(Sec. 2301)* Concurrent Care for Children. Allows children eligible for Medicaid or CHIP to receive hospice services without forgoing any other service to which the child is entitled under Medicaid or CHIP. *(Sec. 2302)* State Eligibility Option for Family Planning Services. Adds a new optional categorically-needy eligibility group to Medicaid comprised of (1) non-pregnant individuals with income up to the highest level applicable to pregnant women covered under the Medicaid or CHIP state plan, and (2) at state option, individuals eligible under the standards and processes of existing section 1115 waivers that provide family planning services and supplies. Benefits would be limited to family planning services and supplies (as per section 1905(a)(4)(C) of the Social Security Act) and would also include related medical diagnosis and treatment services. Allows states to make a "presumptive eligibility" determination for individuals eligible for such services through the new optional eligibility group. States would not be allowed to provide Medicaid coverage through benchmark or benchmark-equivalent plans, which are permissible alternatives to traditional Medicaid benefits, unless such coverage includes family planning services and supplies. Effective on the date of enactment. *(Sec. 2303)* Medicaid Global Payments Demonstration. Requires the Secretary, in coordination with the CMS Innovation Center, to establish a demonstration project in up to five states from 2010 to 2012, under which a large, safety net hospital system participating in Medicaid would be permitted to alter its provider payment system from a fee-for-service structure to a capitated, global payment structure. The CMS Innovation Center would conduct an evaluation of each demonstration project examining any changes in health care quality outcomes and spending. The Innovation Center would be exempted from the budget-neutrality requirements for an initial testing period and would have authority to terminate or modify the demonstration during the testing period. The Secretary would be required to conduct an analysis of the demonstration project and report the findings to Congress within 12 months after the date of completion of the demonstration project. *(Sec. 2705)* Medicaid Emergency Psychiatric Demonstration Project. Establishes a three-year, $75 million demonstration project for states to expand the number of emergency inpatient psychiatric care beds available in communities. Would allow states to cover patients between the ages of 21 and 65 who are eligible for medical assistance in non-governmental freestanding psychiatric hospitals and receive federal Medicaid matching payments to demonstrate that covering patients in these hospitals will improve timely access to emergency psychiatric care, reduce the burden on overcrowded emergency rooms, and improve the efficiency and cost-effectiveness of inpatient psychiatric care. A report to Congress is required no later than December 31, 2013 and must recommend whether the demonstration project should be continued after this date and expanded on a national basis. *(Sec. 2706)* Medicaid and CHIP Payment and Access Commission (MACPAC) Assessment of Policies Affecting All Medicaid Beneficiaries. Authorizes $11 million for MACPAC for FY2010, of which $9 million would come from Medicaid funds and	

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	$2 million would come from CHIP funds. Clarifies the topics to be reviewed by the MACPAC, including assessment (in consultation with MedPAC) of adult services in Medicaid, including for dual eligibles, review of Medicaid and CHIP regulations, etc. Applies more detailed reporting requirements to states and Congress. Changes the reporting dates to March 15 and June 15 of each year, beginning June 2010. *(Sec. 2801)* Payment Adjustment for Health Care-Acquired Conditions (HACs). Effective July 1, 2011, prohibits Federal payments to states for Medicaid services related to health care acquired conditions. The Secretary would define health care acquired conditions, consistent with the definition of hospital acquired conditions under Medicare, but would not be limited to conditions acquired in hospitals and would take into account the differences between the Medicare and Medicaid programs and their beneficiaries. The Secretary would also identify current state practices that prohibit payments for certain health care acquired conditions when implementing this provision. *(Sec. 2702)* Medicaid Waiver Evaluations. Creates a process for public evaluation at the State and Federal level of experimental, pilot, or demonstration projects and would impose a process for establishing requirements relating to the goals, expected costs, and specific plans for the projects. *(Sec. 1021)*	
Expansion of CHIP and Other Children's Provisions	Additional Federal Financial Participation for CHIP. For the period beginning FY 2016 through FY 2019, increases the FMAP for each state by 23 percent, but in no case will the state match exceed 100 percent. State CHIP MOE must continue from the date of enactment through September 30, 2019. Targeted low-income children who are cannot receive child health assistance because of federal allotment caps due to funding shortfalls are deemed ineligible for CHIP, and states are required to establish procedures to ensure those children are provided tax credits to enroll in the State Exchange. No enrollment bonus payments will be made for children enrolled on or after October 1, 2013. Beginning January 1, 2014, modified gross income and household income will be used to determine CHIP eligibility. If as a result of the elimination of the application of income disregards a targeted low-income child is excluded from coverage, the State shall provide child health assistance. *(Sec. 2101)* CHIP-Related Provisions**.** Extends the current reauthorization period of CHIP for two years, through September 30, 2015. This provision also increases outreach and enrollment grants by $40 million, makes some children of public employees eligible for CHIP, and precludes transitioning coverage from CHIP to the Exchange without Secretarial certification. It also requires insurers in the Exchange to report to the Secretary on pediatric quality measures. Amends conditions for receiving payments under Section 1903(a) of the SSA. *(Sec. 10203)* Technical Corrections. Makes technical corrections to CHIPRA of 2009 and ARRA. *(Sec. 2102)*	
Expansion of Medicare	Reinsurance for Early Retirees. Requires the Secretary, within 90 days of enactment, to establish a temporary reinsurance program to provide reimbursement to participating employment-based plans for part of the cost of providing health benefits to retirees (age 55-64) and their families. Sunsets in 2014 when the Exchange is established. Participating employment-based plans would submit claims to the Secretary. The program would reimburse plans for 80 percent of costs of benefits provided per enrollee that are between $15,000 and $90,000 (adjusted based on CPI). Requires plans to use the funds to lower costs borne by plans and	

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	beneficiaries. Requires participating plans to implement programs and procedures to generate cost-savings with respect to participants with chronic and high-cost conditions. Appropriates $5 billion for the program. *(Sec. 1102)* Medicare Coverage for Individuals Exposed to Environmental Health Hazards. Provides Medicare coverage and medical screening services to individuals exposed to environmental health hazards as a result of a public health emergency declaration under the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (CERCLA). Deems individuals determined to be "environmental exposure affected individuals" to meet the conditions of entitlement for Medicare Part A benefits under SSA sec. 226(a) and gives the Secretary discretionary deeming authority. Individuals deemed eligible as environmental exposure affected individuals would be entitled to Part A benefits as of the date of deeming and would be eligible to enroll in Part B beginning in the month of such deeming. Defines environmental exposure affected individual as one who is (a) diagnosed with abestosis, pleural thickening or pleural plaques, mesothelioma or malignancies of particular organs, or any other diagnosis the Secretary determines is an asbestos-related medical condition, and has been present in the Libby Asbestos Superfund site in northwest Montana (the EPA's first and only finding of a public health emergency under the CERCLA) for a certain period of time, or (b) an individual who is diagnosed with a medical condition caused by exposure to a pubic health hazard to which an emergency declaration applies. Establishes a primary pilot program to provide innovative approaches to furnishing comprehensive, coordinated, cost-effective care for certain individuals residing in emergency declaration areas and optional pilot programs for each geographic area subject to an emergency declaration (other than June 17, 2009). Establishes a competitive grant program for certain entities, including hospitals, community health centers, FQHCs, state/local agencies and nonprofits, to screen at-risk individuals for environmental health conditions (asbestosis, mesolthelioma and other pollutant-related conditions); and to develop and disseminate public information and education about the screening program, detection, prevention and treatment of environmental health conditions, and the availability of Medicare benefits to certain individuals. Appropriates $23 million for the period 2010-2014 and $20 million for each 5-year period thereafter. *(Sec. 10323)*	
Long-Term Care Provisions (CLASS Act, Elder Justice Act)	Establishment of National Voluntary Insurance Program for Purchasing Community Living Assistance Services and Support (CLASS program). Establishes a new, voluntary, self-funded public long term care insurance program, to be known as the CLASS Independence Benefit Plan, for the purchase of community living assistance services and supports by individuals with functional limitations. Requires the Secretary to develop an actuarially sound benefit plan that ensures solvency for 75 years; allows for a five year vesting period for eligibility of benefits; creates benefit triggers that allow for the determination of functional limitation; and provides cash benefit that is not less than an average of $50 per day. No taxpayer funds will be used to pay benefits under this provision. *(Sec. 8002)* Community First Choice Option. Establishes an optional Medicaid benefit through which States could offer community-based attendant services and supports to Medicaid beneficiaries with disabilities who would otherwise require the level of care offered in a hospital, nursing facility, or intermediate care facility for the mentally retarded. *(Sec. 2401)* Removal of Barriers to Providing Home and Community-Based Services (HCBS).	Delay in Community First Choice Option. Delays the effective date from October 1, 2010 to October 1, 2011 for the optional Medicaid benefit that would cover attendant services and supports for beneficiaries requiring an institutional level of care. *(Sec. 1205)*

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	Removes barriers to providing HCBS by giving States the option to provide more types of HCBS through a State plan amendment to individuals with higher levels of need, rather than through a waiver, and to extend full Medicaid benefits to individuals receiving HCBS under a State plan amendment. *(Sec. 2402)* Incentives for States to Offer Home and Community Based Services as a Long-Term Care Alternative to SNFs. The manager's amendment adds a new policy that creates financial incentives for States to shift Medicaid beneficiaries out of nursing homes and into home and community based services ("HCBS"). The provision provides Federal Medical Assistance Percentage ("FMAP") increases to States to rebalance their spending between nursing homes and HCBS. *(Sec. 10202).* Money Follows the Person Rebalancing Demonstration. Extends the Money Follows the Person Rebalancing Demonstration through September 30, 2016 and changes the eligibility rules for individuals to participate in the demonstration project by requiring that individuals reside in an inpatient facility for not less than 90 consecutive days. *(Sec. 2403)* Protection for Recipients of Home and Community-Based Services Against Spousal Impoverishment. Requires States to apply spousal impoverishment rules to beneficiaries who receive HCBS. This provision would apply for a five-year period beginning on January 1, 2014. *(Sec. 2404)* Funding to Expand State Aging and Disability Resource Centers. Appropriates, to the Secretary of HHS, $10 million for each of FYs 2010 through 2014 to carry out Aging and Disability Resource Center (ADRC) initiatives. *(Sec. 2405)* Sense of the Senate Regarding Long-Term Care. Expresses the Sense of the Senate that during the 111th Congress, Congress should address long-term services and supports in a comprehensive way that guarantees elderly and disabled individuals the care they need, in the community as well as in institutions. *(Sec. 2406)* Sense of the Senate Promoting Fiscal Responsibility. Expresses the Sense of the Senate that the additional surplus in the Social Security Trust Fund generated by this Act should be reserved for Social Security and not spent in this Act for other purposes, and that the net savings generated by the CLASS program should be reserved for the CLASS program and not spent in this Act for other purposes. *(Sec. 1563)* [Added by Whitehouse Amendment 2870] Elder Justice Act. Short title, "The Elder Justice Act of 2009." *(Sec. 6701)* Provides that the terms used in this subtitle have the same meaning as defined in Section 2011 of the SSA. *(Sec. 6702)* Establishes an Elder Justice Coordinating Council within the Office of the Secretary that will consist of officers or employees of Federal government agencies. Directs the Council to make recommendations to the Secretary for the coordination of activities of the Department of HHS, DOJ, and other relevant Federal, state, local and private agencies and entities, relating to elder abuse, neglect, and exploitation. Establishes a 27-member Advisory Board on elder abuse, neglect, and exploitation, which will create short- and long-term multidisciplinary strategic plans for the development of the field of elder justice and to make recommendations to the Elder Justice Coordinating Council. Appropriates $6.5 million for FY 2011 and $7 million for each of FYs 2012 through 2014. *(Sec. 6703 adding Sections 2021 and 2022)*	

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	Requires the Secretary, in consultation with the Attorney General, to make grants to eligible entities to establish and operate forensic centers, to develop forensic expertise regarding, and provide services relating to, elder abuse, neglect, and exploitation. Appropriates $4 million for FY 2011, $6 million for FY 2012, and $8 million for each of FYs 2013 and 2014. *(Sec. 6703 adding Sec, 2031)* Requires the Secretary to make grants to eligible entities to carry out programs for continued training and varying levels of certification and to provide bonuses or increased compensation for those who achieve certification under such a program. Also requires the Secretary to make grants to eligible entities to enable the entities to provide training and technical assistance. Eligible entities are defined as long-term care facilities and community-based long-term care entities. For these grant programs, along with a grant program for HIT, appropriates $20 million for FY 2011, $17.5 million for FY 2012, and $15 million for each of FYs 2013 and 2014. *(Sec. 6703 adding Sec. 2041)* Adult Protective Services Functions and Grant Programs. Authorizes $3 million for FY 2011 and $4 million for each of FYs 2012 through 2014 for use by the Secretary to ensure that the Department of HHS carries out certain duties related to adult protective services. Appropriates $100 million for each of FYs 2011 through 2014 for the Secretary to annually award grants for the purposes of enhancing adult protective services. Appropriates $25 million for each of FYs 2011 through 2014 for state demonstration programs that test methods for detecting or preventing elder abuse. *(Sec. 6703 adding Sec. 2042)* Long-Term Care Ombudsman Program Grants and Training. Appropriates $5 million for FY 2011, $7.5 million for FY 2012, and $10 million for each of FYs 2013 and 2014 for grants to eligible entities to support the long-term care ombudsman program. Appropriates $10 million for each of FYs 2011 through 2014 for the Secretary to establish programs to provide and improve ombudsman training related to elder abuse. *(Sec. 6703 adding Sec. 2043)* Requires the provision of information by applicants seeking grants under the Elder Justice Act. Requires the evaluation of activities carried out under this section and also requires an evaluation and audit of the certified EHR technology grant program by the Secretary. Requires reports to Congress on these programs. Also requires the Secretary to submit a report to Congress and the Elder Justice Coordinating Council no later than October 1, 2014. *(Sec. 6703 adding Sections 2044, 2045)* Provides an option for a state plan under the program for Temporary Assistance for Needy Families to allow states to indicate whether they intend to assist individuals in providing direct care in a long-term care facility or in other occupations related to elder care. Requires the Secretary to enter into a contract with an entity for the purposes of establishing a National Training Institute for Federal and State surveyors to investigate allegations of elder abuse. Provides grants to state agencies that perform surveys of skilled nursing facilities or nursing facilities. Sets forth reporting requirements for covered individuals (i.e. owner, operator, employee, manager, agent or contractor of a long-term care facility that received at least $10,000 in federal funds the preceding year) who have reasonable suspicion of a crime against an individual receiving care in the facility. Applies CMPs for violations. Provides discretion to the Secretary when determining penalties for providers with underserved populations. Provides additional penalties for retaliation against an employee who reports suspicious activity. Requires a study	

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	on establishing a national nurse aide registry and a subsequent report to Congress on this study. *(Sec. 6703 adding Sec. 2046)*	
Coverage for Young Adults	Extension of Dependent Coverage. Requires individual and group plans offering dependent coverage to allow unmarried individuals up to age 26 to remain covered as dependents. *(Sec. 1001, adding Sec. 2714)*	Income definitions. Allows for exclusion of amounts expended for medical care for children under age 27 from gross income on tax filings, including for the self-employed health insurance deduction. Revises the definitions of "dependant" to include children under age 27 for purposes of sick and accident benefits and benefits for retirees. *(Sec. 1004)* Insurance Reforms. Removes the requirement that dependant children be unmarried to remain covered. *(Sec. 2301)*
Public Plan or Not-for-Profit Option	CO-OPs – Federal Program to Assist Establishment and Operation of Nonprofit, Member-Run Health Insurance Issuers. Requires the Secretary to establish a Consumer Operated and Oriented Plan (CO-OP) program to foster creation of qualified nonprofit health insurance issuers to offer insurance in the individual and small group markets in States where licensed. Prior to July 1, 2013, under the program, the Secretary would provide grants and loans to assist with start up costs and solvency requirements; requires repayment of loans within 5 years and grants within 15 years per regulations to be disseminated by the Secretary. Creates a 15-member Advisory Board that would operate until 2015. Qualified nonprofit health insurers must be organized as nonprofits under state law and have substantially all activities consist of issuance of qualified health plans. Prohibits entities that were health insurance issuers as of July 16, 2009 and government-sponsored entities from qualifying as a nonprofit health insurance issuer. Requires profits to be used to benefit members. Requires compliance with state insurance laws and coordination with state insurance reforms. Allows CO-OP plans to establish a private purchasing council to enter into collective purchasing arrangements and other cost efficiencies. Bars the council from setting payment rates. Appropriates $6 billion for the program. Establishes a new provision for CO-OP health insurance plans within Section 501(c) of the Internal Revenue Code and includes reporting requirements. *(Sec. 1322)* Level Playing Field. Subjects CO-OP plans to the same laws and requirements that apply to private health insurance issuers. *(Sec. 1324)* Basic Health Program. Allows the Secretary to establish a basic health program under which States would have the option of contracting with "standard health plans" in lieu of offering coverage to certain eligible individuals through the Exchange. Defines eligible individuals as those with household income between 133 percent and 200 percent of the poverty line who are not eligible for Medicaid, Medicare, or employer-based coverage. Limits premiums and cost-sharing under the program. Requires "standard" health insurance plans to offer at least the essential benefits package and have a medical loss ratio of at least 85 percent. States would contract for standard health plans through a competitive process, including	

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	negotiation of premiums, cost-sharing, and extra benefits. Requires States to seek to coordinate the administration of standard plans with other States. Provides for transfer of federal funds to States for establishment of trust funds to be used to reduce premiums and cost sharing within the basic health program. The amount of the transfer would be 95 percent of the tax credits and cost-sharing reductions that would otherwise have been provided to individuals enrolled in standard health plans if they were enrolled in qualified health plans. *(Sec. 1331)* Waiver for State Innovation. Allows States to apply for a waiver of certain requirements for plans offered within the State for plan years beginning on or after January 1, 2017. Waivers could be for up to 5 years for requirements relating to qualified health plans, Exchanges, cost-sharing reductions, tax credits, the individual responsibility requirement, and shared responsibility for employers. Requires the Secretary to provide States the aggregate amount of tax credits and cost-sharing reductions that would have been paid to residents of the State in the absence of a waiver. Requires that States continue to provide comprehensive and affordable coverage to at least a comparable number of residents. *(Sec. 1332)* Offering of Plans in More than One State. By July 1, 2013, requires the Secretary, in consultation with NAIC, to issue regulations on health care choice compacts under which 2 or more States may agree to have 1 or more qualified plans offered in both (or all) States. Requires insurers to meet market conduct, trade practices, network adequacy, and other requirements of the state where the purchaser resides. Requires insurers to be licensed in all States where offered. *(Sec. 1333)* Multi-State Plans. Requires the Office of Personnel Management (OPM) to enter into contracts with health insurance issuers to offer at least 2 multi-state qualified health plans through each Exchange in each state. Contracts would be for at least one year, and at least one contractor would be a non-profit. Administration would be modeled on FEHBP. Contracting provisions may include medical loss ratio, profit margin, premiums, or other terms. Eligible insurers would be required to meet the requirements of each Exchange, be licensed in each state, and maintain minimum standards and requirements. Multi-state qualified health plans would offer the essential benefits plan as a uniform benefits package in each state and would meet all other requirements of Title I. Allows states to require that additional benefits be offered, but the amount of federal credits would not increase, and states would be required to assume the cost. State age rating requirements may apply. Permits phase in of multi-state coverage area, such that OPM may contract with a plan offered in 60 percent of the states in the first year, 70 percent in year 2, 85 percent in year 3, and 100 percent in year 4 and beyond. Requires OPM MOE for FEHBP, which would continue to be treated as a separate risk pool. Allows OPM to hire additional staff and creates an advisory board. Authorizes such sums as necessary. *(Sec. 1334)*	
Individual Mandate	Requirement to Maintain Minimum Essential Coverage. Makes findings related to the authority of the federal government to regulate individual health insurance and the effects on the national economy. Amends the Internal Revenue Code to require individuals to maintain minimum essential coverage beginning after 2013. Minimum coverage includes a government plan (Medicare, Medicaid, CHIP, TRICARE, VA, etc.), and employer-sponsored plan, plans in the individual market, grandfathered health plans, or other coverage recognized by the Secretary. Imposes a shared responsibility payment penalty on individuals who fail to maintain coverage for 1 month or more. The amount of the fee would be based on the number of months during which the individual did not have coverage, or an amount equal to the national average premium for a bronze level plan. The monthly premium amount would be based on a flat dollar amount or a set percentage of income. Individuals who do not purchase coverage would pay the greater of $95 in 2014, $495 in 2015 and $750 in 2016, or up to two percent of income by 2016, up to a cap of the	Individual Responsibility. Raises the amount of the penalty fee when based on a set percentage of income to 1.0 percent in 2014, 2.0 percent in 2015, and 2.5 percent for 2016. Lowers flat fee amounts to $325 in 2015 and $695 in 2016. Exempts income below the filing threshold, rather than 100 percent of FPL. *(Sec. 1002)* Income Definitions. Changes income definitions from

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	national average bronze plan premium. Families would pay half the amount for children up to a cap of $2,250 for the entire family. After 2016, dollar amounts will increase by the annual cost of living adjustment. Allows for religious exemptions. Exempts individuals for whom the required contribution for coverage (amount required by an employer or the annual premium for the lowest cost bronze plan) for the month exceeds 8 percent of the individual's household income. Exempts individuals with income below 100 percent FPL and members of Indian tribes. Allows for 3 month gaps in coverage and allows the Secretary to make exceptions based on hardship. Removes criminal penalties otherwise applicable under the tax code for purposes of these payments. Effective in 2013. *(Sec. 1501)* Reporting. Requires reporting of coverage by individuals, employers, and governmental units under the Internal Revenue Code. Requires the IRS to notify individuals of nonenrollment. *(Sec. 1502)*	"modified gross income" to "modified adjusted gross income" for purposes of exemption from the requirement to maintain minimal essential coverage. *(Sec. 1004)*
Employer Mandate	Employer Requirement to Inform Employees of Coverage Options. Requires employers to provide notice to their employees at the time of hiring informing them: of the existence of an Exchange; that if the employer plan's share of the total allowed costs of benefits is less than 60 percent of such costs, that the employee may be eligible for a premium assistance tax credit and cost sharing reduction; and that, if the employee purchases a qualified health plan through the Exchange, the employee will lose the employer contribution (if any). *(Sec. 1512)* Shared Responsibility for Employers. Provides that, if a large employer (more than 50 full-time employees, with exceptions for seasonal workers; includes certain construction industry employers with 5 full-time employees, effective in 2014) does not offer coverage and has at least one full-time employee who has enrolled in a plan for which a premium assistance tax credit or cost-sharing reduction is allowed or paid for the employee, the employer must pay $750 per full-time employee. Imposes a fine of $600 per full-time employee on a large employer that requires a waiting period of more than 60 days before an employee can enroll in health care coverage. Full-time employee means an employee who works an average of 30 hours per week, calculated on a monthly basis. Requires payments to be paid upon notice and demand of the Secretary. Requires the Secretary of Labor to the study and report on the effects of this tax on wages. *(Sec. 1513)* Reporting of Employer Health Insurance Coverage. Requires large employers to report to the Secretary whether they offer full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan, the length of any applicable waiting period, the lowest cost option in each of the enrollment categories under the plan, and the employer's share of the total allowed costs of benefits provided under the plan. Requires the employer to also report the number and names of full-time employees receiving coverage and to furnish statements to employees about whom information is reported. Authorizes the Secretary to verify information. *(Sec. 1514)* Offering of Exchange-Participating Qualified Health Plans Through Cafeteria Plans. Amends the Internal Revenue Code related to cafeteria plans to provide that plans provided through the Exchange will not be an eligible benefit under an employer-sponsored cafeteria plan, except where certain employers offer a choice of plans to their employees through an Exchange. *(Sec. 1515)* Free Choice Vouchers. Requires "offering employers" that offer minimum essential coverage to employees and pay a portion of costs to provide free choice vouchers to qualified employees for the purchase of qualified health plans through Exchanges. The free choice voucher must be equal to the contribution that the employer would	Employer Responsibility. Provides that, the number of individuals employed by a large employer (more than 50 employees) during any month is reduced by 30 for purposes of calculating the amount owed for failure to provide insurance. Raises the per-employee applicable payment amount to $2000. Revises the provision related to requirements for part-time workers; for purposes of determining whether an employer is a large employer, the total number of hours worked by part-time workers in a month, divided by 120, is added to the number of full time employees. Eliminates the Senate bill provision related to waiting periods that exceed 60 days. *(Sec. 1003)*

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	have made to its own plan. Employees would qualify if their required contribution under the employer's plan would be between 8-9.8 percent of their income (indexed based on the rate of premium growth starting in 2014). Excludes free choice vouchers from taxation and voucher recipients are not eligible for tax credits. Employers offering free choice vouchers would not be subject to the shared responsibility penalty under Sec. 1513. *(Sec. 10108)*	
Other Employer Requirements	Prohibition of Discrimination In Favor of Highly Compensated Individuals. Requires group health plans to satisfy IRS requirements prohibiting discrimination in favor of highly paid individuals. *(Sec. 1001, adding Sec. 2716)* Automatic Enrollment for Employees of Large Employers. Requires employers with more than 200 employees to automatically enroll new full-time employees in coverage (subject to any waiting period authorized by law) and to continue the enrollment of current employees. Requires adequate notice and opportunity for opt out for an employee who is auto-enrolled. *(Sec. 1511)* Small Business Procurement. Disallows any waiver of small business contracts under the Federal Acquisition Regulation of the Small Business Act. *(Sec. 1563)*	
Premium Subsidies to Individuals	Refundable Tax Credit Providing Premium Assistance for Coverage under a Qualified Health Plan. Amends the Internal Revenue Code to provide a refundable tax credit for coverage under a qualified health plan. Provides for the credit amount to be calculated based on a sliding scale. The premium assistance amount would be the lesser of monthly premium amount for a taxpayer's plan, or the monthly premium of the second lowest cost silver plan divided by the applicable percentage of taxpayer income. Applicable percentages range from 2 percent of income for those with income that equals or exceeds 100 percent FPL to 9.8 percent of income for those at 200 percent FPL. Premium assistance credits would not account for additional benefits mandated by States. Employees offered coverage by an employer under which the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs, or for whom the premium exceeds 9.8 percent of the employee's income, are eligible for the premium assistance credit. Provides for reconciliation of the premium assistance credit amount at the end of the taxable year. Requires a study on the affordability of health insurance coverage by the Comptroller General. *(Sec. 1401)* Reduced Cost-Sharing for Individuals Enrolling in Qualified Health Plans. Requires that the Secretary notify insurers of "eligible insured" who enroll in plans offered by the insurer. Requires that insurers reduce cost-sharing amounts as specified. Defines "eligible insured" as individuals enrolled in silver level coverage with income 100-400 percent FPL. The standard out-of-pocket maximum limits would be reduced to 1/3 for those between 100-200 percent FPL, 1/2 for those between 200-300 percent FPL, and 2/3 for those between 300-400 percent FPL. Requires coordination in actuarial value limits such that a plan's share of total allowed costs of benefits would be increased to 90 percent for those between 100-150 percent FPL, to 80 percent for those between 150-200 percent FPL, and to 70 percent for those between 200-400 percent FPL. Cost-sharing assistance would not account for additional benefits mandated by States. *(Sec. 1402)* Procedures for Determining Eligibility for Exchange Participation, Premium Tax Credits and Reduced Cost-Sharing, and Individual Responsibility Exemptions. Requires the Secretary to establish a program for determining whether an individual applying for coverage in the individual market by a qualified health plan offered through an Exchange, or who is claiming a premium tax credit or reduced cost-sharing, is a U.S. citizen or national or a lawfully present alien and meets the income	Affordability. Amends the premium assistance amount. Applicable percentages (used to calculate premium assistance amounts) range from 2 percent for individuals with income up to 133 percent FPL to 9.5 percent for those at up to 400 percent FPL. Revises the indexing mechanism for premium assistance amounts. After 2018, additional adjustment could apply, but only apply if the aggregate amount of tax credits and cost-sharing reductions exceeds 0.504 percent of GDP. Employees offered coverage by an employer for whom the premium exceeds 9.5 percent of the employee's income would be eligible for the premium assistance credit. (*Sec. 1001)* Affordability. Requires coordination in actuarial value limits such that a plan's share of total allowed costs of benefits would be increased to 94 percent for those between 100-150 percent FPL, 87 percent for those between 150-200 percent FPL, 73 percent for those between 200-250 percent FPL, and 70 percent for those between 250-400 percent FPL.

