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**SUMMARY OF THE HOUSE HEALTH REFORM BILL**

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**AFFORDABLE HEALTH CHOICES**

**Qualified Health Benefits Plans (QHBP)**

To be considered a “qualified health benefits plan,” a plan must:

- Guarantee access to coverage
- Guarantee access to essential benefits
- Ensure consumer protection

Allows for individual to keep their current coverage. Group health plans have five years to meet the standards to be considered a “qualified health plan.”

This provision prohibits pre-existing condition exclusions, and requires guaranteed issue and renewal of plans offered both through the Exchange or any group health plan. The legislation also sets the following conditions on the premium rate charged under a qualified plan, which may not vary except:

- By age, but no more than a ratio of 2 to 1;
- By area;