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	and coverage requirements; whether coverage offered to an individual under an employer-sponsored health benefits plan is "unaffordable"; and whether to certify that an individual is entitled to an exemption from either the individual responsibility requirement or the related penalty. Requires verification of information provided by applicants and verification of records. Creates processes for appeals by individuals and employers. Provides confidentiality requirements and imposes penalties if applicants submit false or fraudulent information. Requires HHS and the Treasury Department to study administration of the employer responsibility requirement and protection of employer and employee rights. *(Sec. 1411)* Advance Determination and Payment of Premium Tax Credits and Cost-Sharing Reductions. Requires the Secretary to establish a program to allow for the advanced payment of premium assistance tax credits and cost-sharing reductions to plans for eligible individuals upon the request of an Exchange. Also provides for advanced determinations of individual eligibility. Requires the Secretary of the Treasury to make advantage payments under this section to insurers on a monthly basis and requires the insurer to reduce the premium charged accordingly. Cost-sharing reduction payment would also be made to insurers of eligible individuals. Prohibits any Federal payments to individuals who are not lawfully present in the United States. *(Sec. 1412)* Streamlining of Procedures for Enrollment Through an Exchange and State Medicaid, CHIP, and Health Subsidy Programs. Requires the Secretary to establish a system for the residents of each State to apply for enrollment in, receive a determination of eligibility for participation in, and continue participation in, applicable State health subsidy programs. Requires each state to use a single streamlined form for applications to subsidy programs. Requires development of secure electronic interfaces allowing an exchange of data to allow for all determinations of eligibility for all programs based on a single form, and requires a data matching program for determining eligibility. *(Sec. 1413)* Disclosures to Carry out Eligibility Requirements for Certain Programs. Allows for limited disclosure of tax return information to Exchanges or State agencies to carry out eligibility determinations. Authorizes use of Social Security numbers. *(Sec. 1414)* Premium Tax Credit and Cost-Sharing Reduction Payments Disregarded for Federal and Federally-Assisted Programs. Provides that premium assistance tax credits and cost-sharing reductions are not counted as income for purposes of determining eligibility for other programs. *(Sec. 1415)* Study of Geographic Variation in Application of FPL. Requires the Secretary to study the feasibility and implications of adjusting the application of the FPL for different geographic areas and to report to Congress by January 1, 2013. The study would include the territories. *(Sec. 1416)*	(*Sec. 1001)* Income Definitions. Changes income definitions from "modified gross income" to "modified adjusted gross income" for purposes of premiums assistance tax credits and eligibility requirements. *(Sec. 1004)* Income Definitions. Requires Exchanges to provide information to the Secretary and taxpayers for each plan offered in the Exchange, including: the level of coverage; total premium; aggregate amount of any advance payment of credits or reductions; name address and TIN of the primary insured and others obtaining coverage under a policy; information on change of circumstances necessary to determine eligibility for or amount of a credit; and similar information necessary for a determination as to whether a taxpayer has received excess advance payments. *(Sec. 1004)*
Premium Subsidies to Employers	Credit for Employee Health Insurance Expenses of Small Businesses. Amends the Internal Revenue Code to provide small employer health insurance credits equal to the lesser of: 50 percent of the aggregate amount of nonelective contributions made by the employer of behalf of employees, or 50 percent of the contributions an employer would have made based on average premiums in 2014 and beyond (for 2010-2013, eligible employers can receive a small business tax credit for up to 35 percent of their contribution toward the employee's health insurance premium). The credit would phase out based on an employer's number of employees and average wages, with the full credit available to employers with 10 or fewer	

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	employees and average annual wages of less than $25,000 (to be adjusted based on cost of living in years subsequent to 2013), and some credit available to employers with fewer than 25 employees and average annual wages of less than $50,000. Requires that eligible employers contribute at least 50 percent of premium costs. Excludes seasonal workers who work less than 120 days in determining full-time equivalent employees and average annual wages. Provides additional rules, including excepting a 2 percent shareholder or a 5 percent owner from the definition of employee. Provides special rules for tax-exempt eligible small employers. *(Sec. 1421)*	
Private Insurance Market Reform	Effective for plan years beginning 6 months after enactment *(Sec. 1004)*: – No Lifetime or Annual Limits. Prohibits individual and group plans that are required to provide essential health benefits from establishing lifetime or annual limits on the dollar value of benefits for any participant or beneficiary, but for plan years beginning prior to January 1, 2014, allows a plan to establish a restricted annual limit, as defined by the Secretary, on essential benefits. Allows annual or lifetime limits on non-essential benefits. *(Sec. 1001, adding Sec. 2711)* – Prohibition on Rescissions. Prohibits individual and group plans from rescinding coverage except in instances of fraud or intentional misrepresentation of material fact and with prior notice given to enrollees. *(Sec. 1001, adding Sec. 2712)* – Coverage of Preventive Health Services. Requires individual and group plans to cover and not impose cost-sharing on preventive services and immunizations recommended by the U.S. Preventive Services Task Force and the CDC, certain child preventive services recommended by the Health Resources and Services Administration.; for women, additional preventive care screenings as provided for in HRSA guidelines; and current recommendations of the US Preventive Service Task force regarding breast cancer screening, mammography, and prevention. *(Sec. 1001, adding Sec. 2713)* [as amended by Mikulski amendment 2791] – Development and Utilization of Uniform Explanation of Coverage Documents and Standardized Definitions. Requires the Secretary to develop standards for use by health insurers in compiling and providing an accurate summary of benefits and explanation of coverage to be provided to applicants, enrollees, and policyholders. Requires standards to be in a uniform format, using language that is easily understood by the average enrollee, and including uniform definitions of standard insurance and medical terms. Must describe: cost sharing for the essential benefits and other benefits; exceptions and limitations; renewability "coverage facts label" ; and a contract number to allow the consumer to obtain a copy of his/her policy. Preempts any state standards. Imposes a $1,000 fine per willful failure to provide required information. *(Sec. 1001, adding Sec. 2715)* – Ensuring Quality of Care. Requires the Secretary, within 2 years of enactment and in consultation with stakeholders, to develop requirements for health insurers. Insurers would report to the Secretary annually on reimbursement structures that: improve health outcomes through quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including the medical homes model; prevent hospital readmissions; improve patient safety and reduce medical errors	Insurance Reforms. Extends certain insurance reforms to grandfathered plans. When requirements become applicable to other plans, grandfathered individual and group plans would be required to meet requirements related to excessive waiting periods, lifetime limits, rescissions, and extension of dependent coverage. Grandfathered group plans would also be required to meet annual limit and pre-existing condition requirements when applicable to other plans. Grandfathered group plans would be required to cover dependant children up to age 26 starting in 2014, only if the dependant is not otherwise eligible for an employer-sponsored plan. *(Sec. 2301)*

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	through best clinical practices; and implement wellness and health promotion activities (as defined). Wellness and promotion activities may not require disclosure of lawfully-possessed firearms, and premium rates may not depend on firearm ownership or storage. Reports would be available to the public. Permits penalties for failure to report. Requires the Secretary to issue regulations within 2 years and requires a GAO study on the impact of the reporting requirement. *(Sec. 1001, adding Sec. 2717)* – Bringing Down the Cost of Health Care Coverage (Medical Loss Ratio Requirements). Requires health insurance issuers offering group or individual health insurance coverage to submit a report to the Secretary for each plan year concerning the ratio of the incurred loss plus the loss adjustment expense to earned premiums. The report would include the percentage of revenue, after accounting for collections for risk adjustment, coverage spends on: (1) reimbursement for clinical services; (2) activities that improve health care quality; and (3) on all other non-claims costs (excluding taxes and fees). Requires the Secretary to make the information public and available online. If the ratio is less than certain percentages, the plan would be required to provide an annual rebate to each enrollee on a pro rata basis. The applicable percentage would be 85 percent in the large group market (or higher based on state regulation), and 80 percent in the individual or small group market (or higher based on state regulation). Describes methodology for determining rebate amounts; beginning on January 1, 2014, the calculation would be based on the average ratio over the previous 3 years. *(Sec. 1001, adding Sec. 2718)* – Bringing Down the Cost of Health Care Coverage (Standard Hospital Charges Reporting). Requires hospitals to publicize a list of standard charges for items and services provided by the hospitals, including DRGs. *(Sec. 1001, adding Sec. 2718)* – Appeals Process. Requires insurers to implement an effective process for appeals of coverage determinations and claims. Requires plans to maintain both internal and external appeals processes *(Sec. 1001, Sec. 2719)* – Patient Protections. Requires insurers to allow enrollees to designate any participating primary care provider (or pediatrician for children) who is available to accept the individual as the enrollee's primary care provider. Requires covered benefits for emergency department services to be covered without prior authorization requirements and without regard to whether the provider furnishing services is a participating provider. Prohibits plans from requiring authorization or referral for female patients seeking obstetrical or gynecologic care. *(Sec. 1001, Sec. 2719A)* Effective on January 1, 2014 *(Sec. 1255)*: – Prohibition of Preexisting Condition Exclusions or other Discrimination Based on Health Status. Prohibits health plans in the group or individual market from imposing any pre-existing condition exclusion. Effective on January 1, 2014. *(Sec. 1201, adding Sec. 2704)* – Rating Rules - Fair Health Insurance Premiums. Allows premium rates to vary in the individual and small group health insurance markets only with respect to: family structure, geography, the actuarial value of the benefit, age (limited to 3:1), and tobacco use (limited to 1.5:1). Requires each State to establish 1 or	

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	more rating area, subject to Secretarial review. Requires the Secretary to establish permissible age bands. Would apply to the large group market where States allow such coverage to be offered through the Exchange. *(Sec. 1201, adding Sec. 2701)* – Guaranteed Availability of Coverage. Requires insurance issuers in the individual or group market to accept every employer and individual in the State that applies for coverage. Allows for annual and special open enrollment periods. *(Sec. 1201, adding Sec. 2702)* – Guaranteed Renewability of Coverage. Requires guaranteed renewability of coverage in the individual and group markets (other than self-insured group plans). *(Sec. 1201, adding Sec. 2703)* – Prohibiting Discrimination Against Individual Participants and Beneficiaries Based on Health Status. Prohibits group and individual plans from setting eligibility rules based on health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability or any other health statue-related factor determined appropriate by the Secretary. *(Sec. 1201, adding Sec. 2705)* – Premium Differentiation for Employer Wellness Programs. Allows for premium differentiation of up to 30 percent for employer wellness programs. Authorizes a 10-State demonstration for wellness programs in the individual market. *(Sec. 1201, adding Sec. 2705)* – Non-Discrimination in Health Care. Prohibits insurers from discriminating against any health care provider acting within the scope of the provider's professional license and applicable State laws. *(Sec. 1201, adding Sec. 2706)* – Comprehensive Health Insurance Coverage. Requires health insurance issuers in the small group and individual markets to provide coverage for the essential benefits package. Requires group plans to meet cost-sharing requirements. Requires offering of child-only plans in certain circumstances. Not applicable to dental-only plans. *(Sec. 1201, adding Sec. 2707)* – Prohibition on Excessive Waiting Periods. Prohibits any waiting periods for group coverage which exceed 90 days. *(Sec. 1201, adding Sec. 2708)* – Coverage for Individuals Participating in Approved Clinical Trials. Requires group and individual plans to cover routine costs of participation in certain clinical trials by qualified individuals. *(Sec. 1201, adding Sec. 2709)* – Rating Reforms Must Apply Uniformly to All Health Insurance Issuers and Group Health Plans. Standards and requirements adopted by States must be applied uniformly to all plans in each relevant insurance market in a State. *(Sec. 1201, adding Sec. 1252)* – Annual Report on Self-Insured Plans. Requires the Secretary of Labor to prepare an aggregate annual report including general information on self-insured group health plans and data from self-insured employers. *(Sec. 1201, adding Sec. 1253)* – Study of Large Group Market. Requires the Secretary to conduct a study of the fully-insured and self-insured group health markets and to report to Congress	

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	within 1 year of enactment. *(Sec. 1201, adding Sec. 1254)* Preservation of Right to Maintain Existing Coverage. "Grandfathers" existing plans. Provides that nothing in the bill requires an individual to terminate enrollment in existing individual or group health plan. Makes provision of Sections 1001, 1002, 1003, 1201, 1252, and 1255 inapplicable to coverage of an individual enrolled as of the date of enactment, regardless of renewal. Sections 2715 and 2718 of the Public Health Services Act would apply to plans upon enactment. Allows family members and new employers to join existing plans. Effective upon enactment. *(Sec. 1201, adding Sec. 1251)* Administrative Simplification. Accelerates HHS adoption of uniform standards and operating rules for the electronic transactions that occur between providers and health plans that are governed under HIPAA, including benefit eligibility verification, prior authorization, and electronic funds transfer payments. Requires that standards: enable determination of eligibility; be comprehensive; provide for a transparent claims and denial management process; describe all data elements in unambiguous terms. Establishes a process, using recommendations of a qualified nonprofit entity and the National Committee on Vital and Health Statistics, to regularly update the standards and operating rules for electronic transactions. Requires health plans to certify compliance or pay a penalty fee. Provides for an additional penalty for misrepresentation of compliance. Includes deadlines for various rulemaking, including: unique health plan identifier; electronic funds transfer; and health claims attachments. *(Sec. 1104)* Qualified Health Plan Defined. Defines "qualified health benefit plan" as a plan that meets criteria for certification by Exchanges where it is offered; provides the essential health benefits package; and is offered by a licensed insurer that agrees to (1) offer at least one qualified health plan in the "silver" level and at least one plan in the "gold" level in each Exchange through which the plan is offered, (2) agrees to charge the same premium rate for each qualified health plan whether offered in or outside of the Exchange, and (3) complies with federal regulations. Includes a CO-OP plan or a multi-State plan. Permits a qualified health benefit plan to provide coverage through a qualified direct primary care medical home plan. Permits a qualified health benefit plan to vary premiums by rating area. *(Sec. 1301)* Definitions. Applies the definitions in Sec. 2791 of the Public Health Service Act (42 U.S.C. 300gg-91) to Title I of the PPACA. Such terms include: group health plan, medical care, health insurance coverage, health insurance issuer, health maintenance organization, group health insurance coverage, individual health insurance coverage, excepted benefits, employer, plan sponsor, and several other terms used in the title. *(Sec. 1551)* GAO Study Regarding the Rate of Denial or Coverage and Enrollment by Health Insurance Issuers and Group Health Plans. Directs the GAO to study the rate of denial of coverage and enrollment by health insurance issuers and group health plans. Requires a report within 1 year of enactment. *(Sec. 1562)* Developing Methodology to Assess Health Plan Value. Requires the Secretary of HHS to develop a methodology to measure health plan value, in consultation with relevant stakeholders including health insurers, consumers, employers, health care providers and other appropriate entities, taking into consideration the cost to plan enrollees, the quality of care provided under the plan, the efficiency of the plan in providing care, the relative risk of the plan's enrollees, the actuarial value or other	

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	measure of plan benefits and other relevant factors. Requires the Secretary to report to Congress on the methodology by 187 months after enactment. *(Sec. 10329)*	
Benefit Design	Essential Health Benefits Requirements. Defines the Essential Health Benefits Package as coverage that: provides coverage for the essential health benefits as defined; limits cost-sharing; and provides either bronze, silver, gold, or platinum level coverage. Requires the Secretary to define essential health benefits package including items and services within: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorders; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; prevention and wellness services and chronic disease management; pediatric services, including oral and vision care. Requires essential benefits package to be equal to the scope of benefits provided under a typical employer plan. Requires the Secretary to consider certain factors and to use notice and comment rulemaking to establish the package. Limits cost-sharing within a self-only plan beginning in 2014 and other coverage starting in 2015. Imposes an annual limit on deductibles in the small group market to $2,000 for plans covering single individuals and $4,000 for other plans (indexed based on premium adjustments). *(Sec. 1302)* Levels of Coverage. – Bronze level – must provide coverage that is actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan. – Silver – must provide coverage that is actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan. – Gold – must provide coverage that is actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan. – Platinum – must provide coverage that is actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan. The level of coverage of a plan would be determined on the basis that the essential benefits are provided to a standard population. Requires the Secretary to issue regulations whereby the employer contribution would be taken into account in determining the level of a plan offered by an employer. *(Sec. 1302)* Catastrophic Plan. Allows catastrophic only policies for people 30 years or younger who are exempt from the individual responsibility requirement because coverage is unaffordable to them or they have a hardship. *(Sec. 1302)* Payments for FQHCs. Requires qualified health plans to pay for services at FQHCs at the same rate that would have been paid to the center under Sec. 1902(bb). *(Sec. 1302)* Special Rules for Abortion. Allows states to elect to prohibit abortion coverage in qualified health plans offered through an Exchange. Provides that nothing in the Act requires a qualified health plan to cover abortion services for which public funding is allowed or prohibited under current law. Prohibits use of federal funds paid to insurers through credits or cost-sharing reduction to pay for abortion services for which federal funding is prohibited and requires establishment of allocation accounts and segregation of funds. Does not preempt State law or federal law related to abortion or impact federal civil rights law or EMTALA. *(Sec. 1303)* Transitional Reinsurance Program for Individual Market. For 2014, 2015, and 2016, requires each State to contract with a nonprofit reinsurance entity that collects payments from insurers in the individual and group markets and makes payments to such insurers in the individual market that cover high-risk individuals (based on	

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	medical condition). Requires the Secretary to establish Federal standards for the determination of high-risk individuals, a formula for payment amounts, and the contributions required of insurers. Requires each insurer's payments to reflect market share. Requires aggregate contributions to total $10 billion for 2014, $6 billion for 2015, and $4 billion for 2016. Also requires proportionate contributions of an additional $5 billion over the three year period. *(Sec. 1341)* Establishment of Risk Corridors for Plans in Individual and Small Group Markets. Requires the Secretary to establish risk corridors for qualified health plans in 2014, 2015, and 2016. If a plan's costs (other than administrative costs) exceed 103 percent of total premiums, up to 108 percent, requires the Secretary to make payments to the plan to defray 50 percent of the excess. If costs exceed 108 percent, requires the Secretary to make payments equal to 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent. If a plan's costs (other than administrative costs) are less than 97 percent of total premiums but more than 92 percent, requires the plan to make payments to the Secretary of 50 percent of the excess. If plan costs are less than 92 percent, requires the plan to pay 2.5 percent of the target amount plus 80 percent of the excess of 92 percent. *(Sec. 1342)* Risk Adjustment. Requires States to assess charges on health plans with enrollees of lower-than-average risk, and to provide payments to health plans with enrollees of higher-than-average risk. Risk adjustment applies to plans in the individual and small group markets, but not to grandfathered health plans. *(Sec. 1343)*	
Disproportionate Share Hospital (DSH) Payments	Disproportionate Share Hospital Payments. In the first fiscal year that occurs after FY 2012 for which the Secretary determines that the percentage of uncovered individuals residing in the State is at least 45 percent less than the percentage of individuals determined for the State in FY 2009, the State's DSH allotment shall be reduced by: (i) in the case of a low DSH state that has spent not more than 99.90 percent of its DSH allotment on average for the period of FYs 2004 through 2008, 25 percent; (ii) in the case of a low DSH state that has spent more than 99.90 percent of its DSH allotment on average for the period of FYs 2004 through 2008, 17.5 percent; (iii) for a state that is not a low DSH state that has spent not more than 99.90 percent of its DSH allotment on average for the period of FYs 2004 through 2008, 50 percent; and (iv) for a state that is not a low DSH state that has spent more than 99.90 percent of its DSH allotment on average for the period of FYs 2004 through 2008, 35 percent.. For subsequent years, if the Secretary determines that the percentage of uncovered individuals residing in the state is less than the percentage of such individuals determined for the State in the preceding year, the State's DSH allotment will be reduced by 50 percent: (i) in the case of a low DSH state that has spent not more than 99.90 percent of its DSH allotment on average for the period of FYs 2004 through 2008, the product of the percentage reduction in uncovered individuals for the FY from the preceding year and 27.5 percent; (ii) in the case of a low DSH state that has spent more than 99.90 percent of its DSH allotment on average for the period of FYs 2004 through 2008, the product of the percentage reduction in uncovered individuals for the FY from the preceding year and 20 percent; (iii) for a state that is not a low DSH state that has spent not more than 99.90 percent of its DSH allotment on average for the period of FYs 2004 through 2008, the product of the percentage reduction in uncovered individuals for the FY from the preceding fiscal year and 55 percent; and (iv) for a state that is not a low DSH state that has spent more than 99.90 percent of its DSH allotment on average for the period of FYs 2004 through 2008, the product of the percentage reduction in uncovered individuals for the FY from the preceding FY and 40 percent. .In no case could the State's DSH allotment in 2013 or after be reduced by more than 65 percent of the DSH allotment determined for the State in FY 2012.	Medicaid Disproportionate Share Hospital Payments (DSH) Payments. Applies DSH payment reductions to states beginning in 2014. For FYs 2014 through 2020, requires the Secretary to develop a methodology for the reduction of DSH payments to states that will total $14.1 billion over the 7 year period (down from $18.1 billion in the Senate bill). Requires the methodology developed by the Secretary to impose the largest reductions on States with the lowest percentages of uninsured individuals and who do not target their DSH payments to hospitals with high volumes of Medicaid inpatients or high levels of uncompensated care. The smaller percentage reductions should be applied to low DSH states. Provides for partial payment of Medicaid DSH payments to states that currently do not receive DSH allotments. *(Sec. 1203)*

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	Sets the DSH allotment for Hawaii for the 2nd, 3rd, and 4th quarters of FY 2012 at $7,500,000. For FY 2013 and succeeding fiscal years, the DSH allotment for Hawaii will be increased in the same manner as allotments for low DSH states. Specifies that the Secretary may not impose a limitation on the total amount of payments made to hospitals under the QUEST section 1115 Demonstration Project except to ensure the hospital does not receive excess payments. . *(Sec. 2551)* Improvement to Medicare Disproportionate Share Hospital (DSH) Payments. This provision would require the Secretary to update hospital payments to better account for hospitals' uncompensated care costs. Starting in FY2015, requires the Secretary to begin making DSH payments at a rate equal to 25 percent of the DSH payments that would otherwise be made to reflect lower uncompensated care costs relative to increases in the number of insured. Additional payments would be made in proportion to a hospital's continued uncompensated care costs. *(Sec. 3133)*	Medicare Disproportionate Share Hospital (DSH) Payments. Advances Medicare disproportionate share hospital cuts to begin in fiscal year 2014 but lowers the ten-year reduction by $3 billion. *(Sec. 1104)*
Medicare Part A Payment Updates and Other Part A Provisions	Part A Benefit Market Basket Updates. For 2010 and 2011, requires a reduction of 0.25 percent to the market basket increase for *inpatient and outpatient hospitals, inpatient psychiatric facilities, and inpatient rehabilitation.* For *long term care hospitals* for 2010 requires a reduction of 0.25 percent and for 2011 a reduction of 0.5 percent. For 2012 and 2013, requires a reduction of 0.1 percent for *inpatient and outpatient hospitals, inpatient psychiatric facilities, inpatient rehabilitation, and long term care hospitals.* For 2014-2019, requires a reduction for all these providers of 0.2 percent to the market basket increase. For *hospice* providers, requires a reduction of 0.3 percent for 2013-2019. These reductions are in addition to the productivity adjustment and subject to the "give back" described below. *(Sec. 3401)* Productivity Adjustment. Implements a full productivity adjustment (equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (as projected by the Secretary for the applicable fiscal year, year, cost reporting period, or other annual period)) for *inpatient and outpatient hospital services, inpatient psychiatric facilities, inpatient rehabilitation, long term care hospital services and nursing homes beginning* in 2012. It would implement a full productivity adjustment for *hospice* providers beginning in 2013, and a full productivity adjustment for *home health* providers beginning in 2015. *(Sec. 3401)* "Give Back" Based on Level of Insured. For fiscal years 2014-2019 (2013-2019 for hospice), the market basket reduction would be contingent on the level of non-elderly insured population relative to the projection of non-elderly insured at the time of enactment. If, for each of fiscal years 2014 through 2019 (2013-2019 for hospice), the total percentage of the non-elderly insured population for the preceding fiscal year is greater than 5 percentage points below the projection of the total percentage of the non-elderly insured population for such preceding fiscal year (as of the date of enactment), as estimated by the Secretary, the additional adjustment factor (see Part A market basket updates above) for the fiscal year shall be 0.0 percent. Thus, the Secretary would "give back" this payment reduction under these circumstances. *(Sec. 3401)* Hospital Value-Based Purchasing Program. The proposal would establish a value-based purchasing program for hospitals starting in FY2013. Under this program, a percentage of hospital payment would be tied to hospital performance on quality measures related to common and high-cost conditions, such as cardiac, surgical and pneumonia care. Quality measures (other than measures of hospital readmissions)	Market Basket Updates. Revises the market basket update reduction for *inpatient and outpatient hospitals*, *long-term care hospitals, inpatient rehabilitation facilities,* and *psychiatric hospitals* to 0.3 percent for 2014, 0.2 percent for 2015-2016, and 0.75 in 2017-2019. Removes the Senate bill provision that would eliminate the additional market basket for hospitals based on coverage levels. *(Sec. 1105)*

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	included in the program (and in all other quality programs in this title) will be developed and chosen with input from external stakeholders. Certain hospitals would be excluded from the program, including those that fail to report under RHQDAPU; those that have been cited for certain deficiencies; and those for which a minimum number of patients with conditions related to the quality measures or a minimum number of quality measures do not apply. Funding for value-based incentive payments for qualifying hospitals would be generated through reducing Medicare IPPS payments to the hospitals phased-in as follows: 1.0 percent in FY2013; 1.25 percent in FY2014; 1.5 percent in FY2015; 1.75 percent in FY2016; and 2.0 percent in FY 2017 and beyond. The reductions would apply to all MS-DRGs under which a hospital provides services. IPPS add-on payments would not be impacted. Performance standards that reward hospitals based on either attaining a certain performance standard or making improvements on performance relative to a previous performance period would be established. Hospitals would be paid based on whichever level is higher: achievement or improvement. Performance standards would be announced at least 60 days prior to the performance period for which they would apply. In setting standards, the Secretary must take into account past hospital experience with the measures; historical performance standards; improvement rates; and opportunity for continued improvement. Results would include both condition-specific and total hospital performance scores but determination of whether a performance standard was met would be based on the hospital's total performance score. The Secretary would have discretion to determine how to weight various categories of measures/conditions when determining the hospital's total score. Individual hospital performance on each specific quality measure, on each condition or procedure, and on total performance would all be publicly reported. An appeals process would be established to allow hospitals to contest performance score calculations and the resulting value-based incentive payments. Three-year demonstration projects would be established to test value based purchasing models tailored toward critical access hospitals (CAHs) and small hospitals that otherwise would not qualify to participate in the program. Reporting requirements for GAO and CMS would apply. *(Sec. 3001)* <u>Quality Reporting for Long-Term Care Hospitals, Inpatient Rehabilitation Hospitals, and Hospice Programs.</u> Establishes a path toward value-based purchasing for long-term care hospitals, inpatient rehabilitation facilities, and hospice providers by requiring the Secretary to implement quality measure reporting programs for these providers in FY 2014. Providers under this section who do not successfully participate in the program would be subject to a reduction in their annual market basket update. Failure to report quality measures would result in reduction of annual market basket update by 2 percent. Quality measures included in these reporting programs would be selected via the quality measure development and endorsement procedures laid out in the Quality Infrastructure section of the legislation and would cover, to the extent feasible, all dimensions of quality as well as efficiency. *(Sec. 3004)* <u>Quality Reporting for PPS-Exempt Cancer Hospitals.</u> Establishes a quality measure reporting program for PPS-exempt cancer hospitals beginning in FY 2014.	

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	Providers under this section who do not successfully participate in the program would be subject to a reduction in their annual market basket update. *(Sec. 3005)* Pilot Programs for Value-Based Purchasing for IRFs, Psychiatric Hospitals, LTCHs, Cancer Hospitals, and Hospice The manager's amendment contains a new provision that would implement VBP pilot programs, beginning in 2016, for IRFs, LTCHs, psychiatric hospitals, cancer hospitals, and hospice providers. The HHS Secretary could expand the duration and scope of the pilot programs beginning in 2018. *(Sec. 10326).* Payment Adjustment for Conditions Acquired in Hospitals. Starting in FY 2015, hospitals in the top 25th percentile of rates of hospital acquired conditions for certain high-cost and common conditions would be subject to a payment penalty under Medicare. This provision also requires the Secretary to submit a report to Congress by January 1, 2012 on the appropriateness of establishing a healthcare acquired condition policy related to other providers participating in Medicare, including nursing homes, inpatient rehabilitation facilities, long-term care hospitals, outpatient hospital departments, ambulatory surgical centers, and health clinics. *(Sec. 3008)* Protecting Home Health Benefits. Nothing in the provisions of, or amendments made by, this Act shall result in the reduction of guaranteed home health benefits under title XVIII of the Social Security Act. *(Sec. 3143)* [Added by Kerry Amendment 2926] Plans for a Value-Based Purchasing Program for Skilled Nursing Facilities and Home Health Agencies. Directs the Secretary to submit a plan to Congress by FY 2012 (not later than October 1, 2011) outlining how to effectively move these providers into a value-based purchasing payment system. The Secretary would be required to consult with relevant stakeholders and consider experiences with demonstrations that are relevant to value-based purchasing in each setting. Also requires the Secretary to develop a plan to implement a value-based purchasing program for ambulatory surgical centers and requires the Secretary to submit a report containing this plan by January 1, 2011. *(Sec. 3006)* Hospice Reform. This provision would require the Secretary to update Medicare hospice claims forms and cost reports by 2011. Based on this information, the Secretary would be required to implement changes to the hospice payment system to improve payment accuracy in FY2013. The Secretary would also impose certain requirements on hospice providers designed to increase accountability in the Medicare hospice program. *(Sec. 3132)* Medicare Hospice Concurrent Care Demonstration Program. Directs the Secretary to establish a three-year demonstration program that would allow patients who are eligible for hospice care to also receive all other Medicare covered services during the same period of time. The demonstration would be conducted in up to 15 hospice programs in both rural and urban areas and would evaluate the impacts of the demonstration on patient care, quality of life and spending in the Medicare program. *(Sec. 3140)* Extension of Certain Payment Rules for Long-Term Care Hospital Services and of Moratorium on the Establishment of Certain Hospitals and Facilities. Extends Sections 114 (c) and (d) of the Medicare, Medicaid and SCHIP Extension Act of 2007 by one year. *(Sec. 3106)*	

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	Permitting Physician Assistants to order Post-Hospital Extended Care Services. Authorizes physician assistants to order skilled nursing care services in the Medicare program beginning in 2011. *(Sec. 3108)* Hospital Wage Index Improvement. Extends reclassifications under section 508 of the Medicare Modernization Act (P.L 108-173) through the end of FY2010. Beginning on April 1, 2010, the Secretary shall include the average hourly wage data of hospitals whose reclassification was extended only if including such data results in a higher applicable reclassified wage index. If the wage index calculated on April 1, 2010 is lower than for the period beginning on October 1, 2009, and ending on March 31, 2010, the Secretary will pay such hospital the difference by no later than December 31, 2010. In addition, requires the Secretary to provide recommendations to Congress on ways to comprehensively reform the Medicare wage index system by December 31, 2011. Also directs the Secretary to restore the reclassification thresholds used to determine hospital reclassifications to the percentages used in FY2009, starting in FY2011 until the first fiscal year that is on or after the date the Secretary submits the report to Congress on reforming the wage index system. *(Sec. 3137)* Application of Budget Neutrality on a National Basis in the Calculation of the Medicare Hospital Wage Index Floor. Starting on October 1, 2010, the provision would require application of budget neutrality associated with the effect of the imputed rural and rural floor to be applied on a national, rather than State-specific basis through a uniform, national adjustment to the area wage index. *(Sec. 3141)*	
Medicare Part B Provisions – Physicians' Services	Extension of the Work Geographic Index Floor and Revisions to the Practice Expense Geographic Adjustment Factor Under the Medicare Physician Fee Schedule. Extends the 1.0 floor for the geographic index for physician work through 2010. For 2010, the employee wage and rent portions of the practice expense geographic index will reflect ¾ of the difference between the 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. For 2011, these portions will reflect ½ of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national average of such wages and rents. Holds harmless any negative impacts of the adjustments during 2010 and 2011. Directs the Secretary to analyze current methods of establishing practice expense geographic adjustments under the physician fee schedule and evaluate data that fairly and reliably establishes distinctions in the costs of operating a medical practice in the different Medicare payment localities. Based on the analysis and evaluation, the Secretary shall, no later than January 1, 2012, make appropriate adjustments to the practice expense geographic adjustment to ensure accurate geographic adjustments across payment areas. Adjustments made in 2012 would be made without regard to the adjustments made in 2010 and 2011 and in a budget neutral manner. *(Sec. 3102)* Improvements to the Physician Quality Reporting Initiative. Extends the PQRI program through 2014. For 2011, incentive payments would equal 1.0 percent and 0.5 percent for 2012, 2013, and 2014. Eligible professionals who do not report quality data measures would be penalized by 1.5 percent for 2015 and 2 percent for 2016. The Secretary shall provide timely feedback to eligible professionals on their performance with respect to satisfactorily submitting data on quality measures. Not later than January 1, 2011, requires the Secretary to implement an informal process under which an eligible professional may appeal a payment decision made under the program. Not later than January 1, 2012, the Secretary shall develop a plan to	Payment for Imaging Services. Sets the utilization rate assumption for expensive diagnostic imaging equipment (equipment priced over $1 million) at 75 percent for 2011 and subsequent years. This change would be exempt from the traditional budget-neutrality for Part B services. This utilization rate policy would replace the Senate bill's utilization rate policy that would have impacted all advanced diagnostic imaging services. The Senate's contiguous body parts policy and required study by the CMS Actuary were not amended by this Act. *(Sec. 1107)*

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	integrate the clinical reporting on quality measures with the reporting requirements relating to the meaningful use of electronic health records (EHRs). For years after 2010, eligible professionals would be permitted to participate in the PQRI program through Maintenance of Certification (MOC) programs operated by a specialty body of the American Board of Medical Specialties that meet the registry requirements. *(Sec. 3002)* Improvements to the Physician Quality Reporting System. Provides an *additional* 0.5 percent payment bonus to eligible professionals (1) who satisfactorily submit data on quality measures for a year and have such data submitted on their behalf through an MOC program; (2) who participate in such an MOC program more frequently than is required to maintain board certification status and successfully complete a qualified MOC practice assessment for such a year; and (3) for whom the MOC submits to the Secretary information that the eligible professional has met the requirements of (2) and other information. Allows the Secretary to incorporate participation in an MOC program and successful completion of a qualified MOC program practice assessment into the composite measures of quality of care for years after 2014. Eliminates the MA Regional Plan Stabilization Fund. *(Sec. 10327)* Physician Feedback Program. Requires the Secretary, beginning in 2012, to provide reports to physicians comparing their resource use with that of other physicians or groups of physicians caring for patients with similar conditions. Resource use would be measured based on the items and services furnished or ordered by physicians or groups of physicians. Feedback reports would be based on an episode grouper methodology established by the Secretary that would combine separate, but clinically-related services into an episode of care for which the physician is accountable. The episode grouper would be required to be developed by January 1, 2012. The reports would be risk-adjusted and standardized to take into account local health care costs. *(Sec. 3003)*. Public Reporting of Performance Information. Requires the Secretary of HHS to develop by January 1, 2011 a "Physician Compare" website with information on physicians enrolled in the Medicare program and other eligible professionals who participate in the PQRI program. Requires the Secretary to implement by January 1, 2013 a plan for making available through the Physician Compare website information on physician performance that provides comparable information on quality and patient experience measures, including (to the extent scientifically-sound measures are developed) PQRI measures, assessment of patient outcomes, assessment of coordination of care including episodes of care and risk-adjusted resource use, assessment of efficiency, assessment of patient experience, assessment of safety, effectiveness and timeliness of care, and other information determined appropriate. In developing the plan, the Secretary would be required, to the extent practicable, to include processes to assure that the data made public is statistically valid and reliable including risk adjustment mechanisms; processes to allow professionals to review their results before they are made public; processes to assure that the plan and the data on Physician Compare provide a robust and accurate portrayal of physician performance; data that reflects care provided to all patients; processes to assure accurate attribution of care when multiple providers are involved; processes to ensure timely feedback to physicians on the data reported; and implementation of CMS computer and data systems that support valid, reliable and accurate public reporting activities. Requires the Secretary to report to Congress on the Physician Compare website by January 1, 2015. Allows the Secretary to expand the information available on the site before the report is submitted. Allows the Secretary to establish a demonstration program and, by	

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	January 1, 2019, to provide financial incentives to beneficiaries who are furnished services by high-quality physicians (determined based on the above performance measures). *(Sec. 10331)* Value-Based Payment Modifier Under the Physician Fee Schedule. Requires the Secretary to establish a value-based 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 during a performance period. This modifier would be separate and apart from the geographic adjustment factors. Quality and cost measures would be risk adjusted and geographically standardized. Not later than January 1, 2012, requires that the Secretary publish the measures of quality of care and costs, the dates of implementation of the payment modifier, and the initial performance period. The Secretary will apply the payment modifier beginning on January 1, 2015. *(Sec. 3007)* Extension of Payment for Technical Component of Certain Physician Pathology Services. Extends a provision that directly reimburses qualified rural hospitals for certain clinical laboratory services through the end of 2010. *(Sec. 3104)* Misvalued Codes Under the Physician Fee Schedule. Require the Secretary to periodically identify physician services as being potentially misvalued, and make appropriate adjustments to the relative values of such services under the Medicare physician fee schedule. Directs the Secretary to identify potentially misvalued codes based on certain factors including, codes that have had the fastest growth. Adjustments to misvalued procedures would be subject to budget neutrality requirements. *(Sec. 3134)* Modification of Equipment Utilization Factor for Advanced Imaging Services. Increases the utilization rate assumption for advanced diagnostic imaging equipment from 50 percent to 65 percent for 2010-2012; to 70 percent for 2013; and to 75 percent for 2014 and subsequent years. The section would also increase the reduction in the technical component payment for sequential imaging services on contiguous body parts during the same visit from 25 percent to 50 percent. Both payment changes would be exempt from the traditional budget-neutrality for Part B services. The section also requires the CMS Actuary to publish by January 1, 2013 an analysis of whether the total Medicare savings to be produced by these policies over the 2010-2019 period will exceed $3 billion. *(Sec. 3135)*	
Medicare Part B – Market Basket Updates	Part B Market Basket Updates. After the productivity adjustment (below), reduces the update for outpatient hospitals in 2010 and 2011 by 0.25 percent; in 2012 and 2013 by 0.1 percent; and 2014-2019 by 0.2 percent (subject to the "give back" below) and for clinical laboratories by 1.75 percent in each of 2011-2015. For covered items of durable medical equipment and prosthetic devices and orthotics and prosthetics, sets the annual update at CPI for 2011 and subsequent years (subject to the productivity adjustment below). *(Sec. 3401)* Productivity Adjustments. Applies the productivity adjustment (see Part A market basket updates) to outpatient hospitals and dialysis facilities beginning in 2012, and ambulance services, ambulatory surgical center services, laboratory services and certain durable medical equipment beginning in 2011. *(Sec. 3401)* "Give Back". Applies the "give back" provision (see Part A market basket updates) to outpatient hospitals. *(Sec. 3401)* Update and Productivity Adjustment for Future Fee Schedules. If the Secretary	

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	implements a fee schedule for items currently paid on a reasonable charge basis (e.g., medical supplies, blood products), such fee schedule shall be updated for 2011 and subsequent years by CPI reduced by the productivity adjustment. *(Sec. 3401)*	
Medicare Part B – Other Provisions	Temporary Adjustment to the Calculation of Part B Premiums. F or higher-income beneficiaries who pay a higher Part B premium rate, freezes the income thresholds at 2010 levels through 2019. *(Sec. 3402)* Revision of Payment for Power-Driven Wheelchairs. Effective January 1, 2011, eliminates the option for Medicare to purchase power-driven wheelchairs with a lump-sum payment at the time the chair is supplied. Medicare would continue to make the same payments for power-driven chairs over a 13-month period. The purchase option for complex rehabilitative power wheelchairs would be maintained. *(Sec. 3136).* Part B Special Enrollment Period for Disabled TRICARE Beneficiaries. Creates a twelve-month special enrollment period for military retirees, their spouses (including widows/widowers) and dependent children, who are otherwise eligible for TRICARE and entitled to Medicare Part A based on disability or ESRD, but who have declined Part B. *(Sec. 3110)* Payment for Bone Density Tests. Restores payment for dual-energy x-ray absorptiometry (DXA) services furnished during 2010 and 2011 to 70 percent of the Medicare rate paid in 2006. *(Sec. 3111)* Improved Access for Certified Nurse-Midwife Services. Increases the payment rate for certified nurse midwives for covered services from 65 percent of the rate that would be paid were a physician performing a service to the full rate. *(Sec. 3114)* Treatment of Certain Cancer Hospitals. Directs the Secretary to study whether existing cancer hospitals that are exempt from the inpatient prospective payment system have costs under the outpatient prospective payment system (OPPS) that exceed costs of other hospitals, and to make an appropriate payment adjustment under OPPS based on that analysis. *(Sec. 3138)* Payment for Biosimilar Biological Products. Sets the add-on payment rate for biosimilar products reimbursement under Medicare Part B at 6 percent of the average sales price of the brand biological product. (*Sec. 3139)* Exemption of Certain Pharmacies from Accreditation Requirements. Allows pharmacies with less than 5 percent of revenues from Medicare DMEPOS billings to be exempt from accreditation requirements until the Secretary of HHS develops pharmacy-specific standards. *(Sec. 3109)* DMEPOS Competitive Acquisition Program. Expands round 2 of the DME Competitive Bidding program to the next 21 largest metropolitan statistical areas. For competitively bid covered items furnished on or after January 1, 2016, areas must either competitively bid or use competitive bid prices. *(Sec. 6410)*	
Provisions Related to Medicare Parts A and B	Home Health (HH) Market Basket Update. Reduces market basket updates for home health providers by 1 percent in 2011, 2012, and 2013. This reduction is in addition to the productivity adjustment (see Part A market baskets updates) to which home health providers would be subject beginning in 2015 *(Sec. 3401(e))* Payment Adjustments for Home Health Care. Directs the Secretary to improve	

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	payment accuracy through rebasing home health payments starting in 2014 and phased in over four years with a 3.5 percent per year limitation on reductions based on an analysis of the current mix of services and intensity of care provided to home health patients. Effective in 2011, the provision would also establish a 2.5 percent per agency and 10 percent aggregate cap on outlier payments and would reinstate a 3 percent per episode add-on payment for rural home health providers from April 1, 2010 through 2015. In addition, it would require the Secretary to submit a report to Congress by March 1, 2011 on recommended payment reforms related to serving patients with varying severity of illness or to improve beneficiary access to care. *(Sec. 3131)* Study Improving Access to Home Health. Directs the Secretary of HHS to study improving access to home health care for certain patients, including those with high-severity levels of illness, low-income and living in underserved areas, and provides the Secretary authority to conduct a demonstration program based on the results of the study. The amendment allocates $500 million for the period of FY 2015 through 2018 to conduct the study and design, implement, and evaluate the demonstration. Protecting and Improving Guaranteed Medicare Benefits. Provides that nothing in the Act shall result in a reduction of guaranteed benefits under Medicare. Requires that savings generated for Medicare under the Act to be used to: extend the solvency of the Medicare trust funds; reduce Medicare premiums and other cost-sharing for beneficiaries; and improve or expand guaranteed Medicare benefits and protect access to Medicare providers *(Sec. 10303)* [Added by Bennet Amendment 2826]	
Medicare Advantage Reforms – Payment and Administration	Medicare Advantage (MA) Payment. Establishes a competitive basis for setting MA benchmarks. Phases in use of "competitive benchmarks" (weighted average of the unadjusted MA statutory non-drug monthly bid amount for each MA plan in the area) starting in 2012. MA competitive benchmarks would be used alone starting in 2015 after a 4 year transition during which the competitive benchmark would be blended with current benchmarks. Requires the Secretary to compute an MA competitive benchmark amount equal to the weighted average of the unadjusted MA statutory non-drug monthly bid amount for each plan in the area. (Data used for implementing this section will be from 2009.) Creates performance bonus payments based on a plan's level of care coordination and care management and achievement. Creates performance bonus payments for quality performance. Provides special rules for MA plans offered in specified areas. Provides for transitional extra benefits in MSAs and counties where extra benefits currently offered are relatively high. *(Sec. 3201)* Benefit Protection and Simplification. Prohibits MA plans from charging beneficiaries cost sharing for chemotherapy, dialysis services, skilled nursing care, and other designated service that is greater than that charged under FFS Medicare. Effective in 2011. Requires that plans that provide extra benefits give priority to: cost sharing reductions, wellness and preventive care, and lastly benefits not covered under Medicare. *(Sec. 3202)* Application of Coding Intensity Adjustment during MA Payment Transition. Requires the Secretary to incorporate analysis of the coding intensity adjustment in risk scores for 2011, 2012, and 1213. *(Sec. 3203)* Simplification of Annual Beneficiary Election Periods. Provides an annual 45 day period for beneficiaries to disenroll from MA plans and elect to enroll in FFS Medicare. Allows beneficiaries to disenroll from a MA plan and return to FFS	Medicare Advantage (MA) Payments. Repeals sections 3201 and 3203 of the PPACA (competitively bid MA benchmarks and coding intensity adjustment during transition). For most areas, phases in modified MA benchmarks based on Medicare fee-for-service (FFS) rates: freezes MA payments in 2011; in 2012, sets the MA base payment amount at FFS levels for the area and sets 2012 benchmarks as the sum of ½ of the former local benchmark amount plus ½ of the new benchmark; in 2013, fully implements new benchmarks. New benchmarks are the product of the base payment amount (100 percent of FFS for the area) and a percentage that varies as follows: 95 percent for the highest cost quartile of areas, 100 percent for the second

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	Medicare from January 1 to March 15 of each year. *(Sec. 3204)* Extension for Specialized MA Plans for Special Needs Individuals. Extends the SNP program until 2014. Allows the Secretary to apply a frailty payment adjustment to fully-integrated, dual-eligible SNPs that enroll frail populations. Requires the Secretary to transition beneficiaries enrolled in SNPs that do not meet statutory target definitions by 2013. Provides a temporary extension of authority to dual-eligible SNPs and requires such plans to be National Committee for Quality Assurance (NCQA) approved and to contract with State Medicaid programs beginning 2013. Requires an evaluation of MA risk adjustment for special needs individuals with chronic health conditions. *(Sec. 3205)* Extension of Reasonable Cost Contracts. Extends reasonable cost contracts to January 1, 2013. *(Sec. 3206)* Technical Correction to MA Private FFS plans. Extends applicability of the 2008 service area extension waver for MA coordinated care plans to employers that contract directly with MA. *(Sec. 3207)* Making Senior Housing Facility Demonstration Permanent. Allows MA plans that operate in continuing care retirement communities and provide specified services to continue to operate under the MA program. *(Sec. 3208)* Authority to Deny Plan Bids. Beginning in 2011, authorizes the Secretary to deny bids submitted by MA plans that propose to significantly increase beneficiary cost sharing or decrease benefits. *(Sec. 3209)* Development of New Standards for Certain Medigap Plans. Requires the Secretary to request NAIC revisions to the standards for benefit packages classified as "C" and "F" so that these packages include nominal cost sharing that encourages the use of appropriate Part B physician services. *(Sec. 3209)*	highest cost quartile, 107.5 percent for the third highest quartile and 115 percent for the lowest cost quartile. Provides alternative phase-in periods for certain areas: a 4-year phase-in for areas in which the new benchmark methodology would have reduced the benchmark by $30-$50; a 6-year phase-in for areas in which the new benchmark methodology would have reduced the benchmark by at least $50. Caps total payments, including bonuses at current MA payment levels. Beginning in 2012, provides quality-based bonus payments to plans receiving 4 or more stars on a 5-star scale based on data currently collected. Provides for a 1.5 percent bonus in 2012; a 3 percent bonus in 2013; and a 5 percent bonus in 2014 and subsequent years. Provides for double bonuses for qualifying plans in qualifying counties. For plan years 2012-2014, phases in a modified beneficiary rebate system based on quality scores. As of 2014, plans with a quality rating of at least 4.5 stars can offer rebates (as offered now, in the form of additional benefits, reduced cost sharing, etc.) of 70 percent of the difference between the benchmark and the bid; for plans with 3.5-4.5 stars, 65 percent; and for plans with less than 3.5 stars, 50 percent. Extends indefinitely CMS authority to adjust risk scores in MA for observed differences in coding patterns relative to fee-for-service. Repeals the comparative cost adjustment program as added by the Medicare Modernization

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		Act *(Sec. 1102)* Savings from Limits on MA Plan Administrative Costs. Beginning with contract year 2014, requires MA plans that do not have a medical loss ratio (MLR)—the percentage of total revenue spent on medical costs or activities that improve quality of care, rather than profit and overhead—of at least 85 percent for a contract year to remit to the Secretary the difference between the plan's MLR and 85 percent; for plans that do not have an 85 percent MLR for 3 consecutive contract years, prevents new enrollment in the plan; requires the Secretary to terminate the plan contract if the plan fails to have an 85 percent MLR for 5 consecutive contract years. *(Sec. 1103)*
Medicare Advantage Reforms – Beneficiary Protection and Anti-Fraud	No Cuts in Guaranteed Benefits. Provides that nothing in the Act shall result in the reduction or elimination of any benefits guaranteed by law to participants in Medicare Advantage plans. *(Sec. 3602)* [Added by Stabenow Amendment 2899]	
Medicare Advantage Reforms – Treatment of Special Needs Plans		
Medicare Part D	Medicare Coverage Gap Discount Program. As a condition of coverage of a drug under Part D, requires drug manufacturers to participate in the Medicare coverage gap discount program, to enter into and have in effect an agreement under the program, and have entered into and have in effect a contract with a third party with which the Secretary has entered into a contract to administer the program. Under the program, manufacturers must agree to provide a 50 percent discount (off the manufacturer's negotiated price) to Part D beneficiaries at the point of sale (or if between July 1, 2010 and December 31, 2011 it is not practicable, then as soon after the point of sale as is practicable) for brand-name drugs and biologics purchased during the coverage gap. Agreements will be effective for an initial period of not less than 18 months and shall be automatically renewed for a period of not less than 1 year unless terminated by the Secretary or the manufacturer for specific reasons. The Secretary shall establish the discount program no later than July 1, 2010. For an agreement to be effective on July 1, 2010 and ending on December 31, 2011, the manufacturer must enter the agreement by May 1, 2010. For 2012 and subsequent years, the agreement must be renewed by January 30 of the preceding year. Applies civil monetary penalties on manufacturers that fail to provide the applicable discounts. *(Sec. 3301)*	Closing the Medicare Prescription Drug "Donut Hole." For 2010, creates a one-time $250 coverage gap rebate for beneficiaries who have incurred costs for coverage of Part D drugs and who have exceeded the initial coverage limit. This credit would be paid from the Medicare Prescription Drug Account. Repeals Sec. 3315 of the Senate bill (on immediate reduction in coverage gap for 2010). Delays implementation dates for the coverage gap discount program under the Senate bill from July 1, 2010 to January 1, 2011.

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	Immediate Reduction in Coverage Gap for 2010. Increases the initial coverage limit in the standard Part D benefit by $500 for 2010 (but not for subsequent years). Requires the Secretary to establish procedures to fully reimburse PDP sponsors and MA-PD sponsors for the reduction in beneficiary cost sharing associated with the increased coverage limit. *(Sec. 3315)* Improved Information for Subsidy-Eligible Individuals Reassigned to Prescription Drug Plans and MA–PD Plans. Requires HHS, beginning in 2011, to transmit within 30 days of a subsidy-eligible beneficiary being automatically reassigned to a new Part D low-income subsidy plan information on formulary differences between the former and the new plan and information on the coverage determination, exception, appeal and grievance processes. *(Sec. 3305)* Improving Formulary Requirements for Prescription Drug Plans and MA–PD Plans with Respect to Certain Categories or Classes of Drugs. Effective for plan year 2011 and after, codifies the current six classes of clinical concern (anticonvulsants, antidepressants, antineoplastics, antipsychotics, antiretrovirals and immunosuppressants for treatment of transplant rejection), removes the criteria specified in section 176 of MIPPA that would have been used by HHS to identify protected classes of drugs, and gives the Secretary authority to identify classes of clinical concern and exceptions to such classes through rulemaking. *(Sec. 3307)* Reducing Part D Premium Subsidy for High-Income Beneficiaries. Reduces the Part D premium subsidy for beneficiaries with incomes above the Part B income thresholds. *(Sec. 3308)* Elimination of Cost Sharing for Certain Dual-Eligible Individuals. Effective no earlier than January 1, 2012, eliminates cost sharing for beneficiaries receiving care under a home and community-based waiver program who would otherwise require institutional care. *(Sec. 3309)* Reducing Wasteful Dispensing of Outpatient Prescription Drugs in Long-Term Care Facilities Under Prescription Drug Plans and MA-PD plans. Requires Part D plans to develop uniform drug dispensing techniques to reduce prescription drug waste in long-term care facilities associated with 30-day fills. Effective for plan years beginning on or after January 1, 2012. *(Sec. 3310)* Improved Medicare Prescription Drug Plan and MA–PD Plan Complaint System. Requires the Secretary to develop and maintain a widely known and easy to use plan complaint system to collect and maintain complaints regarding Medicare Advantage and Part D plans or their sponsors. Requires the Secretary to develop a model electronic complaint form to be prominently displayed on Medicare.gov. Requires the Secretary to report annually to Congress on the system. *(Sec. 3311)* Uniform Exceptions and Appeals Process for Prescription Drug Plans and MA–PD plans. Requires Part D plans to use a single, uniform exceptions and appeals process with respect to the determination of prescription drug coverage for an enrollee under the plan and to provide instant access to such process through a website and toll-free number. Effective for exceptions and appeals after January 1, 2012. *(Sec. 3312)* Office of the Inspector General Studies and Reports. Requires the OIG to conduct a study comparing prescription drug prices paid under the Medicare Part D program to those paid under State Medicaid programs for the 200 most frequently dispensed covered part D drugs and covered outpatient drugs (as defined under the Medicaid statute) and assessing the impact of any financial discrepancies on the federal	Delays the deadline for manufacturer agreements to 30 days after the establishment of a model agreement. Increases government subsidies through a coinsurance requirement to provide coverage for generic drugs in the coverage gap; the "generic-gap coinsurance percentage" would be 93 percent 2011, decreased by 7 percentage points in years 2012-2019, and the amount would be 25 percent in 2020 and beyond. Creates government subsidies for the negotiated price of covered branded part D drugs; the applicable gap percentage is phased in as follows: 97.5 percent for 2013-2014; 95 percent for 2015-2016; 90 percent for 2017; 85 percent for 2018; 80 percent for 2019; and 75 percent for 2020 and subsequent years. *(Sec. 1101)*

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	government and enrollees. Requires the Secretary to conduct a study and annual report on part D formularies' inclusion of drugs commonly used by dual-eligibles. *(Sec. 3313)* 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. Allows drugs provided to beneficiaries by AIDS Drug Assistance Programs or the Indian Health Service to count toward the annual out-of-pocket threshold, effective January 1, 2011. *(Sec. 3314)* Improvement in Part D Medication Therapy Management (MTM) Programs. Beginning with plan years that begin on or after 2 years after enactment, Part D prescription drug plan sponsors would be required to offer MTM services to targeted beneficiaries, including an annual comprehensive review of medications (either in person or through telehealth technology) by a licensed pharmacist or other qualified provider, which may result in an action plan; a written summary of the review in a standardized format; and follow-up interventions as warranted based on the findings of the review. Sponsors would be required to assess on at least a quarterly basis the medication use of individuals who are at risk but not enrolled in the MTM program. Plans must also enroll beneficiaries who qualify on a quarterly basis and allow for opt out. *(Sec. 10328)*	
Medicare Rural Access Protections	Extension of Outpatient Hold Harmless Provision. Extends the existing outpatient hold harmless provision through the end of FY2010 and would allow Sole Community Hospitals with more than 100 beds to also be eligible to receive this adjustment through the end of FY2010. (*Sec. 3121)* Extension of Medicare Reasonable Costs Payments for Certain Clinical Diagnostic Laboratory Tests Furnished to Hospital Patients in Certain Rural Areas. Reinstates the policy included in the Medicare Modernization Act of 2003 (P.L. 108-173) that provides reasonable cost reimbursement for laboratory services provided by certain small rural hospitals from July 1, 2010 to July 1, 2011. *(Sec. 3122)* Extension of the Rural Community Hospital Demonstration Program. Extends the program for five years and expands eligible sites to additional States and additional rural hospitals. Adjusts the calculation of payments within the demonstration program. *(Sec. 3123)* Extension of the Medicare-dependent hospital (MDH) program. Extends the Medicare-dependent hospital program by one year through October 1, 2012. It would also require HHS to study whether certain urban hospitals should qualify for the MDH program. *(Sec. 3124)* HHS Study on Urban Medicare-Dependent Hospitals. Requires the Secretary to conduct a study on the need for additional Medicare payments for certain urban Medicare-dependent hospitals paid under the inpatient prospective payment system. *(Sec. 3142)* Temporary Improvements to the Medicare Inpatient Hospital Payment Adjustment for Low-Volume Hospitals. Expands the program providing a temporary adjustment to inpatient hospital payments for certain low-volume hospitals (threshold of 1,600 Medicare Part A discharges) through FY2012 and would modify eligibility requirements regarding distance from another facility and number of eligible discharges. *(Sec. 3125)*	

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	Improvements to the Demonstration Project on Community Health Integration Models in Certain Rural Counties. The Medicare Improvements for Patients and Providers Act (MIPPA, P.L. 110-275) authorized a demonstration project that will allow eligible rural entities to test new models for the delivery of health care services in rural areas. This provision will expand the demonstration to allow additional counties to participate and will also allow physicians to participate in the demonstration project. (*Sec. 3126)* MedPAC Study on Adequacy of Medicare Payments for Health Care Providers Serving in Rural Areas. This provision would require MedPAC to review payment adequacy for rural health care providers serving the Medicare program, including an analysis of the rural payment adjustments included in this legislation and beneficiaries' access to care in rural communities. *(Sec. 3127)* Technical Correction Related to Critical Access Hospital Services. This provision clarifies that CAHs can continue to be eligible to receive 101 percent of reasonable costs for providing outpatient care regardless of eligible billing method the facility uses and for providing qualifying ambulance services. *(Sec. 3128)* Extension of and Revisions to Medicare Rural Hospital Flexibility Program. This provision extends the Flex Grant program through 2012 and will allow Flex Grant funding to be used to support rural hospitals' efforts to implement delivery system reform programs, such as value-based purchasing programs, bundling, and other quality programs. (*Sec. 3129)* Protections for Frontier States. Starting in fiscal year 2011, for hospitals and physicians located in states in which at least 50 percent of the counties in the state are frontier (i.e. less than 6 people per square mile), establishes a hospital wage index floor of 1.00, a hospital outpatient department wage adjustment factor floor of 1.00, and a geographic practice expense floor for physician services of 1.00. The 1.00 floor would not apply to hospitals or services in a state that receives a non-labor related adjustment (Alaska and Hawaii). *(Sec. 10324)* Rural Physician Training Grants. Directs the Secretary, acting through HRSA, to establish a grant program for purposes of assisting eligible entities in recruiting students mostly likely to practice 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 rural communities. Appropriates $4,000,000 for each of the FYs 2010 through 2013. *(Sec. 10501(l))*	
Medicare Provisions for Low-Income Beneficiaries	Improvement in determination of Medicare part D low-income benchmark premium. Removes Medicare Advantage rebates and quality bonus payments from the calculation of the low-income subsidy benchmark. *(Sec. 3302)* Voluntary de minimis policy for subsidy-eligible individuals under prescription drug plans and MA–PD plans. Allows Part D plans that bid a nominal amount above the regional low-income subsidy (LIS) benchmark to absorb the cost of the difference between their bid and the LIS benchmark in order to remain a $0 premium LIS plan. Authorizes the Secretary to auto-enroll subsidy eligible individuals in plans that waive de minimis premiums. Effective date January 1, 2011. *(Sec. 3303)* Special rule for widows and widowers regarding eligibility for low-income assistance. Allows the surviving spouse of an LIS-eligible couple to delay LIS redetermination for one year after the death of a spouse. Effective date January 1,	

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	2011. *(Sec. 3304)* 5-Year Period for Demonstration Projects. Clarifies that Medicaid demonstration authority for coordinating care for dual eligibles may extend for a 5-year period. Projects may be extended for additional 5-year periods unless the Secretary determines otherwise. *(Sec. 2601)* Providing Federal Coverage and Payment Coordination for Dual Eligible Beneficiaries. Establishes the Federal Coordinated Health Care Office (CHCO) within CMS no later than March 1, 2010. The CHCO would report directly to the CMS Administrator. CHCO would bring together officials of the Medicare and Medicaid programs to (1) more effectively integrate benefits under the Medicare and Medicaid programs, and (2) improve the coordination between the Federal and state governments for individuals eligible for benefits under both such programs in order to ensure that such individuals get full access to the items and services to which they are entitled. Requires the Secretary to submit an annual report to Congress with recommendations for legislation that would improve care coordination and benefits for DEs. *(Sec. 2602)* Medicare Federally Qualified Health Center Improvements. Directs the Secretary of Health and Human Services to develop and implement a prospective payment system (PPS) for Medicare-covered services furnished by Federally Qualified Health Centers (FQHCs). The Secretary of HHS shall vary payments to FQHCs based on the type, duration, and intensity of services they deliver. Establishes an annual FQHC market basket update. Additionally, adds Medicare-covered preventive services to the list of services eligible for reimbursement when furnished by an FQHC. *(Sec. 5502)* Funding Outreach and Assistance for Low-Income Programs. Provides $45 million for outreach and education activities to State Health Insurance Programs, Administration on Aging, Aging Disability Resource Centers and the National Benefits Outreach and Enrollment. *(Sec. 3306)*	
Medicare Beneficiary Improvements-Reducing Health Disparities		
Medicare - Miscellaneous Improvements	Establishment of Center for Medicare and Medicaid Innovation within CMS. Establishes within the Centers for Medicare and Medicaid Services (CMS) a Center for Medicare & Medicaid Innovation. The purpose of the Center will be to research, develop, test, and expand innovative payment and delivery arrangements (models) to improve the quality and reduce the cost of care provided to patients in each program. For purposes of testing payment and service delivery models, the Secretary may limit testing of a model to a certain geographic area. Successful models can be expanded nationally. (Successful models are those that improve patient care without increasing spending,. Specifies that the Secretary should focus on models that improve the quality of patient care and reduce spending.) Specifies a number of models to be tested but does not limit testing to these models. The Center would be required to conduct an evaluation of each model tested, including an analysis of (i) the quality of care furnished under the model, including the measurement of patient-level outcomes and patient-centeredness criteria determined appropriate by the Secretary; and (ii) the changes in spending by reason of the	

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	model. Requires the Secretary to select measures that reflect national priorities for quality improvement and patient-centered care for purposes of evaluating the models. The scope of the Innovation Center may include the Medicaid and CHIP programs, with the same requirements for testing and evaluation of patient-centered delivery and payment models that have shown evidence of success in Medicaid and CHIP populations as proposed for Medicare. The Center is exempted from budget-neutrality requirements for an initial testing period. Appropriates $5 million from the Treasury not otherwise appropriated for the design, implementation, and evaluation of models for DY 2010; and appropriates $10 billion for Center activities over 10 years. *(Sec. 3021)* Extension of Exceptions Process for Medicare Therapy Caps. Extends the process allowing exceptions to limitations on medically necessary therapy until December 31, 2010. *(Sec. 3103)* Revision to the Medicare Improvement Fund. Eliminates the remaining funds in the Medicare Improvement Fund. *(Sec. 3112)* Modernizing Computer and Data Systems of the Centers for Medicare & Medicaid Services to Support Improvements in Care Delivery. Requires the Secretary of HHS to develop a plan (and a detailed budget for the resources needed to implement such plan) to modernize the computer and data systems of the CMS to support improvements in care delivery. *(Sec. 10330)* Availability of Medicare Data for Performance Measurement. Effective January 1, 2012, authorizes the release and use of standardized extracts of Medicare Parts A, B and D claims data to qualified entities to measure the performance of providers and suppliers. Requires the Secretary to take necessary actions to protect beneficiaries' identity. Requires qualified entities to pay a fee equal to the cost of making the data available, which would be deposited in the Federal Supplementary Medical Insurance Trust Fund. *(Sec. 10332)* GAO Study and Report on Medicare Beneficiary Access to High-Quality Dialysis Services. Directs the Comptroller General to submit to Congress, within one year of enactment, a study on the impact on Medicare beneficiary access to high-quality dialysis services of the end stage renal disease prospective payment system, including an analysis of: the ability of providers of services and renal dialysis facilities to furnish specified oral drugs(drugs or biologicals for which there is no injectable equivalent or other non-oral form) or arrange for the provision of such drugs; their ability to comply with applicable state laws in order to furnish such drugs; whether appropriate quality measures exist to safeguard care for beneficiaries being furnished such drugs; and other appropriate areas. *(Sec. 10336)*	
Health Information Technology (HIT)	Health Information Technology Enrollment Standards and Protocols. Requires, within 180 days after enactment, the Secretary to develop standards and protocols, in consultation with the HIT Policy and Standards Committees, to promote the interoperability of systems for enrollment of individuals in Federal and State health and human services programs. These standards shall allow for electronic matching against federal and state data, simplification of electronic documentation, reuse of stored eligibility information, capability for individuals to apply, recertify and manage their information online, ability to expand enrollment system to integrate new programs, rules and functionalities, notification of eligibility, recertification and other communication, and other functionality to streamline the enrollment process. The Secretary may require State or other entities to incorporate such	

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	standards as a condition of receiving Federal health information technology funds. Provides grants for state and local government entities to develop new and adapt existing technology systems to implement the HIT enrollment standards and protocols developed under this section. *(Sec. 1561)* Elder Justice Act. Authorizes the Secretary to make grants to long-term care facilities for the purpose of assisting such entities in off-setting the costs related to purchasing, leasing, developing, and implementing certified EHR technology. The Secretary shall adopt electronic standards for the exchange of clinical data by long-term care facilities. No later than 10 years after enactment of the Act, the Secretary shall have procedures in place to accept the optional electronic submission of clinical data by long-term care facilities. For this program, along with other grant programs for the enhancement of long-term care, appropriates $20 million for FY 2011, $17.5 million for FY 2012, and $15 million for each of FYs 2013 and 2014. *(Sec. 6703 adding Sec. 2041)* Development of Standards for Financial and Administrative Transactions. Requires the Secretary to consult stakeholders and the National Committee on Vital and Health Statistics and the Health Information Technology Standards and Policy Committees to identify opportunities to create uniform standards for financial and administrative health care transactions, not already named under HIPAA, that would improve the operation of the health system and reduce costs. *(Sec. 10109)*	
Comparative Effectiveness Research (CER)	Patient-Centered Outcomes Research Institute. Establishes a private, non-profit corporation to assist providers, payers, and policy makers in making informed health decisions. Research conducted would be comparative clinical effectiveness research, which is research that evaluates and compares the health outcomes and clinical effectiveness, risks, and benefits of two or more medical treatments, services, or items. Defines treatment, services, and items as: health care interventions, protocols for treatment, care management and delivery, procedures, medical devices, diagnostic tools, pharmaceuticals (including drugs and biologics), integrative health practices, and any strategies or items used in the treatment, management, diagnosis, or prevention of illness or injury in patients. *(Sec. 6301)* Establishes the duties of the Institute, which will be to: (1) identify research priorities and establish a research agenda, (2) carry out the research project agenda, (3) collect appropriate data from CMS, (4) appoint advisory panels, (5) support patient and consumer representatives, (6) establish a methodology committee, (7) provide for a peer-review process for primary research, (8) release research findings, (9) adopt priorities, standards, processes, and protocols, and (10) submit annual reports to Congress, the President, and the public. *(Sec. 6301)* Administration of the Institute. Establishes a 19-member Board of Governors for the Institute. The Directors of AHRQ and the NIH will serve on the Board, and 17 other members will be appointed by the Comptroller General of the GAO and will represent a broad array of health care stakeholders. Members would serve six-year staggered terms and could serve no more than two terms. Board members could not delegate the following duties: identifying research priorities, establishing the research project agenda, and adopting national priorities, methodological standards, and peer review processes. *(Sec. 6301)* Research of the Institute. Tasks the Institute with identifying national priorities for comparative clinical effectiveness research and establishing a research project agenda. Requires the Institute to use the following methods to provide for the conduct of research and synthesis of evidence: (1) systematic reviews and	

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	assessments of existing evidence; (2) primary research, such as randomized clinical trials, molecularly informed trials, and observational studies and; (3) any other methodologies recommended by the methodology committee and adopted by the Board. *(Sec. 6301)* Dissemination of Research. The Office of Communication and Knowledge Transfer at AHRQ, in consultation with the NIH, will broadly disseminate research findings. *(Sec. 6301)* Capacity for Research. AHRQ, in consultation with NIH, will build capacity for comparative clinical effectiveness research by establishing a grant program that provides for the training of researchers. Secretary shall also provide for the coordination of relevant Federal health programs to build data capacity for comparative clinical effectiveness research (including the development and use of clinical registries and health outcomes research data networks). *(Sec. 6301)* Addressing Subpopulations. Specifies that patient subpopulations will be considered during the research. *(Sec. 6301)* Institute Contracts. Allows the Institute to enter into contracts with Federal agencies or with private sector research or study-conducting entities for the management and conduct of research. Preference shall be given to AHRQ and the NIH. Requires that each entity under contract with the Institute abide by transparency and conflict of interest requirements, comply with adopted methodological standards, consult with expert advisory panels for clinical trials, and rare disease, be allowed to submit original research for publication, have processes in place to manage data privacy and meet ethical standards, comply with the requirements of the Institute for making information available to the public, and comply with any other terms deemed necessary. Allows the researchers to publish their findings as long as it is consistent with Institute policies. *(Sec. 6301)* Advisory Panels. Requires the Institute to appoint expert advisory panels to assist in identifying research priorities and establishing the research project agenda. Expert advisory panels could also assist in carrying out the research project agenda and could advise on the research question, design, or protocol of the study. Separate advisory panels would be appointed for studies on rare diseases. Representatives of each manufacturer of each medical technology could be included on panels where relevant. Also directs the Institute to provide training and ongoing education to enable patient and consumer representatives to participate in technical discussions. *(Sec. 6301)* Methodology Committee. Establishes a Methodology Committee, to be made up of no more than 15 individuals, who are experts in their scientific field, appointed by the Comptroller General of the GAO. (Directors of AHRQ and the NIH would be included as additional members.) Within eighteen months of enactment, the committee would determine a process to establish and maintain detailed methodological standards for comparative clinical effectiveness studies and to create a translation table that is designed to provide guidance to the Board when determining research methods that are most likely to address each specific research question. Allows the Committee to consult and contract with the IOM and academic, non-profit, or other private and governmental entities with relevant expertise in order to develop the methodological standards and to create the translation table. *(Sec. 6301)*	

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	Dissemination of Information. Within 90 days after the conduct or receipt of research findings, requires the Institute to disseminate the research findings to clinicians, patients, and the public in a comprehensible manner and form and prohibits any dissemination of research findings that would include practice guidelines, coverage recommendations, or policy recommendations. *(Sec. 6301)* Peer Review Process. The Institute shall ensure there is a process for the peer review of primary research. *(Sec. 6301)* Oversight. Requires the Institute to submit a yearly report to Congress, the President, and the public. Requires the Institute to undergo financial audits by a private entity and also grants several additional oversight responsibilities to the Comptroller General of the GAO. *(Sec. 6301)* Institute Transparency and Access. Requires the Institute to establish procedures to ensure transparency, credibility, and access through public comment periods, forums, public availability of information, and protocols for conflicts of interest. Requires conflicts of interest for any individual throughout the entire research process to be disclosed in the annual report and on the Internet web site of the Institute and the GAO. *(Sec. 6301)* Use of Institute Findings. Establishes that the Institute findings will not include coverage, reimbursement, or other policies for any public or private payer. *(Sec. 6301)* Limitations on the Use of Comparative Clinical Effectiveness Research. Prohibits the Secretary from: (1) denying coverage based solely on a study conducted by the Institute; (2) using the Institute's research in determining coverage, or creating reimbursement or incentive programs, for a treatment in ways that treat extending the life of an elderly, disabled, or terminally ill patient of lower value than extending the life of a person who is younger, non-disabled, or not terminally ill; (3) using the Institute's research in determining coverage, or creating reimbursement or incentive programs, for a treatment in a manner that precludes, or with intent to discourage, an individual from choosing a health care treatment based on how the individual values the tradeoff between extending the length of their life and the risk of disability. Also prohibits the Institute from developing or employing a dollars per quality adjusted life year (or similar measure) as a threshold to establish what health care is cost-effective or recommended. Does not limit the application of differential copayments based on factors such as cost or type of service nor does it prevent the Secretary from using evidence or findings from such research in determining coverage, reimbursement, or incentive programs based upon a comparison of the difference in the effectiveness of alternative health care treatments in extending an individual's life due to that individual's age, disability or terminal illness. *(Sec. 6301)* Patient-Centered Outcomes Research Trust Fund. Establishes the Patient-Centered Outcomes Research Trust Fund (PCORTF) to fund the Institute and its activities. Transfers from the general funds in the Treasury to the PCORTF the following amounts: $10 million in FY 2010, $50 million in FY 2011, $150 million in FY 2012, and $150 million for FYs 2013 through 2019. From the Medicare Federal Hospital Insurance and the Federal Supplemental Medical Trust Funds and from health insurance and self-insured health plans the following: (1) $1 multiplied by the average number of individuals enrolled in the plans (Medicare, health insurance policies, and self-insured policies) for FY 2013, and; (2) $2 (increased by annual	

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	medical inflation after FY 2014) multiplied by the average number of individuals enrolled in the plans for FY 2014 through FY 2019. Fees for health insurance and self-insurance policies would sunset after 2019. *(Sec. 6301)* Federal Coordinating Council for Comparative Effectiveness Research. Terminates the Federal Coordinating Council on the date of enactment of the Act. *(Sec. 6301)*	
Independent Payment Advisory Board	Independent Payment Advisory Board. Independent Payment Advisory Board. Creates a 15-member Independent Payment Advisory Board (IPAB) tasked with presenting Congress with comprehensive proposals to reduce excess cost growth and improve quality of care for Medicare beneficiaries. In years when Medicare costs are projected to be unsustainable, the Board's proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings. Congress would be allowed to consider an alternative provision on a fast-track basis. The Board would be prohibited from making proposals that ration care, raise taxes or Part B premiums, or change Medicare benefit, eligibility, or cost-sharing standards. The IPAB would be composed of 15 members appointed for 6-year terms by the President with the advice and consent of the Senate; the Secretary, CMS Administrator and HRSA Administrator would be ex officio non voting members. Appointed members would include individuals with national recognition for expertise in health finance and economics, actuarial science, health facility management and other related fields, including physicians/other health professionals, experts in pharmaco-economics or prescription drug benefit programs, employers, third party payers, and individuals skilled in health-related research and interpretation. The IPAB shall also include representatives of consumers and the elderly. The IPAB would be tasked with presenting proposals to the President by January 15 of each year (beginning with 2014) except in years in which the CMS Actuary determines that the Medicare per capita growth rate does not exceed the target per capita growth rate, or the projected percentage increase in the medical care category of the CPI is less than the projected increase in CPI-U, or (for 2019 or subsequent years) the per capita growth rate for national health expenditures exceeds the Medicare per capita growth rate. The manager's amendment requires the board to send proposals to the Congress at the same time they are sent to the President. Proposals shall include recommendations that would reduce Medicare spending by targeted amounts compared to the trajectory of Medicare spending. The IPAB would be prohibited from presenting proposals that would ration care, increase revenues, or otherwise change Medicare beneficiary cost-sharing (including premiums), benefits, or eligibility standards. Proposals submitted prior to December 31, 2018 shall not include any recommendation that would reduce payment rates for items and services furnished before December 31, 2019 by providers of services and suppliers scheduled under the PPACA to receive a reduction to the inflationary payment updates in excess of a reduction due to productivity. The IPAB shall, as appropriate, include recommendations to reduce payments under Part C and Part D, such as through reductions in direct subsidies to MA-PDPs and PDPs related to administrative expenses for basic coverage, denying high bids or removing high bids for prescription drug coverage from the calculation of the national average monthly bid amount, and reductions to payments to MA plans related to administrative expenses and performance bonuses. If the projected Medicare per-capita growth rate exceeds the target per capita	

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	growth rate (for years prior to 2018, the projected 5-year average percentage increase in CPI-U and CPI-M), the Actuary shall establish a savings target equal to the product of the total projected Medicare program spending for the proposal year and the applicable percent (the lesser of either 0.5 percent for 2015, 1 percent for 2016, 1.25 percent for 2017 and 1.50 percent for 2018 and later, or the percentage by which the per capita growth rate exceeds the target growth rate). The IPAB would be required to submit a proposal that would reduce spending by the savings target. The manager's amendment expands the board to review, and make *non-binding recommendations* – even if Medicare spending is not increasing at a faster rate than the national health spending – 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 Medicare. Regardless of whether the IPAB submits a proposal as above for a given year, it may submit an advisory report on matters related to the Medicare program, including recommendations for improvements to payment systems not otherwise subject to the scope of the IPAB's recommendations. Such an advisory report would not be subject to rules of Congressional consideration. Beginning in 2020, the manager's amendment requires the board to make binding biennial recommendations to Congress if the growth in overall health spending exceeds growth in Medicare spending; such recommendations would focus on slowing overall health spending while maintaining or enhancing beneficiary access to quality care under Medicare. Establishes Congressional consideration procedures and administrative implementation procedures for IPAB proposals. In years when Medicare costs are projected to be unsustainable, the Board's proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings. Congress would be allowed to consider an alternative provision on a fast-track basis. Changes implemented as a result of this provision would not be subject to administrative or judicial review. Establishes a consumer advisory council (CAC), which would be composed of 10 consumer representatives appointed by GAO that would advise the IPAB on the impact of Medicare payment policies on consumers. The council would be subject to the Federal Advisory Committee Act. Requires the GAO, by July 1, 2015, to conduct a study on the effect of the IPAB's proposals. Specifically, the study would assess the effect of the IPAB's proposal on Medicare beneficiaries' access to providers, affordability of premiums and cost-sharing, and quality of care provided. Subsequent studies would be required. Prohibits reduction in Medicare outlays from being used to offset any non-Medicare outlays. *(Sec. 3403)*	
Follow-On Biologics	Short Title. The "Biologics Price Competition and Innovation Act of 2009." The Senate expresses that a biosimilars pathway balancing innovation and consumer interests should be established. *(Sec. 7001)* Approval Pathway for Biosimilar Biological Products. Establishes a process under	

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	which the Secretary is required to license a biological product that is shown to be biosimilar to, or interchangeable with, a licensed biological product (i.e., a reference product). Applies risk evaluation and mitigation strategies (REMS) to biological products. Prohibits the approval of an application as either biosimilar or interchangeable until 12 years from the date on which the reference product is first approved, or 12 years and 6 months if pediatric studies are conducted. If the Secretary determines that a biological is interchangeable to a reference product, such interchangeable product maintains exclusivity until the earlier of 1 year after the first commercial marketing of the product as interchangeable to the reference product; 18 months after a final court decision on all patent suits in an action against the applicant that submitted the initial application or the dismissal of such suit with or without prejudice; or 42 months after approval of the initial application if the applicant has been sued or 18 months after approval of the initial application if the applicant has not been sued. Beginning not later than October 1, 2010, the Secretary shall develop recommendations to Congress with respect to user fees for the review of biosimilar biological product applications. It is the sense of the Senate that based on the Secretary's recommendations Congress should authorize the collection of user fees as of October 1, 2012. If a reference product has been designated by the FDCA for a rare disease or condition (i.e., orphan drug), a biological product seeking approval for such disease or condition as a biosimilar to, or interchangeable with, such reference product may be licensed by the Secretary only after the expiration for such reference product of the later of – the 7-year period described under section 527(a) of the FDCA or the 12-year period described under section 351(k)(7). *(Sec. 7002)* Savings. The Secretary of the Treasury, in consultation with the Secretary of HHS, shall for each FY determine the amount of savings to the federal government as a result of these provisions. Such savings shall be used for deficit reduction. *(Sec. 7003)*	
Expansion of 340B Program	Expanded Participation in the 340B Program. Expands the list of covered entities eligible to receive discounted prices under the 340B Program. Specifically, this section amends Section 340B of the Public Health Service Act (PHSA) by adding the following entities to the list of covered entities eligible to participate in the 340B Program: (1) children's hospitals or a free-standing cancer hospital excluded form the Medicare prospective payment system and that would meet the requirements of current PHSA Section 340B(a)(4)(L) (which applies to certain hospitals that are government-owned/operated, have been formally granted governmental powers, or have government contracts to provide health care services to certain low-income individuals), including the requirement regarding the disproportionate share adjustment percentage if the hospital were a subsection (d) hospital; (2) critical access hospitals; and (3) an entity that is a rural referral center or a sole community hospital that would meet the requirements of current PHSA Section 340B(a)(4)(L)(i) and have a disproportionate share hospital percentage equal to or greater than 8 percent. Extends 340B discount to drugs used in connection with an inpatient or outpatient service provided by hospitals participating in the program. Prohibits group purchasing arrangements with respect to covered outpatient drugs. Specifically, the	Drugs Purchased by Covered Entities. Eliminates the Senate bill's expansion of the 340B program to inpatient drugs. Removes the Senate bill provision related to exemptions to the GPO exclusion (reverts to current law). Exempts orphan drugs from the expansion of the 340B program to new covered entities. *(Sec. 2302)*

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	bill removes the language currently found in PHSA Section 340B(a)(4)(L)(iii), which prohibits certain hospitals that are participating or seeking to participate in the 340B Program as covered entities from obtaining covered outpatient drugs through group purchasing organizations (GPOs) or other group purchasing arrangements. The bill retains this general prohibition in a new, separate provision of PHSA Section 340B, and this new provision applies not only to those hospitals to which the existing GPO prohibition currently applies but also to those children's hospitals, free-standing cancer hospitals, critical access hospitals, sole community hospitals, and rural referral centers that are eligible to purchase discounted drugs under the 340B Program pursuant to the language added to the PHSA by the Act. This prohibition does not apply to drugs purchased for inpatient use. Requires hospitals enrolled in the 340B Program to provide a credit on inpatient drugs to each state for the estimated annual costs of covered drugs provided to Medicaid recipients for inpatient use. Provides that enrolled hospitals shall have multiple options for purchasing covered drugs for inpatients, including through GPOs Provisions shall be effective as of January 1, 2010 and shall apply to drugs purchased on or after January 1, 2010. *(Sec. 7101)* Improvements to the 340B Program Integrity. Improves the integrity of the 340B Program by: (1) requiring the Secretary to carry out activities to increase compliance by manufacturers and covered entities with the requirements of the drug discount program; (2) establishing an administrative process to resolve claims by covered entities that have been overcharged for drugs purchased under the program and claims by manufacturers, after audits of violations of the program; (3) providing clarifications about the ceiling price used to sell to 340B participants; and (4) imposing civil money penalties. Appropriates the sums necessary for FY 2010 and each subsequent year. *(Sec. 7102)* GAO Study to Make Recommendations on Improving the 340B Program. Requires the GAO to make recommendations to congress within 18 months of the Act's enactment on improvements to the program. *(Sec. 7103)*	
Average manufacturer price (AMP)	Providing Adequate Pharmacy Reimbursement Limits. Changes the Federal Upper Limit (FUL) to no less than 175 percent of the weighted average (determined on the basis of utilization) of the most recent AMPs for pharmaceutically and therapeutically equivalent multiple source drugs available nationally through commercial pharmacies. Clarifies what transactions, discounts, and other price adjustments are included in the definition of AMP. Clarifies that retail community pharmacies do not include mail order, nursing home pharmacies, long-term care pharmacies, hospital pharmacies, clinics, charitable or non-profit pharmacies, government pharmacies, or pharmacy benefit managers. Specifies that the application of survey retail prices is only to retail community pharmacies. Clarifies the definition of wholesalers. Expands the disclosure requirement to include monthly weighted average AMPs and the average retail survey prices. Effective on the first day of the first calendar year quarter that begins at least 180 days after enactment of the Act. *(Sec. 2503)*	Closing the Medicare Prescription Drug "Donut Hole." Makes a conforming amendment to add discounts provided by manufacturers under the donut hole provisions to the list of exclusions of customary pay discounts and other payments from the definition of AMP. *(Sec. 1101)*
Medicaid Prescription Drug Rebates and Other Provisions	Increase in Minimum Rebate Percentage for Single Source Drugs and Innovator Multiple Source Drugs. Beginning January 1, 2010, the bill would increase the flat rebate percentage used to calculate Medicaid's basic rebate for outpatient single source and innovator multiple source prescription drugs from 15.1 percent to 23.1 percent (except for certain clotting factors and outpatient drugs that are approved by the Food and Drug Administration exclusively for pediatric indications, for which the basic rebate would increase to 17.1 percent). The bill would also limit total	Drug Rebates for New Formulations of Existing Drugs. Limits the application of the additional rebate for new formulations of existing drugs to line extensions of a single source drug or an innovator

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	rebate liability on an individual single source or innovator multiple source drug to 100 percent of AMP for that drug product. Additional revenue generated by this provision will be remitted to the federal government. Other features of the drug rebate program, such as Medicaid's best price provision, would remain unchanged. *(Sec. 2501(a),(e))* Increase in Rebate for Other Drugs. For non-innovator, multiple source drugs, the bill would increase the rebate from 11 percent to 13 percent of AMP beginning January 1, 2010. Additional revenue generated by this provision will be remitted to the federal government. *(Sec. 2501(b))* Extension of Prescription Drug Discounts to Enrollees of Medicaid Managed Care Organizations. The bill would require brand and generic manufacturers to pay rebates for beneficiaries who receive care under risk-based agreements similar to the way rebates are now required for fee-for-service (FFS) beneficiaries. Drug manufacturers would be required to pay the MCO rebates directly to states (as they do under FFS). Under this provision, the capitation rates paid to Medicaid MCOs must be based on the MCOs actual cost experience (including the drug rebate) and would be subject to Medicaid law covering actuarially sound rates. The MCOs would be required to report to the State information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed to individuals enrolled with the MCO. The bill would not prohibit MCOs from negotiating with manufacturers and wholesalers for rebates above Medicaid's statutory rebates. Covered outpatient drugs purchased through the 340B program by Health Maintenance Organizations (HMOs), including Medicaid MCOs, would not be subject to the Medicaid MCO rebates. *(Sec. 2501(c))* Additional Rebate for New Formulations of Existing Drugs. The bill would apply an additional rebate for new formulations of existing single source or innovator multiple source drugs paid for by a State after December 31, 2009. The rebate would be the greater of the basic rebate for the new drug or the product of: (1) the AMP for each dosage form and strength of the new formulation of the single source or innovator multiple source drug, (2) the highest additional rebate (calculated as a percentage of AMP) for any strength of the original single source or innovator multiple source drug, and (3) the total number of units of each dosage form and strength of the new formulation paid for by the state in the rebate period. However, new formulations of orphan drugs would be exempted (even if the exclusivity period has expired). *(Sec. 2501(d))* Elimination of Exclusion of Coverage of Certain Drugs. Removes smoking cessation drugs, barbiturates, and benzodiazepines from Medicaid's excluded drug list, effective January 1, 2014. *(Sec. 2502)*	multiple source drug that are an oral solid dosage form. *(Sec. 1206)*.
Other Drug-Related Issues	Labeling Changes. Amends the Federal Food, Drug, and Cosmetic Act with respect to requirements applicable to the labeling of generic drugs. *(Sec. 10609)*	
Bundling	National Pilot Program on Payment Bundling. Direct the Secretary to develop a national, voluntary pilot program encouraging hospitals, doctors, and post-acute care providers to improve patient care and achieve savings for the Medicare program through bundled payment models. Entities comprised of groups of providers including a hospital, a physician group, a SNF and a home health agency may apply to participate. Requires the Secretary to establish this program by January 1, 2013 for a period of five years. Before January 1, 2016, the Secretary is also required to submit a plan to Congress to expand the pilot program if doing so will result in improving (or not reducing) the quality of patient care and reducing spending.	

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	The Secretary would select ten conditions to be included in the program based on a number of enumerated factors. Additionally, the program may cover: acute care inpatient hospitalizations; physician services delivered inside and outside of the acute care hospital; outpatient hospital services, including emergency department visits; services associated with acute care hospital readmissions; PAC services; and other services the Secretary deems appropriate. The episode of care established in the pilot would start three days prior to a qualifying admission to the hospital and span the length of the hospital stay and 30 days following the patient discharge, unless the Secretary determines another timeframe is more appropriate. At any point after January 1, 2016, the HHS Secretary may expand the scope and duration of the pilot program if the pilot has reduced spending (without reducing quality) or improved quality and reduced spending. The manager's amendment also requires the Secretary to separately pilot test the continuing care hospital ("CCH") model. The CCH bundle could test bundling for conditions not included in the 10 selected by the Secretary and would include the stay in the CCH and 30 days post discharge. A continuing care hospital provides traditional services of an IRF, LTCH, and SNF under common management. (*Sec. 3023)* Demonstration Project to Evaluate Integrated Care Around a Hospitalization. Establishes a bundled payment demonstration project under Medicaid in up to eight states, which will begin on January 1, 2012 and end on December 31, 2016. Demonstration projects may be targeted to particular categories of beneficiaries, beneficiaries with particular diagnoses, or particular geographic regions. Participating hospitals will be required to establish robust discharge planning programs for Medicaid beneficiaries requiring post-acute care. Secretary shall submit a report to Congress within 1 year after the conclusion of the demonstration project. *(Sec. 2704)*	
Readmissions	Hospital Readmissions Reduction Program. Beginning in FY2012, this provision would adjust payments for hospitals paid under the inpatient prospective payment system based on the dollar value of each hospital's percentage of potentially preventable Medicare readmissions for the three conditions with risk adjusted readmission measures that are currently endorsed by the National Quality Forum. Also, provides the Secretary authority to expand the policy to additional conditions in future years and directs the Secretary to calculate and make publicly available information on all patient hospital readmission rates for certain conditions. *(Sec. 3025)* Community-Based Care Transitions Program. Beginning January 1, 2011 for a 5-year period, requires the Secretary to establish a program under which the Secretary would provide funding to hospitals and community-based entities that furnish evidence-based care transition services to Medicare beneficiaries at high risk for readmission. The legislation defines "high-risk Medicare beneficiary" as a beneficiary who has attained a minimum hierarchical conditions category score, as determined by the Secretary, based on a diagnosis of multiple chronic conditions or other risk factors associated with a hospital readmission or substandard transition into post-hospitalization care, which may include 1 or more of the following: cognitive impairment, depression, a history of multiple readmissions, any other chronic disease or risk factor as determined by the Secretary. *(Sec. 3026)*	
Quality Improvements	National Strategy. Requires the Secretary to establish and update annually a national strategy to improve the delivery of health care services, patient health outcomes, and population health. Requires consideration of the limitations set forth for use of	

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	comparative effectiveness research when establishing the National Strategy for Quality Improvement. Establishes, not later than January 1, 2011, a Federal health care quality internet website. *(Sec. 3011)* Interagency Working Group on Health Care Quality. Requires the President to convene an Interagency Working Group on Health Care Quality comprised of Federal agencies to collaborate on the development and dissemination of quality initiatives consistent with the national strategy, to avoid inefficient duplication of quality improvement efforts and resources, and to assess alignment of quality efforts in the public sector with private sector initiatives. *(Sec. 3012)* Quality Measure Development. Authorizes $75 million over 5 years for the development of quality measures at AHRQ and the Centers for Medicare and Medicaid Services (CMS). Quality measures developed under this section will be consistent with the National Strategy. The Secretary would identify, not less than triennially, gaps where no quality measures exist, or where existing measures need improvement consistent with the National Strategy and priorities. The Secretary would be required to develop: measures that would fill identified gaps by contracting with an entity that has expertise and capacity in the development and evaluation of quality measures; procedures in place to take into the account the view of payers or providers whose performance will be assessed by the measures and the views of other parties, such as consumers and health care purchasers; transparent policies regarding governance and conflicts of interest; and processes to collaborate with the qualified consensus-based entity. Requires the Secretary to develop and update (not less than every 3 years) provider-level outcome measures for hospitals and physicians. Outcome measures for the 5 most prevalent and resource-intensive acute and chronic medical conditions and for primary and preventative care will be developed. In addition, requires the Secretary to report on measures for hospital-acquired conditions currently used by CMS. *(Sec. 3013)* Clinical Practice Guidelines. Requires the Secretary to contract with the Institute of Medicine for the identification of existing and new clinical practice guidelines. *(Sec. 10303)* Quality Measurement. Provides $20 million to support the endorsement and use of endorsed measures by the HHS Secretary for use in Medicare, reporting performance information to the public, and in health care programs. Specifically, the Secretary would establish a pre-rulemaking process to obtain input from the consensus-based entity and multi-stakeholder group on the selection of quality and efficiency measures. By not later than December 1 each year, starting in 2011, the Secretary shall make public a list of measures being considered for selection with respect to Medicare reporting and payment systems. The Secretary may include measures that have and have not been endorsed by the consensus-based entity. Not later than February 1, the consensus-based entity must give the Secretary its recommendations regarding the proposed measures. The entity would convene the stakeholder group to consult on the recommendations. The entity would ensure an open and transparent process. *(Sec. 3014)* Data Collection; Public Reporting. Requires the Secretary to establish and implement an overall strategic framework to carry out the public reporting of performance information and to collect and aggregate consistent data on quality and resource use measures from information systems used to support health care delivery. *(Sec. 3015)*	

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	Adult Health Quality Measures. Directs the Secretary to develop an initial set of health care quality measures specific to adults who are eligible for Medicaid no later than January 1, 2012. No later than January 1, 2013 requires the Secretary, in consultation with the States, to develop a standardized format for reporting information based on the quality measures. Within 12 months after the release of the recommended measures (which are due for public comment by no later than January 1, 2011), requires the Secretary to establish the Medicaid Quality Measurement Program, which would expand upon existing quality measures, identify gaps in current quality measurement, establish priorities for the development and advancement of quality measures, and consult with relevant stakeholders. The Secretary, along with states, would regularly report to Congress the progress made in identifying quality measures and implementing them in each state's Medicaid program. *(Sec. 2701)* Payment Adjustment for Health Care-Acquired Conditions (HACs). Effective July 1, 2011, prohibits Federal payments to states for Medicaid services related to health care acquired conditions. The Secretary would define health care acquired conditions, consistent with the definition of hospital acquired conditions under Medicare, but would not be limited to conditions acquired in hospitals and would take into account the differences between the Medicare and Medicaid programs and their beneficiaries. The Secretary would also identify current state practices that prohibit payments for certain health care acquired conditions when implementing this provision. *(Sec. 2702)* Health Care Delivery System Research; Quality Improvement Technical Assistance. Enables the Director of AHRQ to identify, develop, evaluate, disseminate, and provide training in innovative methodologies and strategies for quality improvement practices in the delivery of health care services that represent best practices in health care quality, safety, and value. Directs the Director to implement a model to carry out such research in connection with other related federal agencies. The Center for Quality Improvement and Patient Safety (the "Center") of the AHRQ, or any relevant agency designated by the Director, shall carry out and support such research through grants. The Center's research findings shall be disseminated to the public and shared with the Office of the National Coordinator to inform the activities of the health information technology extension program (section 3012), as well as any relevant standards, certification criteria, or implementation specifications. Appropriates $20,000,000 for FYs 2010 through 2014. Establishes technical assistance grants for eligible entities to assist health care providers, and implementation grants for eligible entities, to adopt the quality improvement models and practices identified by the Center's research in the delivery of health care. *(Sec. 3501)* Establishing Community Health Teams to Support the Patient-Centered Medical Home. Directs the Secretary to establish a program to provide grants to or enter into contracts with eligible entities that can establish community-based interdisciplinary, interprofessional teams to support primary care practices, including obstetrics and gynecology practices, within the hospital services areas served by the entities. Participating entities shall submit to the Secretary a report that describes and evaluates the activities carried out by the entity. *(Sec. 3502)* Medication Management Services in Treatment of Chronic Disease. Requires the Secretary, acting through the Patient Safety Research Center, to establish a program to provide grants or contracts to eligible entities to implement medication	

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	management ("MTM") services provided by licensed pharmacists, as a collaborative, multidisciplinary, interprofessional approach to the treatment of chronic diseases for "targeted individuals." "Targeted individuals" include those who take 4 or more medications, take any high risk medications, have 2 or more chronic diseases, and present with factors that are likely to create a high risk of medication-related problems. The goal of the program is to improve the quality of care and to reduce the overall cost in the treatment of such diseases. The program would begin no later than May 1, 2010. Participating entities shall report to the Secretary on their activities. Directs the Secretary to report to Congress. *(Sec. 3503)* Program to Facilitate Shared Decision-Making. Establishes a program at HHS to facilitate collaborative processes between patients, caregivers, or authorized representatives, and clinicians that engages the patient, caregiver or authorized representative in decision-making; provides patients, caregivers or authorized representatives with information about trade-offs among treatment options; and facilitates the incorporation of patient preferences and values into the medical plan. The program would develop, test, and disseminate educational tools for providers to assist patients, caregivers, and authorized representatives with decision-making. Appropriates such sums necessary for FY 2010 and each subsequent FY. *(Sec. 3506)* Presentation of Prescription Benefit and Risk Management. Directs the Secretary, acting through the Commissioner of the FDA, to determine whether the addition of quantitative summaries of the benefits and risks of prescription drugs in a standardized format (e.g., a drug facts box) to the promotional labeling or print advertising of such drugs would improve health care decision-making by clinicians, patients and consumers. The Secretary shall review all available scientific evidence and research on decision-making and social and cognitive psychology and consult with drug manufacturers, clinicians, patients, and consumers. Not later than 1 year after the Act's enactment, the Secretary shall report to Congress on its review. If the Secretary determines such additional information would improve health care decision-making by clinicians, patients, and consumers, not later than 3 years after submission of its report, the Secretary shall promulgate proposed regulations accordingly. (*Sec. 3507)* Demonstration Program to Integrate Quality Improvement and Patient Safety Training and Clinical Education of Health Professionals. Permits the Secretary to award grants to eligible entities or consortia to carry out demonstration projects to develop and implement academic curricula that integrates quality improvement and patient safety in the clinical education of health professionals. Directs Secretary to report to Congress not later than 2 years after the Act's enactment and, annually thereafter. *(Sec. 3508)* Patient Navigator Program. Reauthorizes demonstration programs to provide patient navigator services through 2015. Appropriates $3,500,000 for FY 2010 and the sums necessary for FYs 2011 through 2015. *(Sec. 3510)* Authorization of Appropriations. Except where otherwise provided or amended, appropriates the necessary sums to carry out the quality improvement provisions in sections 3501-3510. *(Sec. 3511)* Quality Reporting for Psychiatric Hospitals. Creates a quality measure reporting program for psychiatric hospitals. Requires the Secretary to publish the measures	

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	selected no later than October 1, 2012, and the program will begin in RY 2014. Psychiatric hospitals not submitting data will experience a reduction in their annual update. *(Sec. 10322)*	
Medical Home/ Chronic Disease	State Option to Provide Health Homes for Enrollees with Chronic Conditions. Creates a new Medicaid state plan option under which enrollees with at least two chronic conditions, or with one chronic condition and at risk of developing another, or with at least one serious and persistent mental health condition, could designate a provider, a team of health care professionals, or a health team as their health home. Qualifying providers would have to meet certain standards established by the Secretary, including demonstrating that they have systems and infrastructure in place to provide comprehensive and timely high-quality care either in-house or by contracting with a team of health professionals. The designated provider or team would offer comprehensive care management; care coordination and health promotion; comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; patient and family support; referral to community and social support services, if relevant; and as feasible use health information technology to link such services. Teams of providers could be a free-standing, virtual, or hospital-based, community health center, community mental health center, clinic, physician's office, or physician group practice. Designated providers would be required to report to the state on all applicable quality measures in the state Medicaid program. The state would develop a mechanism to pay the health home and the state plan amendment would include a plan for tracking avoidable hospital readmissions and a plan for producing savings resulting from improved chronic care coordination and management. When appropriate the state will consult and coordinate with the Substance Abuse and Mental Health Services Administration specifically in addressing the prevention and treatment of mental illness and substance abuse. Provides an enhanced match of 90 percent FMAP for 2 years for states that take the option. Small planning grants may be available to help states intending to take the option. FMAP rules would apply. Requires the Secretary to survey states and report to Congress on the nature, extent, and use of this option, particularly as it pertains to hospital admission rates, chronic disease management, and coordination of care for the chronically ill. The state option would be available beginning on January 1, 2011. An independent evaluation of the impact of this option on reducing hospital admissions, emergency room visits, and admissions to skilled nursing facilities would be conducted. *(Sec. 2703)* Independence at Home Demonstration Program. Creates a new demonstration program to begin not later than January 1, 2012, for chronically ill Medicare beneficiaries to test a payment incentive and service delivery system that utilizes physician and nurse practitioner directed home-based primary care teams aimed at reducing expenditures and improving health outcomes. Appropriates $5 million for each of fiscal years 2010 through 2015. *(Sec. 3024)*	
Emergency/ Trauma Care	Trauma Care Centers and Service Availability. Directs the Secretary to establish 3 programs to award grants to qualified public, nonprofit Indian Health Services, Indian tribal, and urban Indian trauma centers to strengthen the country's trauma care by, for example, assisting in defraying substantial uncompensated care costs. Appropriates $100,000,000 for FY 2009 and sums necessary for FYs 2010 through 2015.	

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	Establishes grants to the states to promote universal access to trauma care provided by trauma centers and trauma-related physician specialties. Appropriates $100,000,000 for FYs 2010 through 2015. *(Sec. 3505)* Design and Implementation of Regionalized Systems for Emergency Care. Directs the Secretary, acting through the Assistant Secretary for Preparedness and Response, to award not fewer than 4 multi-year contracts or competitive grants to eligible entities to support pilot projects that design, implement, and evaluate innovative models of regionalized, comprehensive, and accountable emergency care and trauma systems. Participating entities shall report to the Secretary not later than 90 days after completion of a pilot project. The Secretary shall disseminate findings to the public and Congress, as appropriate. Appropriates $24,000,000 for FYs 2010 through 2014 for such programs. Requires the Secretary to support emergency medical research, including pediatric emergency medical research conducted by federal agencies. Appropriates the sums necessary for FYs 2010 through 2014 for such research. *(Sec. 3504)* Extension of Ambulance Add-Ons. Extends bonus payments made by Medicare for ground and air ambulance services in rural and other areas through the end of 2010. *(Sec. 3105)*	
Prevention and Wellness	National Prevention, Health Promotion and Public Health Council. Directs the President to establish the National Prevention, Health Promotion and Public Health Council (the "Council") composed of the heads of virtually all the federal departments and agencies (e.g., HHS; DHS; Agriculture; Transportation; FTC; etc.), and dedicated to promoting "healthy policies" at the federal level. Chairing the Council would be the Surgeon General. Among other things, the Council would: (1) provide coordination at the federal level on prevention, wellness, and health promotion practices; (2) develop a national prevention, health promotion, public health, and integrative health care strategy that incorporates the most effective and achievable means of improving health and reducing incidence of preventable illness; (3) provide recommendations to the President and Congress on achieving public health goals (i.e., reduction of tobacco use, sedentary behavior, and poor nutrition); (4) propose evidence-based models and innovative approaches for producing health and wellness; (5) establish processes for continual public input; (6) submit reports; and (7) carry out other activities required by the President. Not later than July 1, 2010, and annually thereafter through January 1, 2015, the Council will report to the President and Congress on the health promotion activities of the Council. *(Sec. 4001)* Prevention and Public Health Fund. Establishes a Prevention and Public Health Investment Fund to provide for investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs. Appropriates to the Fund, out of any monies in the Treasury not otherwise appropriated - $500,000,000 for FY 2010; $750,000,000 for FY 2011; $1,000,000,000 for FY 2012; $1,250,000,000 for FY 2013; $1,500,000,000 for FY 2014; and $2,000,000,000 for FY 2015 and thereafter. *(Sec. 4002)* Clinical and Community Preventive Services Task Forces. Expands the efforts of, and improves the coordination between, two task forces that provide recommendations for preventive interventions – the U.S. Preventive Services Task Force is an independent panel of experts in primary care and prevention that systematically reviews the scientific evidence related to the effectiveness,	

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	appropriateness, and cost-effectiveness of clinical preventive services, and develops recommendations for their use; and the Community Preventive Services Task Force is a panel of individuals of varying expertise that reviews the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of community preventive interventions, and develop recommendations for their use. Appropriates the sums necessary to carry out the activities of both Task Forces. *(Sec. 4003)* Education and Outreach Campaign Regarding Preventive Benefits. Directs the Secretary to provide for the planning and implementation of a national public–private partnership for a prevention and health promotion outreach and education campaign to raise public awareness of health improvement across the life span. Requires the Secretary to consult with the IOM to provide ongoing advice on evidence-based scientific information for policy, program development and evaluation. The campaign shall be subject to an independent evaluation every 2 years and shall report every 2 years to Congress on the effectiveness of the campaign in meeting science-based metrics. Not later than January 1, 2011, and every 3 years thereafter through January 1, 2017, the Secretary shall report to Congress on its efforts with states and Medicaid enrollees with respect to preventative and obesity-related services with the goal of reducing incidences of obesity. Appropriates the sums necessary to carry out these provisions. *(Sec. 4004)* School-Based Health Centers. Establishes a grant program for eligible entities to support the operation of "school-based health centers," as defined in the Children's Health Insurance Program Reauthorization Act of 2009. Preference will be given to school-based health centers that serve a large population of medically underserved children. Appropriates $50,000,000 for FYs 2010 through 2014. *(Sec. 4101)* Oral Healthcare Prevention Activities. Beginning 2 years after the Act's enactment, the Secretary, acting through the Director of CDC and in consultation with professional oral health organizations, shall establish a 5-year national, public education campaign that is focused on oral healthcare prevention and education. The Campaign shall be targeted to certain populations, including children, the elderly, and pregnant women. Requires the Secretary to award demonstration grants to eligible entities to demonstrate the effectiveness of research-based dental caries disease management activities. Appropriates sums necessary for FYs 2010 through 2014. *(Sec. 4102)* Medicare Coverage of Annual Wellness Visit Providing a Personalized Prevention Plan. Provides coverage under Medicare for an annual wellness visit where individuals are provided a personalized prevention plan services. The personalized plan would include a heath risk assessment, take into account the results of the assessment, and may contain various elements including a screening schedule for the next 5 to 10 years. No co-payment or deductible would apply. A beneficiary would be eligible to receive only an initial preventive physical examination in the 12-month period after the date that Part B coverage begins and would be eligible to receive personalized prevention plan services each year thereafter. Effective on or after January 1, 2011. *(Sec. 4103)* Removal of Barriers to Preventive Services in Medicare/Amendment Relating to Waiving Coinsurance for Preventive Services. Waives coinsurance in all settings (co-payment and deductible) for certain preventive and screening services, an initial preventive physical examination, and personalized prevention plan services. Such services for which coinsurance would be waived must be recommended (rated "A" or "B") by the U.S. Preventive Services Task Force, for any indication or	

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	population. Provides that the waiver of coinsurance for colorectal cancer screening shall apply regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as the screening test. *(Sections 4104, 10406)* Evidence-Based Coverage of Preventive Services in Medicare. As of January 1, 2010, authorizes the Secretary to modify the coverage of certain preventive services covered by Medicare and the coverage of the services included in the initial preventive physical examination, to the extent that such modification is consistent with the recommendations of the U.S. Preventive Services Task Force. Prohibits the Secretary from making payment for preventive services that have not been graded A, B, C, or I by the Task Force. *(Sec. 4105)* Improving Access to Preventive Services for Eligible Adults in Medicaid. Amends the current Medicaid state option to provide "other diagnostic, screening, preventive, and rehabilitative services" to include – any clinical preventive services assigned a grade of A or B by the U.S. Preventive Services Task Force; approved vaccines recommended by the Advisory Committee on Immunization Practices (with respect to adults); and any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level. States that elect to cover these additional services and waive coinsurance would receive a 1 percent FMAP increase. Effective January 1, 2013. *(Sec. 4106)* Coverage of Comprehensive Tobacco Cessation Services for Pregnant Women in Medicaid. Requires states to cover diagnostic, therapy, and counseling services and pharmacotherapy (including prescription and nonprescription tobacco cessation agents) for cessation of tobacco use by pregnant women who use tobacco products or who are being treated for tobacco use by or under the supervision of a physician or any other authorized health care professional. Waives coinsurance amounts. Effective October 1, 2010. *(Sec. 4107)* Incentives for Prevention of Chronic Diseases in Medicaid. Directs the Secretary to award grants to states to carry out initiatives to provide incentives to Medicaid beneficiaries who successfully participate in programs designed to promote healthy lifestyles (e.g., ceasing use of tobacco products, controlling or reducing weight, lowering cholesterol, lowering blood pressure, and avoiding the onset of diabetes or improving the management of diabetes) and demonstrate changes in health risk and outcomes. Grants will be awarded beginning on January 1, 2011, or the date on which the Secretary develops program criteria, whichever is earlier. States awarded grants shall carry out such programs within the 5-year period from when the program begins. Requires the Secretary to report to Congress not later than January 1, 2014 with an initial report and not later than January 1, 2016 with a final report. Appropriates $100,000,000 for the 5-year period beginning on January 1, 2011. *(Sec. 4108)* Community Transformation Grants. Authorizes the Secretary to establish a grant program, acting through the CDC, to award competitive grants to states 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-	

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	base of effective prevention programming, with not less than 20 percent of such grants being awarded to rural and frontier areas. Appropriates the sums necessary for FYs 2010 to 2014. *(Sec. 4201)* Healthy Aging, Living Well; Evaluation of Community-Based Prevention and Wellness Programs for Medicare Beneficiaries. Authorizes the Secretary to establish a grant program, acting through the CDC, to award grants to states and local health departments and Indian tribes to carry out 5-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 grants shall be used to provide services, such as public health interventions, community preventive screenings, and clinical referrals/treatments for chronic diseases. Directs the Secretary to conduct an annual evaluation of the pilot programs. Appropriates the sums necessary for FYs 2010 through 2014. Directs the Secretary to conduct an evaluation of community-based prevention and wellness programs and develop a plan for promoting healthy lifestyles and chronic disease self-management for Medicare beneficiaries. Not later than September 30, 2013, the Secretary shall report to Congress on its findings. Appropriates $50,000,000 to CMS from the Federal Hospital Insurance Trust Fund and the Federal Supplemental Medical Insurance Trust Fund. *(Sec. 4202)* Removing Barriers and Improving Access to Wellness for Individuals with Disabilities. Not later than 24 months after the Act's enactment, the Architectural and Transportation Barriers Compliance Board shall, in consultation with the Commissioner of the FDA, promulgate regulatory standards setting forth the minimum technical criteria for medical diagnostic equipment used in (or in conjunction with) physicians' offices, clinics, emergency rooms, hospitals, and other medical settings. Such standards shall ensure that equipment is accessible to, and usable by, individuals with accessibility needs. *(Sec. 4203)* Immunizations. Authorizes the Secretary to negotiate and enter into contracts with manufacturers of vaccines for the purchase and delivery of vaccines to adults. States may obtain additional quantities of such adult vaccines through the purchase of vaccines from manufacturers at the applicable price negotiated by the Secretary. Establishes through the CDC 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, population-based interventions for high-risk populations. Reauthorizes the Immunization Program under Section 317 of the Public Health Services Act. Requires a GAO study on the ability of Medicare beneficiaries who are 65 years or older to assess routinely recommended vaccines covered under Medicare Part D. Not later than January 1, 2011, the GAO shall submit a report on such study to Congress. Appropriates $1,000,000 for FY 2010 out of any funds in the Treasury not otherwise appropriated. *(Sec. 4204)* Nutrition Labeling of Standard Menu Items at Chain Restaurants. Requires restaurants or similar retail food establishments that are part of a chain with 20 or more locations doing business under the same name (regardless of the type of ownership and locations) and offering for sale substantially the same menu items, the restaurant or similar retail food establishment shall disclose the nutrient content for food that is a standard menu item that is offered for sale in a written form available on the premises and to the consumer upon request and on the menu or menu board. For food sold in vending machines, the vending machine operator shall provide a sign in close proximity to each article of food or the selection button	

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	that includes a clear statement on the calories included in the article of food. *(Sec. 4205)* Demonstration Project Concerning Individualized Wellness Plan. Directs the Secretary to establish a pilot program to test the impact of providing at-risk populations who utilize community health centers an individualized wellness plan that is designed to reduce risk factors for preventable conditions as identified by a comprehensive risk-factor assessment. The Secretary shall enter into agreements with not more than 10 community health centers to conduct activities under the pilot program. Appropriates sums necessary to carry out the section. *(Sec. 4206)* Reasonable Break Time for Nursing Mothers. Amends the Fair Labor Standards Act of 1938 by requiring employers to provide a reasonable break time and place for an employee to breastfeed for 1 year after the child's birth. This section would not apply to employers with less than 50 employees if such requirement would impose an undue hardship by causing significant difficulty or expense to the employer. *(Sec. 4207)* Research on Optimizing the Delivery of Public Health Services. Directs the Secretary, acting through the Director of the CDC, to provide funding for research in the area of public health services and systems. Such research shall include – (1) examining evidence-based practices relating to prevention, with a particular focus on high priority areas as identified by the Secretary in the National Prevention Strategy or Healthy People 2020 and including comparing community-based public health interventions in terms of effectiveness and cost; (2) analyzing the translation of interventions from academic settings to real world setting; and (3) identifying effective strategies for organizing, financing, or delivering public health services in real world community settings. The Secretary shall submit an annual report to Congress. *(Sec. 4301)* Understanding Health Disparities: Data Collection and Analysis. By not later than 2 years after the Act's enactment, the Secretary shall ensure that any federally conducted or supported health care or public health program, activity or survey collects and reports, to the extent practicable, data on race, ethnicity, primary language, data at the smallest geographic level, and any data deemed appropriate by the Secretary regarding health disparities. Directs the Secretary to analyze such data to detect and monitor trends in health disparities. Not later than 24 months after the Act's enactment, the Secretary shall implement the approaches identified in such analyses for the ongoing, accurate, and timely collection and evaluation of data on health care disparities. Not later than 4 years after the Act's enactment, and 4 years thereafter, the Secretary shall report to Congress. *(Sec. 4302)* CDC and Employer-Based Wellness Programs. Requires the CDC to study and evaluate best employer-based wellness practices and provide an educational campaign and technical assistance to promote the benefits of worksite health promotion to employers. *(Sec. 4303)* Epidemiology-Laboratory Capacity Grants. Subject to availability of appropriations, the Secretary, acting through the Director of the CDC, shall establish an Epidemiology and Laboratory Capacity Grant Program to award grants to state health departments, local health departments, and tribal jurisdictions that meet certain criteria determined appropriate by the Secretary. Such grants will be awarded to assist public health agencies in improving surveillance for, and response to, infectious diseases and other conditions of public health importance.	

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	Appropriates $190,000,000 for FYs 2010 through 2013. *(Sec. 4304)* Funding for Childhood Obesity Demonstration Project. Appropriates $25,000,000 for FYs 2010 through 2014 for the demonstration project to develop a comprehensive and systematic model for reducing childhood obesity to be developed under the Children's Program Reauthorization Act of 2009. *(Sec. 4306)* Effectiveness of Federal Health and Wellness Initiatives. Directs the Secretary to conduct an evaluation of such programs as they relate to changes in health status of the American public and specifically on the health status of the federal workforce, including absenteeism of employees, the productivity of employees, the rate of workplace injury, and the medical costs incurred by employees, and health conditions, including workplace fitness, health food and beverages, and incentives in the Federal Employee Health Benefits Program. Secretary must report to Congress on such evaluation. *(Sec. 4402)* Community-Based Collaborative Care Networks. Provides grants to eligible entities to support community-based collaborative care networks, defined as a consortium of providers with a joint governance structure that provides comprehensive coordinated and integrated care to low-income populations. Networks must include (1) a hospital meeting the required level of Medicaid inpatient utilization or low-income utilization that applies to disproportionate share hospitals, and (2) all FQHCs located in the community. Grant funds could be used to assist low income individuals to access and appropriately use health services, enroll in health coverage programs and obtain a regular primary care provider or medical home; provide case management and care management; perform health outreach using neighborhood health workers or other means; provide transportation; expand capacity through telehealth, after-hours services or urgent care; and provide direct patient care services. Authorizes such funds as may be necessary for 2011-2015. *(Sec. 10333)* Better Diabetes Care. Directs the Secretary of HHS to develop a national report card on diabetes to be updated every two years, including aggregate health outcomes related to diabetes and prediabetes (including preventive care practices and quality of care, risk factors and outcomes); trend analysis for the nation and states if possible. Directs the Secretary to work with health professionals and States to improve data collection related to diabetes and other chronic diseases. Provides for an Institute of Medicine study on the impact of diabetes on the practice of medicine and the appropriateness of the level of diabetes medical education that should be requires prior to licensure. *(Sec. 10407)* Grants for Small Businesses to Provide Comprehensive Workplace Wellness Programs. Establishes a 5-year grant program for eligible employers (employing less than 100 employees who work 25 or more hours per week and not providing a wellness program as of the date of enactment) to provide their employees with access to comprehensive workplace wellness programs. Authorizes an appropriation of $200 million for 2011-2015. *(Sec. 10408)* Programs Relating to Congenital Heart Disease. Allows the Secretary of HHS to enhance and expand existing infrastructure to track the epidemiology of congenital heart disease and to organize such information into a National Congenital Heart Disease Surveillance System. Expands, intensifies, and coordinates research at the NIH on congenital heart disease. *(Sec. 10411)* Young Women's Breast Health Awareness and Support of Young Women	

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	Diagnosed with Breast Cancer. Directs the Secretary, acting through the CDC to conduct a national evidenced-based education campaign to increase awareness of young women's knowledge regarding breast health and awareness. The CDC, not later than 60 days after the Act's enactment, shall establish an advisory committee to assist in creating and conducting the education campaign. The CDC shall also conduct a similar education campaign among physicians and other health care professionals and conduct prevention research on breast cancer in younger women. Directs the Secretary to award grants to organizations to provide health information and substantive assistance for young women diagnosed with breast cancer and pre-neoplastic breast diseases. Appropriates $9,000,000 for each of the FYs 2010 through 2014. *(Sec. 10413).* National Diabetes Prevention Program. Directs the Secretary, acting through the CDC, to establish a national diabetes prevention program targeted at adults at high risk for diabetes in order to eliminate the preventable burden of diabetes through community-based prevention services. Appropriates sums necessary through FYs 2010 through 2014. *(Sec. 10501(g))* Preventive Medicine and Public Health Training Grant Program. Requires the Secretary, acting through HRSA and in consultation with CDC, to award grants to, or enter into contracts with, eligible entities to provide training to graduate medical residents in preventive medicine specialties. Appropriates $43,000,000 for FY 2011 and such sums necessary for each of FYs 2012 through 2015. *(Sec. 10501(m))*	
Workforce Issues	Definitions. Establishes definitions for the Health Care Workforce title of the PPACA. *(Sec. 5002)* National Health Care Workforce Commission. Establishes a national commission tasked with reviewing health care workforce and projected workforce needs. The overall goal of the Commission is to provide comprehensive, unbiased information to Congress and the Administration about how to align Federal health care workforce resources with national needs. Congress will use this information when providing appropriations to discretionary programs or in restructuring other Federal funding sources. The commission shall be composed of 15 members appointed by GAO, including at least one representative of the following: health care workforce and health professionals, employers, third-party payers, individuals skilled in health care-related research, consumers, labor unions, small businesses, state/local workforce investment boards, and educational institutions. *(Sec. 5101)* State Health Care Workforce Development Grants. Creates a competitive grant program for the purpose of enabling state partnerships to complete comprehensive planning and to carry out activities leading to coherent and comprehensive health care workforce development strategies at the State and local levels. Grants will support innovative approaches to increase the number of skilled health care workers such as health care career pathways for young people and adults. Planning grants would be awarded for 1 year and up to $150,000 for "eligible partnerships" including state workforce investment boards meeting certain membership requirements. Implementation grants would be awarded for up to 2 years for state partnerships that received a planning grant and completed all requirements of that grant or completed an application including a plan to coordinate with required partners and complete the required implementation activities. State partnerships receiving a planning grant must match 15 percent of the grant and those receiving an implementation grant must match 25 percent of the grant. Appropriates $8 million for planning grants for 2010 and such sums as may be necessary for subsequent years, and $150 million for implementation grants for 2010 and such sums as may be necessary for subsequent years. *(Sec. 5102)*	

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	Health Care Workforce Assessment. Codifies the existing national center for health care workforce analysis and establishes several regional centers for health workforce analysis to collect, analyze, and report data related to Title VII (of the Public Health Service Act) primary care workforce programs. The centers will coordinate with State and local agencies collecting labor and workforce statistical information and coordinate and provide analyses and reports on Title VII to the Health Care Workforce Commission under section 5101. *(Sec. 5103)* Interagency Task Force to Assess and Improve Access to Health Care in the State of Alaska. Establishes an "Interagency Access to Health Care in Alaska Task Force" that shall assess access to health care for beneficiaries in Alaska and develop a strategy for the federal government to improve delivery of health care to beneficiaries in Alaska. The Task Force shall be compromised of appointed federal members and established not later than 45 days after the Act's enactment. *(Sec. 5104)* Federally Supported Student Loan Funds. Eases current criteria for schools and students to qualify for loans, shorten payback periods, and decreases the non-compliance provision to make the primary care student loan program more attractive to medical students. *(Sec. 5201)* Nursing Student Loan Program. Increases loan amounts and updates the years for nursing schools to establish and maintain student loan funds. *(Sec. 5202)* Health Care Workforce Loan Repayment Programs. Establishes a loan repayment program for pediatric subspecialists and providers of mental and behavioral health services to children and adolescents who are or will be working in a Health Professional Shortage Area, Medically Underserved Area, or with a Medically Underserved Population. Appropriates $30 million for each of years 2010-2014 for pediatric medical and surgical specialists and $20 million for each of years 2010-2013 for child and adolescent mental and behavioral health. *(Sec. 5203)* Public Health Workforce Recruitment and Retention Program. Establishes the Public Health Workforce Loan Repayment Program to ensure an adequate supply of public health professionals to eliminate shortages in federal, state, local, or tribal public health agencies. Offers loan repayment to public health students and workers in exchange for working at least 3 years at a federal, state, local, or tribal public health agency. Authorizes $195 million for 2010 and such sums as may be necessary for 2011-2015. *(Sec. 5204)* Allied Health Workforce Recruitment and Retention Program. Offers loan repayment to allied health professionals employed at public health agencies or in settings providing health care to patients, including acute care facilities, ambulatory care facilities, residences, and other settings located in Health Professional Shortage Areas, Medically Underserved Areas, or serving Medically Underserved Populations. *(Sec. 5205)* Grants for States and Local Programs. Awards scholarships to mid-career public and allied health professionals employed in public and allied health positions at the Federal, State, tribal, or local level to receive additional training in public or allied health fields. Authorizes $60 million for 2010 and such sums as may be necessary for 2011-2015. Fifty percent shall be allotted to public health mid-career professionals and 50 percent to allied health mid-career professionals. *(Sec. 5206)* Funding for National Health Service Corps. Increases and extends the authorization	

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	of appropriations for the National Health Service Corps scholarship and loan repayment program for 2010-2015. Authorizes a total of $2.7 billion for the period 2010-2015; for 2016 and subsequent years, authorizes the amount appropriated in the prior year adjusted by a certain percentage based on the costs of education and the number of individuals residing in health professions shortage areas. *(Sec. 5207)* Nurse-Managed Health Clinics. Strengthens the health care safety-net by creating a $50 million grant program administered by HRSA to support nurse-managed health clinics. *(Sec. 5208)* Elimination of Cap on Commissioned Corps. Eliminates the artificial cap on the number of Commissioned Corps members, allowing the Corps to expand to meet national public health needs. *(Sec. 5209)* Establishing a Ready Reserve Corps. Establishes a Ready Reserve Corps within the Commissioned Corps for service in times of national emergency. Ready Reserve Corps members may be called to active duty to respond to national emergencies and public health crises and to fill critical public health positions left vacant by members of the Regular Corps who have been called to duty elsewhere. Authorizes $5 million for recruitment and training and $12.5 million the Ready Reserve Corps for each of fiscal years 2010-2014. *(Sec. 5210)* Training in Family Medicine, General Internal Medicine, General Pediatrics, and Physician Assistantship. Provides grants and contracts to support and develop primary care training programs through accredited public or nonprofit hospitals, schools of medicine, physician assistant training programs or other public or nonprofit entities the Secretary determines are capable of carrying out a grant or contract. Provides grants or contracts for capacity building in primary care through accredited schools of medicine. Grants or contracts will develop and operate training programs, provide financial assistance to trainees and faculty, enhance faculty development in primary care and physician assistant programs, and to establish, maintain, and improve academic units in primary care. Priority is given to programs that educate students in team-based approaches to care, including the patient-centered medical home. Awards would be for a period of 5 years. Authorizes $125 million for 2010 and such sums as may be necessary for 2011-2014. *(Sec. 5301)* Training Opportunities for Direct Care Workers. Provides grants for entities to provide new training opportunities for direct care workers employed in long-term care settings. Eligible entities are institutions of higher education that have established a public-private educational partnership with a long-term care facility or agency or entity providing home and community based services to individuals with disabilities or other long-term care providers. Eligible individuals are those enrolled in the institution who agree to work in the field of geriatrics, disability services, long term care services and supports or chronic care management for at least 2 years. Authorizes $10 million for the period 2011-2013. *(Sec. 5302)* Training in General, Pediatric, and Public Health Dentistry. Reinstates dental funding in Title VII of the Public Health Service Act. Allows dental schools and education programs to use grants for pre-doctoral training, faculty development, dental faculty loan repayment, and academic administrative units. Authorizes $30 million for 2010 and such sums as may be necessary for 2011-2015. *(Sec. 5303)* Alternative Dental Health Care Provider Demonstration Project. Authorizes the Secretary to award grants to establish training programs for alternative dental health care providers to increase access to dental health care services in rural, tribal, and underserved communities. Authorizes such sums as may be necessary. *(Sec. 5304)*	

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Policy	Senate Bill (H.R. 3590)	Reconciliation Bill (H.R. 4872)
	Geriatric Education and Training; Career Awards; Comprehensive Geriatric Education. Authorizes funding for grants or contracts with geriatric education centers to support training in geriatrics, chronic care management, and long-term care for faculty in health professions schools and family caregivers; develop curricula and best practices in geriatrics; expand the geriatric career awards to advanced practice nurses, clinical social workers, pharmacists, and psychologists; and establish traineeships for individuals who are preparing for advanced education nursing degrees in geriatric nursing. Establishes awards for advanced practice nurses, social workers, pharmacists, or psychology students who are pursuing advanced degrees in geriatrics or related fields and agree to teach or practice in the field of geriatrics, long term care or chronic care management for at least 5 years. Authorizes $10.8 million for education centers for 2011-2014 and $10 million for individual awards for 2011-2013. *(Sec. 5305)* Mental and Behavioral Health Education and Training Grants. Awards grants to schools for the development, expansion, or enhancement of training programs in social work, graduate psychology, professional training in child and adolescent mental health, and pre-service or in-service training to paraprofessionals in child and adolescent mental health. Authorizes a total of $35 million for 2010-2013. *(Sec. 5306)* Cultural Competency, Prevention, and Public Health and Individuals with Disabilities Training. Reauthorizes and expands programs to support the development, evaluation, and dissemination of model curricula for cultural competency, prevention, and public health proficiency and aptitude for working with individuals with disabilities training for use in health professions schools and continuing education programs. Authorizes such sums as may be necessary for 2010-2015. *(Sec. 5307)* Advanced Nursing Education Grants. Strengthens language for accredited Nurse Midwifery programs to receive advanced nurse education grants in Title VIII of the Public Health Service Act. *(Sec. 5308)* Nurse Education, Practice, and Retention Grants. Awards grants to nursing schools to strengthen nurse education and training programs and to improve nurse retention. Authorizes such sums as may be necessary for 2010-2012. *(Sec. 5309)* Loan Repayment and Scholarship Program. Adds faculty at nursing schools as eligible individuals for loan repayment and scholarship programs. *(Sec. 5310)* Nurse Faculty Loan Program. Establishes a Federally-funded student loan repayment program for nurses with outstanding debt who pursue careers in nurse education. Nurses agree to teach at an accredited school of nursing for at least 4 years within a 6-year period. Payments to individuals who completed a master's or equivalent degree in nursing may not exceed $10,000 per calendar year or $40,000 total during 2010-2011; payments to individuals who completed a doctorate or equivalent degree in nursing may not exceed $20,000 per calendar year or $80,000 total during 2010-2011. Authorizes such sums as may be necessary for 2010-2014. *(Sec. 5311)* Authorization of Appropriations for Parts B through D of title VIII. Authorizes $338 million to fund Title VIII of the Public Health Service Act nursing programs. *(Sec. 5312)* Grants to Promote the Community Health Workforce. Authorizes the Secretary to	

A&B Health Care Public Policy Group Health Care Reform Chart

Policy	Senate Bill (H.R. 3590)	Reconciliation Bill (H.R. 4872)
	award grants to States, public health departments, clinics, hospitals, Federally qualified health centers, and other nonprofits to promote positive health behaviors and outcomes in medically underserved areas through the use of community health workers. Community health workers offer interpretation and translation services, provide culturally appropriate health education and information, offer informal counseling and guidance on health behaviors, advocate for individual and community health needs, and can provide some direct primary care services and screenings. Authorizes such sums as may be necessary for 2010-2014. *(Sec. 5313)* Fellowship Training in Public Health. Authorizes the Secretary to address workforce shortages in State and local health departments in applied public health epidemiology and public health laboratory science and informatics. Authorizes $39.5 million for the programs under this section for each of 2010-2013 of which $5 million shall be made available for the epidemiology fellowship training program, $5 million for laboratory fellowship training programs, $5 million for the public health informatics fellowship programs, and $24.5 million for expanding the Epidemic Intelligence Service. *(Sec. 5314)* United States Public Health Sciences Track. Directs the Surgeon General to establish a U.S. Public Health Sciences Track to train physicians, dentists, nurses, physician assistants, mental and behavior health specialists, and public health professionals emphasizing team-based service, public health, epidemiology, and emergency preparedness and response in affiliated institutions. Students receive tuition remission and a stipend and are accepted as Commission Corps officers in the U.S. Public Health Service with a 2-year service commitment for each year of school covered. Funds these activities with such sums as may be necessary from the Public Health and Social Services Emergency Fund beginning with 2010. *(Sec. 5315)* Demonstration Grants for Family Nurse Practitioner Training Programs. Directs the Secretary to establish a training demonstration program for family nurse practitioners to employ and provide 1-year training for practitioners who have graduated from a nurse practitioner program for careers as primary care providers in federally qualified health centers (FQHCs) and nurse-managed health clinics (NMHCs). Three-year grants will be awarded to eligible entities for an amount not to exceed $600,000 per year. Appropriates sums necessary for FYs 2011 through 2014. *(Sec. 5316)* Centers of Excellence. The Centers of Excellence program, which develops a minority applicant pool to enhance recruitment, training, academic performance and other supports for minorities interested in careers in health, is reauthorized at 150 percent of 2005 appropriations, $50 million, and such sums as are necessary for subsequent fiscal years. *(Sec. 5401)* Health Professions Training for Diversity. Provides scholarships for disadvantaged students who commit to work in medically underserved areas as primary care providers, and expands loan repayments for individuals who will serve as faculty in eligible institutions. Includes faculty at schools for physician assistants as eligible for faculty loan repayment. Funding is increased from $37 to $51 million for 2009 through 2013. *(Sec. 5402)* Interdisciplinary, community-based linkages. Authorizes a total of $130 million for each of fiscal years 2010-2014 to establish community-based training and education grants for Area Health Education Centers (AHECs) and Programs. Two programs are supported - Infrastructure Development Awards and Points of Service Enhancement and Maintenance Awards - targeting individuals seeking careers in the health professions from urban and rural medically underserved communities. *(Sec.*	

A&B Health Care Public Policy Group Health Care Reform Chart

Policy	Senate Bill (H.R. 3590)	Reconciliation Bill (H.R. 4872)
	5403) Workforce Diversity Grants. Expands the allowable uses of nursing diversity grants to include completion of associate degrees, bridge or degree completion program, or advanced degrees in nursing, as well as pre-entry preparation, advanced education preparation, and retention activities. *(Sec. 5404)* Primary Care Extension Program. Creates a Primary Care Extension Program to educate and provide technical assistance to primary care providers about evidence-based therapies, preventive medicine, health promotion, chronic disease management, and mental health. The Agency for Healthcare Research and Quality (AHRQ) will award planning and program grants to State hubs including, at a minimum, the State health department, State-level entities administering Medicare and Medicaid, and at least one health professions school. These State hubs may also include Quality Improvement Organizations, AHECs, and other quality and training organizations. Authorizes $120 million for each of fiscal years 2011 and 2012 and such sums as may be necessary for 2013 and 2014. *(Sec. 5405)* Distribution of Additional Residency Positions. Beginning July 1, 2011, directs the Secretary to redistribute residency positions that have been unfilled for the prior three cost reports and directs those slots for training of primary care physicians. In distributing the residency slots under this section, special preference will be given to programs located in States with a low physician resident to general population ratio and to programs located in States with the highest ratio of population living in a health professional shortage area (HPSA) relative to the general population. *(Sec. 5503)* Counting Resident Time in Outpatient Settings and Allowing Flexibility for Jointly Operated Residency Training Programs. Modifies rules governing when hospitals can receive indirect medical education (IME) and direct graduate medical education (DGME) funding for residents who train in a non-provider setting so that any time spent by the resident in a non-provider setting shall be counted toward DGME and IME if the hospital incurs the costs of the stipends and fringe benefits. *(Sec. 5504)* Rules for Counting Resident Time for Didactic and Scholarly Activities and Other Activities. Modifies current law to allow hospitals to count resident time spent in didactic conferences toward IME costs in the provider (i.e., hospital) setting (effective for cost reporting periods beginning on or after October 1, 2001) and toward DGME in the non-provider (i.e., non-hospital) setting (effective for cost reporting periods beginning on or after July 1, 2009). The Secretary is not required to reopen certain settled cost reports in applying changes to Medicare graduate medical education payment rules related to didactic training. *(Sec. 5505)* Preservation of Resident Cap Positions from Closed Hospitals. Directs the Secretary to redistribute medical residency slots from a hospital that closes on or after the date that is two years before enactment of the this legislation based on certain criteria. *(Sec. 5506)* Demonstration Project to Address Health Professions Workforce Needs; Extension of Family-to-Family Health Information Centers. Establishes a demonstration grant program through competitive grants to provide aid and supportive services to low-income individuals with the opportunity to obtain education and training for occupations in the health care field that pay well and are expected to experience labor shortages or be in high demand. The demonstration grant is to serve low-income persons including recipients of assistance under State Temporary Assistance	

A&B Health Care Public Policy Group Health Care Reform Chart

Policy	Senate Bill (H.R. 3590)	Reconciliation Bill (H.R. 4872)
	for Needy Families (TANF) programs. Also establishes a demonstration program to competitively award grants for up to six States for three years to develop core training competencies and certification programs for personal and home care aides. Appropriates $85 million for the demonstration programs for each of fiscal years 2010-2014. Extends funding for family-to-family health information centers at $5 million for 2010-2012. *(Sec. 5507)* Increasing Teaching Capacity. Directs the Secretary to establish a grant program to support new or expanded primary care residency programs at teaching health centers and authorizes $25 million for 2010, $50 million for 2011 and 2012 and such sums as may be necessary for each fiscal year thereafter to carry out such program. Also provides $230 million in funding under the Public Health Service Act for 2011-2015 to cover the indirect and direct expenses of qualifying teaching health centers related to training primary care residents in certain expanded or new programs. *(Sec. 5508)* Graduate Nurse Education Demonstration Program. This provision directs the Secretary to establish a demonstration program for up to 5 eligible hospitals to increase graduate nurse education training under Medicare and authorizes $50 million to be appropriated from the Medicare Hospital Insurance Trust Fund for each of the fiscal years 2012 through 2015 for such purpose. *(Sec. 5509)* Spending for Federally Qualified Health Centers (FQHCs). Authorizes the following appropriations: 2010 - $2.98 billion; 2011 - $3.86 billion; 2012 - $4.99 billion; 2013 - $6.44 billion; 2014 - $7.33 billion; 2015 - $8.33 billion. For 2016 and subsequent years, authorizes the amount for the prior year adjusted by a percentage based on the increase in costs per patient served and the increase in the number of patients served. *(Sec. 5601)* Negotiated Rulemaking for Development of Methodology and Criteria for Designating Medically Underserved Populations and Health Professions Shortage Areas. Directs the Secretary, in consultation with stakeholders, to establish a comprehensive methodology and criteria for designating medically underserved populations and Health Professional Shortage Areas. *(Sec. 5602)* Reauthorization of Wakefield Emergency Medical Services for Children Program. Reauthorizes program to award grants to States and medical schools to support the improvement and expansion of emergency medical services for children needing trauma or critical care treatment. *(Sec. 5603)* Co-locating Primary and Specialty Care in Community-based Mental Health Settings. Authorizes $50 million in grants for coordinated and integrated services through the co-location of primary and specialty care in community-based mental and behavioral health settings. *(Sec. 5604)* Key National Indicators. Establishes a Commission on Key National Indicators to conduct a comprehensive oversight of a newly established key national indicators system, with a required annual report to Congress. *(Sec. 5605)* State Grants to Health Care Providers Who Provide Services to a High Percentage of Medically Underserved Populations or Other Special Populations. Establishes state grant programs for health care providers who treat a high percentage of medically underserved populations or other special populations in the state. *(Sec. 5606)* National Health Service Corps Improvements. Improves the National Health Service Corps program by increasing the loan repayment amount, allowing for half-	

A&B Health Care Public Policy Group Health Care Reform Chart

Policy	Senate Bill (H.R. 3590)	Reconciliation Bill (H.R. 4872)
	time service, and allowing for teaching to count for up to 20 percent of the Corps service commitment. *(Sec. 10501(n))*	
Fraud and Abuse	Provider Screening and Other Enrollment Requirements Under Medicare, Medicaid, and CHIP. Requires the Secretary to screen all providers and suppliers participating in Medicare, Medicaid, and CHIP. The Secretary may impose additional screening measures, such as criminal background checks, fingerprinting, unscheduled and unannounced site visits, database checks, and other screening mechanisms, as determined appropriate based on the risk of fraud, waste, and abuse. Application fees would be imposed on providers and suppliers to cover the costs of screening. A hardship exception to the fee would be permitted, as would a waiver of the fee for Medicaid providers for whom the state can demonstrate the fee would impede beneficiary access to care. Screening will begin: (i) for providers who are not enrolled in these programs as of the date of enactment on or after the date that is 1 year after enactment; (ii) for providers already enrolled in these programs as of the date of enactment on or after the date that is 2 years after enactment, and (iii) for the revalidation of providers beginning 180 days after such date of enactment. Imposes new disclosure requirements on providers and suppliers enrolling in Medicare by requiring these providers and suppliers to report any current or previous affiliation with a provider of medical or other items or services or supplier that has uncollected debt, has been or is subject to a payment suspension, has been excluded from participation in a federal or state health program, or has had its billing privileges denied or revoked (on or after the date that is 1 year after the date of enactment). Secretary could impose a moratorium on enrollment of new providers and suppliers if necessary to prevent or combat fraud, waste, or abuse. Requires providers and suppliers to establish compliance programs as a condition of enrollment. Grants states authority to impose similar screening efforts in state Medicaid programs. *(Sec. 6401)* Medicare and Medicaid Program Integrity Provisions. Requires CMS to complete development of the Integrated Data Repository (IDR), which would expand existing program integrity data sources and data sharing across Federal agencies (Medicare, Medicaid, CHIP, health-related programs administered by the Departments of Veterans Affairs (VA) and Defense (DOD), the Social Security Administration, and the Indian Health Service (IHS). Grants the OIG and the Attorney General access to the database. *(Sec. 6402)* Program Sanctions. Allows the Secretary to impose an appropriate administrative penalty if an individual knowingly participated in a Federal health care fraud offense or conspiracy to commit an offense. *(Sec. 6402)* Overpayments. Any person who knows of an overpayment would be required to return the overpayment to the Secretary, the state, or a Medicare contractor by the later of: 60 days after the date on which the overpayment was identified or the date any corresponding cost report is due. *(Sec. 6402)* National Provider Identifier. Requires the Secretary to promulgate a regulation no later than January 1, 2011 requiring all providers and suppliers that qualify for a national provider identifier to include this identifier on all applications for enrollment. *(Sec. 6402)* Medicaid Statistical Information System. Permits the withholding of federal matching payments for states that fail to report enrollee encounter data in the Medicaid Statistical Information System. *(Sec. 6402)*	Community Mental Health Centers. Requires community mental health centers that provide a significant share of their services to individuals not eligible for Medicare to meet new requirements for receiving Medicare billing privileges. Effective for items and services furnished on or after the first day of the first calendar quarter that is at least 12 months from the date of enactment. *(Sec. 1301)* Medicare Prepayment Medical Review Limitations. Repeals Section 1847A(h) of the SSA that relates to the conduct of prepayment review to allow Medicare Administrative Contractors to perform additional reviews to limit fraud and abuse. *(Sec. 1302)* CMS-IRS Data Match to Identify Fraudulent Providers. Allows the IRS to disclose information to HHS regarding Medicare providers who have a seriously delinquent tax debt. This information can be used when determining whether to grant or deny a provider's enrollment or reenrollment in Medicare. Authorizes the adjustment of Medicare payments in order to collect past due tax obligations. Provides protections for the use of this data. *(Sec. 1303)* Funding to Fight Fraud, Waste, and Abuse. Provides a $250 million increase in funding between 2011 and 2016 for the Health Care Fraud and Abuse Control Fund. Indexes funds under the Medicaid Integrity Program in years after 2010 by the consumer price index for all urban consumers. *(Sec.* 1304) 90-Day Period of Enhanced

A&B Health Care Public Policy Group Health Care Reform Chart

Policy	Senate Bill (H.R. 3590)	Reconciliation Bill (H.R. 4872)
	Permissive Exclusions. Allows permissive exclusions for individuals or entities that knowingly make false statements or misrepresentations of material facts. *(Sec. 6402)* Deterrence/Civil and Criminal Penalties. The CMP law would be amended in several respects to increase penalties to $50,000 for each false statement or misrepresentation. Amends the Anti-Kickback statute so that a claim that includes items or services violating the statute would also constitute a false or fraudulent claim. Also amends the intent requirement so that a person need not have actual knowledge or specific intent to commit a violation of this section. *(Sec. 6402)* Subpoena Authority. Grants the Secretary subpoena authority in exclusion-only cases. *(Sec. 6402)* Surety Bond Requirements. Allows the Secretary to determine surety bond requirements for DME and home health providers based on an amount commensurate with the volume of the billing of the provider. *(Sec. 6402)* Suspension of Payments. Secretary may suspend Medicare and Medicaid payments to a provider or supplier pending an investigation of fraud. *(Sec. 6402)* Program Integrity Funding and Reporting Requirements. Health Care Fraud and Abuse Control (HCFAC) program funding would be increased by $10 million each year for 10 years, and would remain available until expended. Permanently applies the CPI adjustment to HCFAC and Medicare Integrity Program funding. *(Sec. 6402)* Medicare and Medicaid Integrity Programs. Requires entities that are enrolled in Medicare and Medicaid to submit performance statistics on the number of fraud referrals, overpayments recovered, and return on investment. *(Sec. 6402)* Transition from Healthcare Integrity and Protection Data Bank to the National Practitioner Data Bank. Requires Secretary to maintain a data collection program for the reporting of final adverse actions against health care providers. Provides for a transition period and the transfer of data from the Healthcare Integrity and Protection Data Bank ("HIPDB") to the National Practitioner Data Bank ("NPDB"). Eliminates use of the HIPDB. Allows reasonable fees to be charged for the disclosure of information, but provides access to the NPDB free of charge to the Secretary of Veterans Affairs for one year. *(Sec. 6403)* Payment. The maximum period for submission of Medicare claims would be reduced to not more than 12 months. Effective for services furnished on or after January 1, 2010. For services furnished before January 1, 2010 claims must be submitted no later than December 31, 2010. *(Sec. 6404)* Requirements Related to Durable Medical Equipment and Home Health. Requires physicians, who order durable medical equipment or home health services that are billable to Medicare, to be Medicare participating physicians or eligible professionals, as determined by the Secretary. Allows the Secretary to extend this requirement to other services or items, including covered Part D drugs, if the Secretary determines it would reduce the risk of fraud and abuse. Effective July 1, 2010. *(Sec. 6405)* The manager's amendment provides a technical correction to Section 6405 and clarifies that only physicians enrolled in the Medicare program may order home	Oversight for Initial Claims of DME Suppliers. Beginning January 1, 2011, permits the Secretary to withhold payment to DME suppliers initially enrolling in the Medicare program who are within a category or geographic area deemed to be at significant risk of fraudulent activity for 90 days. *(Sec. 1305).*

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Policy	Senate Bill (H.R. 3590)	Reconciliation Bill (H.R. 4872)
	health services under Medicare Part A and Part B. *(Sec. 10604)* Allows the Secretary to revoke enrollment for a period of not more than one year for each act for a physician or supplier who fails to maintain or does not provide access to documentation relating to written orders of requests for payment for DME, certifications for home health services, or referrals for other items or services specified by the Secretary. Amends provisions related to the OIG's exclusion authority to include physicians and suppliers who fail to maintain or provide access to this documentation. Effective January 1, 2010. *(Sec. 6406)* Requires physicians to have a face-to-face encounter (or through the use of telehealth and other than with respect to encounters that are incident to services involved) with patients within a reasonable timeframe as determined by the Secretary under Part A or within six months or a reasonable time as determined by the Secretary under Part B prior to certification or re-certification for home health services under Medicare. Payment for durable medical equipment is subject to this requirement and the face-to-face encounter must occur within six months of the written order. Allows the Secretary to extend the requirement of a face-to-face (or telehealth) encounter to other items or services, if the Secretary determines it would reduce the risk of fraud and abuse. Applies the face-to-face encounter requirements for home health services, durable medical equipment, and any other applicable item or service identified by the Secretary to items or services paid for under Medicaid. *(Sec. 6407)* The manager's amendment clarifies that the face-to-face encounter required prior to certification for home health services may be performed by a physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife, or physician assistant. *(Sec. 10605).* Enhanced Penalties. Applies CMPs of $15,000 for each day an entity fails to provide timely access, upon reasonable request, to the Inspector General of the Department of HHS for the purpose of audits, investigations, evaluations, or other statutory functions. Also applies CMPs of $50,000 for each false record or statement made to a Federal health care program. Applies penalties in Section 1857(g)(2) of the SSA to an expanded list of violations by Medicare Advantage (MA) or Part D plans that includes: (1) enrollment of individuals in a MA or Part D plan without their consent, (2) transfer of an individual from one plan to another for the purpose of earning a commission, (3) failure to comply with marketing restrictions or applicable implementing regulations or guidance, or (4) the employment of or contracting with an individual or entity that commits a violation. (The expanded list of violations for MA and PDPs takes effect on the date of enactment of the Act.) Also ensures timely inspections relating to contracts with MA organizations. Amends the penalties for MA and Part D plans that misrepresent or falsify information. Allows the Secretary to exclude from federal programs any individual or entity that has been convicted of obstructing an audit conducted in relation to certain specified criminal offenses. Apart from the expanded list of violations for MA and PDPs, the provisions of this section are effective for acts committed on or after January 1, 2010. *(Sec. 6408)* Provider Self-Disclosure Protocol. Within 180 days, the Secretary would be required to develop a mechanism for providers to voluntarily disclose specific information regarding actual and potential violations of the physician self-referral law. Secretary may reduce the amount due for the violations based on a number of mitigating factors. *(Sec. 6409)*	

A&B Health Care Public Policy Group Health Care Reform Chart

Policy	Senate Bill (H.R. 3590)	Reconciliation Bill (H.R. 4872)
	Expansion of the Recovery Audit Contractor (RAC) Program. Expands RAC program to Medicaid and Medicare Parts C and D. Requires RACs to ensure that MA and PDPs implement anti-fraud plans. *(Sec. 6411)* Termination of Provider Participation. Terminates a provider's participation in Medicaid if enrollment under Medicare or another state plan is terminated. *(Sec. 6501)* Medicaid Exclusion from Participation. Requires State Medicaid agencies to exclude from Medicaid participation for a period any entity that owns, controls, or manages an entity or is owned, controlled, or managed by an individual or entity that has unpaid overpayments, is suspended or excluded from participation, or is affiliated with an entity that has been suspended or excluded. *(Sec. 6502)* Required Registration under Medicaid. Requires agents, clearinghouses, and other alternate payees to register under Medicaid. *(Sec. 6503)* Required Reporting Under Medicaid Management Information System (MMIS). For contract years beginning on or after January 1, 2010, requires entities (including managed care organizations) to report additional data elements under MMIS as the Secretary determines necessary. *(Sec. 6504)* Prohibited Payments. Prohibits payments to institutions located outside the United States. *(Sec. 6505)* Overpayments. Effective on enactment, extends the period for collection of overpayments from 60 days to 1 year. Where a final determination on the amount of the overpayment has not been made within a year, no adjustment in the Federal payment will be made before the date that is 30 days after the date of a final judgment. *(Sec. 6506)* National Correct Coding Initiative. Effective October 1, 2010, requires states to use the National Correct Coding Initiative. *(Sec. 6507)* General Effective Date. The general effective date for provisions in this subtitle is January 1, 2011. *(Sec. 6508)* Prohibition on False Statements and Representations. Prohibits any person, in connection with a plan or other arrangement that is a multiple employer welfare arrangement, from making a false statement in connection with the marketing or sale of such plan. Applies criminal penalties to violations of this section. *(Sec. 6601)* Clarifying Definition. *(Sec. 6602)* Development of Model Uniform Report Form. Requires the Secretary to request that the National Association of Insurance Commissioners (NAIC) develop a model uniform report form for private health insurance issuers seeking to refer suspected fraud and abuse to state insurance departments. *(Sec. 6603)* Applicability of State Law to Combat Fraud and Abuse. Allows the Secretary to adopt regulatory standards or issue an order establishing that a person engaged in the business of providing insurance through a multiple employer welfare arrangement is subject to the laws of the states in which such person operates which	

A&B Health Care Public Policy Group Health Care Reform Chart

Policy	Senate Bill (H.R. 3590)	Reconciliation Bill (H.R. 4872)
	regulate insurance. *(Sec. 6604)* Issue of Summary Cease and Desist Orders. Allows the Secretary of Labor to issue cease and desist orders and summary seizure orders against multiple employer welfare arrangements (MEWAs), if the Secretary determines the MEWA is in a financially hazardous condition. Any person adversely affected may request a hearing. *(Sec. 6605)* MEWA Plan Registration with the Department of Labor. MEWAs must register with the Secretary of Labor. *(Sec. 6606)* Permitting Evidentiary Privilege and Confidential Communications. Secretary may provide for evidentiary privilege and confidential communications between certain federal agencies during investigations, audits, examinations, or inquiries. *(Sec. 6607)* Health Care Fraud Enforcement. Increases the federal sentencing guidelines for health care fraud. Changes the intent requirement for fraud under the Anti-Kickback statute such that a person need not have actual knowledge of this section or specific intent to violate this section. Increases subpoena authority relating to health care fraud. *(Sec. 10606)*	
Accountable Care Organizations	Pediatric ACO Demonstration Project. Establishes a demonstration project for states, which would allow pediatric medical providers who meet certain criteria to be recognized as accountable care organizations (ACOs). Participating providers would be eligible to share in the federal and state cost savings achieved for Medicaid and CHIP. States, in consultation with the Secretary, would establish a minimum level of savings that would need to be achieved by an ACO in order for it to share in the savings. The Secretary, in consultation with states and pediatric providers, would develop guidelines to ensure that the quality of care delivered by the ACOs would be at least as high as it would have been absent the demonstration project. The demonstration project shall begin on January 1, 2012 and end on December 31, 2016. Providers desiring to be recognized as an ACO under the demonstration shall enter into an agreement with the state to participate for not less than a 3-year period. *(Sec. 2706)* Medicare Shared Savings Program. Not later than January 1, 2012, requires the Secretary to establish a shared savings program that would reward Accountable Care Organizations ("ACOs") that take responsibility for the costs and quality of care received by their patient panel over time. ACOs can include groups of health care providers (including physician groups, hospitals, nurse practitioners and physician assistants, and others). ACOs that meet quality-of-care targets and reduce the costs of their patients relative to a spending benchmark are rewarded with a share of the savings they achieve for the Medicare program (as determined by the Secretary). Grants the Secretary flexibility in implementing innovative payment models for ACOs, such as the partial capitation model. Secretary may give preference to ACOs participating in similar arrangements with other payers. Allows the Secretary to enter into an agreement with an ACO under the demonstration authorized by Section 1866A of the SSA during the period between the date of enactment and the date this program is established. *(Sec. 3022)*	
Whistleblower Protections		
Primary Care Services	Training in Family Medicine, General Internal Medicine, General Pediatrics, and Physician Assistantship. Provides grants and contracts to support and develop	

A&B Health Care Public Policy Group Health Care Reform Chart

Policy	Senate Bill (H.R. 3590)	Reconciliation Bill (H.R. 4872)
	primary care training programs through accredited public or nonprofit hospitals, schools of medicine, physician assistant training programs or other public or nonprofit entities the Secretary determines are capable of carrying out a grant or contract. Provides grants or contracts for capacity building in primary care through accredited schools of medicine. Grants or contracts will develop and operate training programs, provide financial assistance to trainees and faculty, enhance faculty development in primary care and physician assistant programs, and to establish, maintain, and improve academic units in primary care. Priority is given to programs that educate students in team-based approaches to care, including the patient-centered medical home. Awards would be for a period of 5 years. Authorizes $125 million for 2010 and such sums as may be necessary for 2011-2014. *(Sec. 5301)* Primary Care Extension Program. Creates a Primary Care Extension Program to educate and provide technical assistance to primary care providers about evidence-based therapies, preventive medicine, health promotion, chronic disease management, and mental health. The Agency for Healthcare Research and Quality (AHRQ) will award planning and program grants to State hubs including, at a minimum, the State health department, State-level entities administering Medicare and Medicaid, and at least one health professions school. These State hubs may also include Quality Improvement Organizations, AHECs, and other quality and training organizations. Authorizes $120 million for each of fiscal years 2011 and 2012 and such sums as may be necessary for 2013 and 2014. *(Sec. 5405)* Expanding Access to Primary Care Services and General Surgery Services. Beginning in 2011, provides primary care practitioners, as well as general surgeons practicing in health professional shortage areas, with a 10 percent Medicare payment bonus for five years. Half of the cost of the bonuses would be offset through an across-the-board reduction in all other Services through the conversion factor. *(Sec. 5501)* Increasing Teaching Capacity. Directs the Secretary to establish a grant program to support new or expanded primary care residency programs at teaching health centers and authorizes $25 million for 2010, $50 million for 2011 and 2012 and such sums as may be necessary for each fiscal year thereafter to carry out such program. Also provides $230 million in funding under the Public Health Service Act to cover the indirect and direct expenses of qualifying teaching health centers related to training primary care residents in certain expanded or new programs. *(Sec. 5508)*	
Skilled Nursing Facilities	Productivity Adjustment. Implements a full productivity adjustment (equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (as projected by the Secretary for the applicable fiscal year, year, cost reporting period, or other annual period) for inpatient and outpatient hospital services, inpatient psychiatric facilities, inpatient rehabilitation, long term care hospital services and SNFs beginning in 2012. It would implement a full productivity adjustment for hospice providers beginning in 2013, and a full productivity adjustment for home health providers beginning in 2015. *(Sec. 3401)* Revisions to SNF Provisions. The manager's amendment delays the implementation of certain SNF "RUGs-IV" payment system changes by one year to October 1, 2011. The amendment requires the Secretary to implement on October 1, 2010 the concurrent therapy change and changes to the "look-back" period to ensure that only those services furnished after admission are included in determining case mix classification. *(Sec. 10325).* Required Disclosure of Ownership and Additional Disclosable Parties Information.	

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Policy	Senate Bill (H.R. 3590)	Reconciliation Bill (H.R. 4872)
	Requires that skilled nursing facilities (SNFs) under Medicare and nursing facilities (NFs) under Medicaid make available on request by the Secretary, the Inspector General of the Department of Health and Human Services, the States, and the State long-term care ombudsman, information on ownership, including a description of the governing body and organizational structure of the facility and information regarding additional disclosable parties. *(Sec. 6101)* Accountability Requirements for SNFs and NFs. Requires SNFs and NFs to implement a compliance and ethics program to be followed by the facility's employees and its agents within 36 months of enactment, and requires the Secretary to evaluate this program and report the results to Congress. *(Sec. 6102)* Nursing Home Compare Medicare Website. Requires the Secretary to publish the following information on the Nursing Home Compare Medicare website: standardized staffing data, links to State internet websites regarding State survey and certification programs, the model standardized complaint form, a summary of substantiated complaints, and the number of adjudicated instances of criminal violations by a facility or its employee. *(Sec. 6103)* Reporting of Expenditures. Requires the Secretary to modify cost reports for SNFs to require reporting of expenditures on wages and benefits for direct care staff, breaking out registered nurses, licensed professional nurses, certified nurse assistants, and other medical and therapy staff. *(Sec. 6104)* Standardized Complaint Form. Requires the Secretary to develop a standardized complaint form for use by residents (or a person acting on a resident's behalf) in filing complaints with a State survey and certification agency and a State long-term care ombudsman program. States would also be required to establish complaint resolution processes. *(Sec. 6105)* Ensuring Staffing Accountability. Requires the Secretary to develop a program for facilities to report staffing information in a uniform format based on payroll data, and to also take into account services provided by any agency or contract staff. *(Sec. 6106)* GAO Study and Report on Five-Star Quality Rating System. Requires the Government Accountability Office ("GAO") to conduct a study on the Five Star Quality Rating System, which would include an analysis of the systems implementation and any potential improvements to the system. *(Sec. 6107)* Civil Money Penalties. Provides the Secretary with authority to reduce civil monetary penalties (CMPs) from the level that they would otherwise be by 50 percent for certain facilities that self-report and promptly correct deficiencies within ten calendar days of imposition. For CMPs that are cited at the level of actual harm and immediate jeopardy, the Secretary would be provided with the authority to place CMPs in an escrow account following completion of the informal dispute resolution process, or the date that is 90 days after the date of the imposition of the CMP, whichever is earlier. If the facility's appeal is successful, the CMP, with interest, would be returned to the facility. If the appeal is unsuccessful, some portion of the proceeds may be used to fund activities that benefit facility residents. *(Sec. 6111)* National Independent Monitor Demonstration Project. Directs the Secretary to establish a demonstration project within one year of enactment for developing,	

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Policy	Senate Bill (H.R. 3590)	Reconciliation Bill (H.R. 4872)
	testing and implementing a national independent monitor program to conduct oversight of interstate and large intrastate chains. The HHS OIG would evaluate the demonstration project after two years. *(Sec. 6112)* Notification of Facility Closure. Requires the administrator of a facility that is preparing to close to provide written notification to residents, legal representatives of residents or other responsible parties, the State, the Secretary and the long-term ombudsman program in advance of the closure by at least 60 days. Facilities would be required to prepare a plan for closing the facility by a specified date that is provided to the State, which must approve it and ensure the safe transfer of residents to another facility or alternative setting that the State finds appropriate in terms of quality, services and location, taking into consideration the needs and best interests of each resident. *(Sec. 6113)* National Demonstration Projects on Culture Change and Use of Information Technology in Nursing Homes. Requires the Secretary to conduct two facility-based demonstration projects that would develop best practice models in two areas. The first would be designed to identify best practices in facilities that are involved in the "culture change" movement, including the development of resources where facilities may be able to access information in order to implement culture change. The second demonstration would focus on development of best practices in information technology that facilities are using to improve resident care. *(Sec. 6114)* Dementia and Abuse Prevention Training. Requires facilities to include dementia management and abuse prevention training as part of pre-employment initial training for permanent and contract or agency staff, and if the Secretary determines appropriate, as part of ongoing in-service training. *(Sec. 6121)* Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long Term Care Facilities and Providers. Requires the Secretary to establish a nationwide program for national and State background checks on direct patient access employees of certain long-term supports and services facilities or providers. This program is based on the background check pilot program in the Medicare Modernization Act. *(Sec. 6201)*	
Marriage and Family Therapist Services and Mental Health Counselor		
Extension of Physician Fee Schedule Mental Health Add-On	Extension of Physician Fee Schedule Mental Health Add-On. Increases the payment rate for psychiatric services by 5 percent for two years, through the end of 2010. *(Sec. 3107)*	
Clinical Laboratory	Fee schedule reduction. For 2011-2015, reduces the annual fee schedule update by 1.75 percent after the productivity adjustment (below). This adjustment may result in a negative update or in payment rates being less than the preceding year. *(Sec. 3401(l))* Productivity Adjustment. Implements the productivity adjustment (see Part A market basket updates) beginning in 2011 except in a year where the fee schedule increase is zero or negative. The productivity adjustment shall not cause the annual	

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Policy	Senate Bill (H.R. 3590)	Reconciliation Bill (H.R. 4872)
	fee schedule update to be less than zero. Treatment of Certain Complex Diagnostic Laboratory Tests. Creates a demonstration program to test the impact of direct payments for certain complex laboratory tests on Medicare quality and costs. A complex laboratory test is defined as a diagnostic laboratory test: that is an analysis of gene protein expression, topographic genotyping, or a cancer chemotherapy sensitivity assay; that is determined by the Secretary to be a laboratory test for which there is not an alternative test having equivalent performance 9 characteristics; which is billed using a HCPCS code other than a not otherwise classified code; which is approved or cleared by the FDA or is covered under the Social Security Act; and is described in section 1861(s)(3) of the SSA (diagnostic X-ray tests issued under section 354 of the Public Health Service Act, diagnostic laboratory tests, and other diagnostic tests). Appropriates $5 million from the Federal Supplemental Medical Insurance Trust Fund for this provision. *(Sec. 3113).*	
Transparency Provisions	Limitation on Medicare Exception to the Prohibition on Certain Physician Referrals for Hospitals. Prohibits physician-owned hospitals that do not have a provider agreement prior to August 1, 2010, from participating in Medicare. Hospitals that have a provider agreement prior to August 1, 2010 may continue to participate in Medicare subject to certain reporting requirements relating to conflict of interest, bona fide investments, and patient safety issues, and expansion limitations. The Secretary shall make information submitted by hospitals relating to physician ownership and investment available to the public. The Secretary shall establish policies and procedures to ensure compliance with such provisions. This may include unannounced site reviews of hospitals. Not later than May 1, 2012, the Secretary shall conduct audits to determine if hospitals are in violation of such provisions. *(Sec. 6001)* Transparency Reports and Reporting of Physician Ownership or Investment Interests. Beginning on March 31, 2013, and on the 90th day of each calendar year beginning thereafter, any covered drug, device, biological, or medical supply manufacturer that provides a payment or other transfer of value to a physician or teaching hospital shall submit to the Secretary certain information with respect to the preceding year. Such information shall include, among other things, the name of the recipient, the amount of the payment or other transfer of value, and the nature of the payment or other transfer. Similarly directs any applicable manufacturer or group purchasing organization to submit to the Secretary information relating to any ownership or investment interest held by a physician in the applicable manufacturer or group purchasing organization. Noncompliance by the manufacturer or group purchasing organization will result in civil money penalties of not less than $1,000 and not more than $10,000 for each violation. Reported information to the Secretary will be made available to the public. Preempts state law as of January 1, 2012, unless state law is beyond the scope of this section. *(Sec. 6002)* Disclosure Requirements for In-Office Ancillary Services Exception to the Prohibition on Physician Self-Referral for Certain Imaging Services. Amends requirement to the in-office ancillary exception of the Stark law that would include a requirement that with respect to magnetic resonance imaging, computed tomography, positron emission tomography, and any other designated health services, as determined by the Secretary, the referring physician must inform the individual at the time of the referral that the individual may obtain the services from a person other than the referring physician, a physician who is a member of the same group practice as the referring physician, or an individual who is directly supervised by the physician or by another physician in the group practice. The	Physician Ownership-Referral. Delays the date after which physician-owned hospitals that do not have a prior provider agreement can participate in Medicare (from August 1, 2010 to December 31, 2010). Allows high Medicaid facilities to apply for an exception from the prohibition. High Medicaid facilities are defined as hospitals that, for the most recent 3 years for which data is available, treat the highest percentage of Medicaid patients in their county (and are not a sole community hospital). *(Sec 1106).*

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Policy	Senate Bill (H.R. 3590)	Reconciliation Bill (H.R. 4872)
	individual must be provided with a written list of suppliers who furnish services in the area in which the individual resides. This new requirement would apply to services furnished on or after January 1, 2010. *(Sec. 6003)* Prescription Drug Sample Transparency. Beginning in 2012, not later than April of each year, each drug manufacturer and authorized distributer of record shall submit to the Secretary information with respect to the preceding year on the identity and quantity of drug samples requested and the identity and quantity of drug samples distributed during that year. *(Sec. 6004)* Pharmacy Benefit Managers Transparency Requirements. Requires Pharmaceutical Benefit Managers (PBMs) or a qualified health benefits plan offered through an exchange to provide to the Secretary, and in the case of a PBM, to the plan with which the PBM is under contract with, the following information - (i) the percentage of all prescriptions that are provided through retail pharmacies compared to mail order pharmacies, and the percentage of prescriptions for which a generic drug was available and dispensed, by a pharmacy type that is paid by the health benefits plan or PBM under the contract; (ii) the aggregate amount and types of rebates, discounts and price concessions that the PBM negotiates that are attributable to patient utilization under the plan, and that are passed through to the plan sponsor, and; (iii) the aggregate amount of the difference between the amount the plan pays the PBM and the amount the PBM pays the retail and mail order pharmacy and the total number of prescriptions that are dispensed. All disclosed information would be confidential, except for certain specific purposes that do not identify the PBM, plan, or prices charge for drugs. The same penalties that apply to a manufacturer under agreement with the Secretary under the Medicaid rebate statute would apply to PBMs and plans that fail to provide required information. *(Sec. 6005)* Transparency in Government. Not later than 30 days after the date of enactment of this Act, the HHS Secretary shall publish on the HHS website a list of all of the authorities provided to the Secretary under this Act. *(Sec. 1552)*	
Revenue Provisions	Excise Tax on High Cost Employer-Sponsored Health Insurance. Imposes an excise tax on insurers if aggregate value of employer-sponsored health coverage for an employee exceeds a threshold amount. The tax would be equal to 40 percent of the aggregate value that exceeds the threshold amount (i.e., excess benefit). For 2013, the threshold amount would be $8,500 for individual coverage and $23,000 for coverage other than individual coverage. For plans that cover individuals who are qualified retirees or who participate in a plan sponsored by an employer, the majority of whose employees are engaged in a high-risk profession (as defined by the section) or employed to repair or install electrical or telecommunications lines, the threshold amounts are increased by $1,350 for individual coverage and $3,000 for coverage other than for the individual. For years after 2013, the amounts will be increased by the CPI-U plus 1 percentage point. A transition rule applies to high cost states such that the annual limitation for those states would be 120 percent of the annual limitation for 2013; 110 percent of the annual limitation for 2014; and 105 percent of the annual limitation for 2015. Imposes penalties for incorrectly calculating the excess benefit for purposes of paying the tax. The tax would not be deductible for federal income tax purposes. Plans providing certain excepted benefits will not be subject to the excise tax. Effective for taxable years beginning after December 31, 2012. *(Sec. 9001)* Inclusion of Cost of Employer-Sponsored Health Coverage on W-2. An employer would be required to disclose the value of the benefit provided by the employer for	High-Cost Plan Excise Tax. Delays application of the tax from 2013 to 2018. Raises the threshold amount from $8,500 to $10,200 for individuals and $23,000 to $27,500 for families (indexed for inflation). In 2018, if the per employee cost for providing coverage under the Blue Cross/Blue Shield standard benefit option under the FEHBP exceeds the cost of that plan in 2010 indexed based on general inflation, then the threshold amount will be immediately increased by this amount. Allows adjustments to the threshold for employers with significantly different age/gender employee compositions from that of the national workforce. Increases

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Policy	Senate Bill (H.R. 3590)	Reconciliation Bill (H.R. 4872)
	each employee's health insurance coverage on the employee's annual Form W-2. Effective beginning in the first taxable year after December 31, 2010. *(Sec. 9002)* Distribution for Medicine Qualified Only if for Prescribed Drug or Insulin. Effective for expenses incurred, and amounts paid, after December 31, 2010, provides that nontaxable reimbursements from health flexible spending accounts (FSAs), health reimbursement arrangements (HRAs), and health savings accounts (HSAs) do not include a medicine or drug unless the medicine or drug is prescribed or is insulin. *(Sec. 9003)* Increase in Additional Tax on Distributions from HSAs and Archer MSAs not Used for Qualified Medical Expenses. Increases the additional tax for HSA withdrawal prior to 65 that are used for purposes other than qualified medical expenses from 10 to 20 percent. The additional tax for Archer MSA withdrawals would increase from 15 to 20 percent. Effective for distributions after December 31, 2010. *(Sec. 9004)* Limitation on Health Flexible Spending Arrangements Under Cafeteria Plans. Limits the amount of salary contributions to Health FSAs under a cafeteria plan to $2,500. Effective for taxable years beginning after December 31, 2010. For any taxable year after December 31, 2011, the $2,500 will be adjusted by the CPI-U. *(Sec. 9005)* Expansion of Information Reporting Requirements. Requires businesses that pay any amount greater than $600 during the year to corporate and non-corporate providers of property and services to file an information report with each provider and with the IRS. *(Sec. 9006)* Additional Requirements for Charitable Hospitals. Establishes additional requirements to quality as a section 501(c)(3) charitable hospital organization, including conducting community needs assessments. Imposes an excise tax of $50,000 on a hospital organization that fails to meet the requirements of section 501(r)(3) for any taxable year. Limits the amount that can be charged by a charitable hospital for emergency or medically necessary to individuals eligible for assistance to the amount generally billed for such care. Directs the Secretary of the Treasury to review at least once every 3 years the community benefit activities of each hospital organization to which 501(r) applies. The Secretary of the Treasury, in consultation with the Secretary of HHS, shall annually report to Congress. Effective for taxable years beginning after the Act's enactment except with the respect to the community health needs assessment, which will apply 2 years after the Act's enactment. *(Sec. 9007)* Imposition of Annual Fee on Branded Prescription Pharmaceutical Manufacturers and Importers. Imposes a $2,300,000,000 aggregate fee on all manufacturers and importers with gross receipts from branded prescription drug sales to be paid to the Secretary of the Treasury not later than the annual payment date of each calendar year beginning after 2009. The fee for each manufacturer and importer is based on the market share of branded prescription drugs sales and would not apply to companies with sales of $5,000,000 or less. Applies to any branded prescription drug sales after December 31, 2008. *(Sec. 9008)* Imposition of Annual Fee on Medical Device Manufacturers and Importers. Imposes a fee on any person that manufacturers or imports medical devices offered for sale in the U.S. For years 2011 through 2017, the aggregate fee on the sector	the threshold for individuals who are retirees or work in certain high-risk fields ($11,850 for individuals and $30,950 for families). Exempts dental and vision coverage from the premium amounts subject to the tax. *(Sec. 1401)* Medicare Tax. Amends the IRC to include net investment income in the taxable base. Imposes on individuals a 3.8 percent tax of the net investment income for such taxable year or the excess (if any) of the modified adjusted gross income for such taxable year over the threshold amount ($250,000 for joint filers or a surviving spouse; $125,000 for a married taxpayer filing separately; $200,000 for anyone else) whichever is less. In the case of estates and trusts, the tax would be 3.8 percent of the undistributed net investment income for such taxable year or the excess (if any) of the adjusted gross income for such taxable year over the dollar amount at which the highest bracket begins for such taxable year, whichever is less. Net investment income is the excess (if any) of the sum of gross income from interest, dividends, annuities, royalties, and rent, other than income derived in the ordinary course of trade or business. Net investment income is reduced by properly allocable deductions to such income. Effective for taxable years beginning after December 31, 2012. *(Sec. 1402)* Amends FICA and SECA tax increases to apply to married taxpayers filing separately with incomes over $125,000 during the applicable taxable year. Effective for taxable years

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	would be $2,000,000,000 apportioned among companies each year based on relative market share and payable annually. For years after 2017, the aggregate fee would be $3,000,000,000. "Medical device sales" include sales for any medical device, other than class II products that are primarily sold to consumers for not more than $100 per unit and class I devices. Not later than the date following the end of the calendar year determined by the Secretary of the Treasury, each company shall report to the Secretary on gross receipts from medical device sales. Imposes penalties for failing to report to the Secretary. Effective for medical device sales after December 31, 2008. *(Sec. 9009)* Imposition of Annual Fee on Health Insurance Providers. Beginning in 2011, imposes an annual fee to any U.S. health insurance provider with respect to health insurance. The aggregate annual fee for all U.S. health insurance providers would be $2,000,000,000 for 2011; $4,000,000,000 for 2012; $7,000,000,000 for 2013; $9,000,000,000 for 2014 through 2016; and $10,000,000,000 for 2017 and thereafter. Not later than the date following the end of the calendar year determined by the Secretary of the Treasury, each insurer shall report to the Secretary on their net premiums. Imposes penalties for failing to report to the Secretary. Exempts from the fee certain insurers including nonprofits with a medical loss ration of 90 percent or more. Applies to any net premiums written after December 31, 2009. *(Sec. 9010)* Study and Report of Effect on Veterans Health Care. Directs Secretary of Veterans Affairs to conduct a study on the effect (if any) of the provisions relating to the fees on branded pharmaceutical manufacturers and importers, medical device manufacturers and importers, and health insurance providers on the cost of medical care provided to veterans and veterans' access to medical devices and branded prescription drugs. The Secretary shall report on its study to Congress not later than December 31, 2012. *(Sec. 9011)* Elimination of Deduction for Expenses Allocable to Medicare Part D Subsidy. Eliminates the deduction for the subsidy for employers who maintain prescription drug plans for their Medicare Part D eligible retirees. *(Sec. 9012)* Modification of Itemized Deduction for Medical Expenses. Increases the threshold for the deduction from 7.5 percent of adjusted gross income (AGI) to 10 percent of AGI for regular income tax purposes. For taxable year beginning after December 31, 2012 and ending before January 1, 2017, individuals age 65 and older (and their spouses) are exempt from the increased threshold and would continue to be eligible to claim the section 213 deduction if their medical expenses exceed 7.5 percent of AGI. Effective for taxable years beginning after December 31, 2012. *(Sec. 9013)* Limitation on Excessive Remuneration Paid by Certain Health Insurance Providers. Beginning after December 31, 2012, creates a special rule under section 162(m) regarding the deductibility of excessive remuneration (including deferred deduction remuneration) by an insurance provider, 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 creditable coverage requirements in the legislation (i.e., a "covered health insurance provider"). Specifically, no deduction would be allowed for remuneration that is attributable to services performed by an applicable individual (e.g., officers, employees, directors, other workers or service providers performing services for or on behalf of a covered health insurance provider) during a taxable year to the extent that such remuneration exceeds $500,000. Effective for remuneration paid in taxable years beginning after	beginning after December 31, 2012. *(Sec. 1402)* Delay of Limitation on Health Flexible Spending Arrangements Under Cafeteria Plans. Imposes two year delay. Postpones application of this provision from taxable years beginning after December 31, 2010 to taxable years beginning after December 31, 2012. For any taxable year after December 31, 2013, the $2,500 will be adjusted by the CPI-U. *(Sec. 1403)* Brand Name Pharmaceuticals. Imposes a one year delay. Postpones the tax on brand name pharmaceuticals until 2011. Replaces the $2,300,000,000 with an "applicable amount" as defined in the Act. *(Sec. 1404)* Excise Tax on Medical Device Manufacturers. Repeals this provision in the Senate bill. Converts the annual fee in the Senate bill to an excise tax of 2.9 percent of the price of the medical device sold. Exempts from the tax class I devices, eyeglasses, contact lenses, hearing aids, and any other medical device determined by the Secretary to be of a type that is generally purchased by the general public at retail for individual use. Effective for medical device sales after December 31, 2012. *(Sec. 1405)* Health Insurance Providers. Delays fee by 3 years to 2014. Modifies the annual fee for revenue neutrality. For tax-exempt insurance providers, only 50 percent of their net premiums will count towards calculating the fee. Exempts voluntary employee benefit

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Policy	Senate Bill (H.R. 3590)	Reconciliation Bill (H.R. 4872)
	December 31, 2009. *(Sec. 9014)* Additional Hospital Insurance Tax on High-Income Taxpayers. Increases hospital insurance tax (FICA and SECA) rate by 0.9 percent on individual taxpayers earning over $200,000 and for taxpayers filing jointly that earn over $250,000. Applies with respect to remuneration received, and taxable years beginning, after December 31, 2012. *(Sec. 9015)* Modification of Section 833 Treatment of Certain Health Organizations. Requires that nonprofit Blue Cross Blue Shield organizations have a medical loss ratio of 85 percent or higher in order to take advantage of the special tax benefits provided to them under section 833 of the IRC. Effective for taxable years beginning after December 31, 2009. *(Sec. 9016)* Excise Tax on Indoor Tanning Services. Imposes a tax equal to 10 percent of the amount paid for any indoor tanning service, whether paid by insurance or otherwise, on the individual for whom the services are performed. Effective for services performed on or after July 1, 2010. *(Sec. 9017)* Exclusion for Assistance Provided to Participants in State Student Loan Repayment Programs for Certain Health Professionals. Excludes from gross income any amount received under any State loan repayment or loan forgiveness program that is intended to provide for the increased availability of health care services in underserved or health professional shortage areas. Applies to amounts received by an individual in taxable years beginning after December 31, 2008. *(Sec. 10908)* Expansion of Adoption Credit and Adoption Assistance Programs. Increases the adoption tax credit and adoption assistance exclusion to $13,170 with CPI-U adjustments in taxable years beginning after December 31, 2010. Makes the credit refundable. Extends the credit through December 31, 2011. Applies to taxable years beginning after December 31, 2009. *(Sec. 10909)* Protecting Middle Class Families from Tax Increases. Expresses the sense of the Senate that the Senate should reject any procedural maneuver that would raise taxes on middle class families. *(Sec. 9023)* [Added by Baucus Amendment 3183]	associations and non-profits that receive more than 80 percent of gross revenues from government programs under the Social Security Act that target low-income, elderly, and disabled populations. *(Sec. 1406)* Delay of Elimination of Deduction for Expenses Allocable to Medicare Part D Subsidy. Imposes a two year delay. Postpones application of this provision from taxable years beginning after December 31, 2010 to taxable years beginning after December 31, 2012. *(Sec. 1407)* Elimination of Unintended Application of Cellulosic Biofuel Producer Credit. Adds a new revenue provision. Excludes unprocessed fuels (e.g., black liquor) where more than 4 percent of the fuel is any combination of water and sediment or the ash content is more than 1 percent. Effective for fuels sold or used on or after January 1, 2010. *(Sec. 1408)* Codification of Economic Substance Doctrine and Penalties. Adds a new revenue provision. Clarifies the manner in which the economic substance doctrine should be applied in courts. Imposes penalties on underpayments attributable to transactions lacking economic substance. Effective for transactions entered into after the date of the enactment of this Act. *(Sec. 1409)* Time for Payment of Corporate Estimated Taxes. Increases the corporate estimated tax to 14.5 percent for 2014 under the Corporate Estimated Tax Shift

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		Act of 2009. *(Sec. 1410)* No Impact on Social Security Trust Funds. Directs the Secretary to annually estimate the impact of this Act on the income and balances of the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund. Requires the Secretary to transfer funds from the general revenues of the Federal government, not less frequently than quarterly, to ensure that the income and balances of such trust funds are not reduced as a result of this Act. *(Sec. 1411)*
Miscellaneous Provisions	Prohibition against Discrimination on Assisted Suicide. Prevents the Federal government, and any State or local government or health care provider that receives Federal financial assistance from subjecting any individual or institutional health care entity to discrimination on the basis that the entity does not provide assisted suicide, euthanasia, or mercy killing. *(Sec. 1553)* Access to Therapies. Prevents the HHS Secretary from promulgating regulations that create unreasonable barriers to individuals obtaining medical care; impede timely access to health care services; interfere with communications regarding a full range of treatment options between patient and provider; restrict the ability of providers to provide full disclosure of all relevant information for making health care decisions; violate the principles of informed consent and ethical standards of health care professionals; or limit the availability of treatment for the full duration of a patient's medical needs. *(Sec. 1554)* Freedom Not to Participate in Federal Health Insurance Programs. Provides that no individual, company, business, nonprofit entity, or health insurance issuer shall be required to participate in any Federal health insurance program created under this Act. *(Sec. 1555)* Improving Women's Health. Establishes an Office of Women's Health in the Office of the Secretary, the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration, the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, and the Food and Drug Administration. *(Sec. 3509)* Equity for Certain Eligible Survivors. Provides for improvements to the Black Lung Benefits Act. *(Sec. 1556)* Nondiscrimination. Protects individuals against discrimination under the Civil Rights Act, the Education Amendments Act, the Age Discrimination Act, and the Rehabilitation Act, through exclusion from participation in or denial of benefits under any health program or activity. *(Sec. 1557)* Protection for Employees. Amends the Fair Labor Standards Act to ensure that no employer shall discharge or in any manner discriminate against any employee with	Implementation Funding. Creates a $1,000,000,000 Health Insurance Reform Implementation Fund within HHS for implementation on the Patient Protection and Affordable Care Act and the Reconciliation Act. (*Sec. 1005)* Community Health Centers. Increases mandatory funding for community health centers. *(Sec. 2303)*

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Policy	Senate Bill (H.R. 3590)	Reconciliation Bill (H.R. 4872)
	respect to his or her compensation, terms, conditions, or other privileges of employment because the employee has received a premium tax credit; has provided or caused to be provided information relating to a violation of Title I of the PPACA; has testify or is about to testify about such violation; has assisted or is about to assist in such a proceeding; or has objected to or refused to participate in an activity the employee reasonably believes to be in violation of Title I of the PPACA. *(Sec. 1558)* Oversight. The Inspector General of the Department of HHS shall have oversight authority with respect to the administration and implementation of title I related to quality affordable health care for all Americans. *(Sec. 1559)* Rules of Construction. Nothing in this title shall be construed to modify, impair, or supersede the operation of any antitrust laws. Nothing in this title shall modify or limit the application of the exemption for Hawaii's Prepaid Health Care Act under ERISA. Nothing in this title shall be construed to prohibit an institution of higher education from offering a student health insurance plan, to the extent that such requirement is otherwise permitted under applicable Federal, State, or local law. *(Sec. 1560)* Extension of Gainsharing Demonstration. The Deficit Reduction Act of 2005 authorized a demonstration to evaluate arrangements between hospitals and physicians designed to improve the quality and efficiency of care provided to beneficiaries. This provision would extend the demonstration through September 30, 2011 and extend the date for the final report to Congress on the demonstration to September 30, 2012. It would also authorize an additional $1.6 million in FY2010 for carrying out the demonstration. *(Sec. 3027).* Maternal, Infant and Early Childhood Home Visiting Programs. Adds new section 511 in Title V of the Social Security Act (Maternal and Child Health block grant program) to require states, as a condition for receiving the MCH block grant, to conduct a needs assessment to identify communities that are at risk for poor maternal and child health and have few quality home visitation programs. Establishes new state grant program for early childhood home visitation and appropriates $1.5 billion between FY2010 and FY2014. *(Sec. 2951 adding Sec. 511)* Support, Education, and Research for Postpartum Depression. Provides for support services to women suffering from postpartum depression and psychosis and helps educate mothers and their families about these conditions. Authorizes $3 million for FY 2010 and such sums as may be necessary for FYs 2011 and 2012. Encourages support for research into the causes, diagnoses, and treatments for these conditions. *(Sec. 2952)* Personal Responsibility Education. Provides $75 million per year through FY2014 for Personal Responsibility Education grants to States for programs to educate adolescents on both abstinence and contraception for prevention of teenage pregnancy and sexually transmitted infections, including HIV/AIDS. Funding is also available for 1) innovative teen pregnancy prevention strategies and services to high-risk, vulnerable, and culturally under-represented populations, 2) allotments to Indian tribes and tribal organizations, and 3) research and evaluation, training, and technical assistance. (*Sec. 2953 adding Sec. 513)* Restoration of Funding for Abstinence Education. Restores the appropriation of $50 million for each of FYs 2010 through 2014 for abstinence education. *(Sec. 2954)*	

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	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. Provides for the education of children, who are transitioning out of foster care, about a health care power of attorney, health care proxy, or other document and provides an opportunity for the adolescent to designate a medical power of attorney. Effective October 1, 2010. *(Sec. 2955)* Exclusion of Health Benefits Provided by Indian Tribal Governments. Provides an exclusion from gross income for the value of specified Indian tribal health benefits. (*Sec. 9021)* Establishment of Simple Cafeteria Plans for Small Business. Provides a safe harbor from the nondiscrimination requirements for eligible small employers that maintain "simple cafeteria plans." Employers must meet minimum contribution requirements. All employees must be eligible for the employers to meet the eligibility requirements, except that certain employees may be excluded. "Small employer" means an employer that employs an average of 100 or fewer employees on business days during either of the two preceding years. Effective for years beginning after December 31, 2010. *(Sec. 9022)* Qualifying Therapeutic Discovery Project Credit. Creates a 2-year temporary tax credit to an overall cap of $1,000,000,000 to encourage investments in new therapies to prevent, diagnose, and treat acute and chronic diseases. For any taxable year the credit is an amount equal to 50 percent of the qualified investment with respect to any qualifying therapeutic discovery project of an eligible taxpayer (i.e., a taxpayer that employs not more than 250 employees in all businesses of the taxpayer at the time of the submission of the application). An investment shall be considered a qualified investment if such investment is made in taxable year beginning in 2009 or 2010. Not later than 60 days after the Act's enactment, the Secretary of the Treasury shall establish a qualifying therapeutic discovery program to consider and award certifications for qualified investments eligible for credits to qualifying therapeutic discovery project sponsors. Similar provisions apply to grants for qualified investments in therapeutic discovery projects in lieu of tax credits. Effective to amounts paid or incurred after December 31, 2008. *(Sec. 9023)* GAO Study and Report on Causes of Action. Within two years of enactment, requires the Comptroller General to submit a study on whether certain provisions of the bill create new causes of action or claims. *(Sec. 3512)* Support for Pregnant and Parenting Teens and Women. Defines certain terms. Establishes a Pregnancy Assistance Fund for the purpose of awarding competitive grants to States to assist pregnant and parenting teens and women. Fund shall be established by the Secretary in coordination with the Secretary of Education. States may distribute these funds to high schools, community service centers, and institutions of higher education. Institutions of higher education that receive funding must provide funding from non-Federal funds equal to 25 percent of the amount of the Federal funding provided. Funds may be used to assess available pregnancy and parenting resources and to set goals for improving these resources and access to such resources. States must submit an annual report on the funds distributed for this program and the number of students served. States may also use the funds to improve services for pregnant women who are victims of domestic violence, sexual violence, sexual assault, and stalking. States may also use a portion of the funding to raise awareness concerning the services available to	

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	pregnant and parenting teens and women. Appropriates $25 million for each of FYs 2010 through 2019. *(Sections 10211, 10212, 10213, 10214)* Minority Health. Codifies the Office of Minority Health at the Department of Health and Human Services (HHS) and a network of minority health offices located within HHS. Elevates the Office of Minority Health at the National Institutes of Health from a Center to an Institute. The Offices of Minority Health would monitor health, health care trends, and quality of care among minority patients and evaluate the success of minority health programs and initiatives. *(Sec. 10334)* Cures Acceleration Network. Authorizes the Cures Acceleration Network (CAN), within the National Institutes of Health (NIH), to award grants and contracts to eligible entities (public or private entities including research institutions, institutions of higher education, medical centers, biotechnology/pharma companies, disease/patient advocacy organizations and academic research institutions) to develop cures and treatments of diseases. Grants would be awarded to accelerate the development of high-need cures, including through the development of medical products and behavioral therapies. The network would work with the Food and Drug Administration (FDA) to streamline protocols assuring compliance with regulations and standards that meet regulatory requirements at all stages of manufacturing, review, approval, and safety surveillance. Grants would be not more than $15 million per project for the first fiscal year and could be up to $15 million for a fiscal year after the initial award. Appropriates $500 million for 2010 and such sums as may be necessary for subsequent fiscal years. *(Sec. 10409)* Centers of Excellence for Depression. Directs the Administrator of the Substance Abuse and Mental Health Services Administration to award grants to centers of excellence in the treatment of depressive disorders (mental or brain disorders relating to depression, including major depression, bipolar disorder and related mood disorders). Appropriates $100 million for each of fiscal years 2011-2015 and $150 million for each of fiscal years 2016-2020. *(Sec. 10410)* State Demonstration Programs to Evaluate Alternatives to Current Medical Tort Litigation. Authorizes states to conduct demonstration programs to evaluate alternatives to current medical tort litigation. Grants may be awarded for no more than 5 years. Alternatives to tort litigation should allow for resolution of disputes and promote a reduction of health care errors by encouraging the collection and analysis of patient safety data related to disputes resolved by organizations that engage in efforts to improve patient safety and the quality of health care. The Secretary shall submit to Congress an annual compendium of the annual reports submitted to the Secretary from states. MedPAC and MACPAC shall conduct independent reviews of the alternatives to current tort litigation implemented by the states and submit reports to Congress not later than December 31, 2016. Appropriates $50,000,000 for the 5-year FY period beginning with FY 2011. *(Sec. 10607)* Extension of Medical Malpractice Coverage to Free Clinics. Extends the protections from liability contained in the Federal Tort Claims Act to free clinics. Effective on the date of the Act's enactment. *(Sec. 10608)* Infrastructure to Expand Access to Care. Appropriates $100,000,000 for FY 2010, to remain available for obligation until September 30, 2011, 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. *(Sec.*	

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	10502) Community Health Centers and the National Health Service Corps Fund. Creates a Community Health Center Fund to be administered by HHS to provide for expanded and sustained national investment in community health centers and the National Health Service Corps. *(Sec. 10503)* Demonstration Project to Provide Access to Affordable Care. Not later than 6 months after the Act's enactment, the Secretary, acting through HRSA, shall establish a 3-year demonstration in 10 states to provide access to comprehensive health care services to the uninsured at reduced fees. Appropriates the sums necessary to carry out the section. *(Sec. 10504)*	
Programs – Pain Care and Management Programs	Advancing Research and Treatment for Pain Care Management. Not later than 1 year after funds are appropriated to carry out this section, the Secretary shall seek to enter into an agreement with IOM to convene a conference on pain management. Among other things, the conference would increase the recognition of pain as a significant public health problem. Directs the Secretary to report to Congress not later than June 30, 2011. Appropriates such sums necessary for FYs 2010 and 2011. Authorizes the Pain Consortium at the NIH to enhance and coordinate clinical research on pain causes and treatments. Not later than 1 year after the Act's enactment establishes an Interagency Pain Research Coordinating Committee to coordinate all efforts within HHS and other federal agencies that relate to pain research. Appropriates sums necessary for FYs 2010 through 2012. *(Sec. 4305)*	
Indian Health	Indian Health Care Improvement. With amendment, incorporates S. 1790 entitled "A bill to amend the Indian Health Care Improvement Act to revise and extend that Act, and for other purposes." *(Sec. 10221)*	

Acronyms used in this chart are defined as follows:

ACO - Accountable Care Organization
AHRQ - Agency for Healthcare Research and Quality
AMP - Average Manufacturer Price
CDC - Centers for Disease Control and Prevention
CHIP – Children's Health Insurance Program
CMP - Civil Money Penalty
CO-OP - Consumer Operated and Oriented Plan
CPI - Consumer Price Index
DMEPOS - DME, Prosthetics, and Supplies
ERISA - Employee Retirement Income Security Act
Early and Periodic Screening, Diagnostic, and Testing
FDA - Food and Drug Administration
FEHBP - Federal Employees Health Benefits Program
FMAP - Federal Medical Assistance Percentage
FPL – Federal Poverty Level
GAO - Government Accountability Office
HSA - Health Savings Account
HHS - Health and Human Services
HCFAC- Health Care Fraud and Abuse Control Account
HRSA - Health Resources and Services Administration
HIT – Health Information Technology
IRS - Internal Revenue Service
LIS - Low-Income Subsidy
MCO - Managed Care Organizations
MCC - Minimum Creditable Coverage
MSA - Metropolitan Statistical Areas
NIH - National Institutes of Health
PAC – Post-Acute Care
PQRI - Physician Quality Reporting Initiative
PHSA - Public Health Service Act
RHQDAPU - Reporting Hospital Quality Data for Annual Payment Update
SAMHSA - Substance Abuse and Mental Health Services Administration
SNPs - Special Needs Plans
VBP - Value-Based Purchasing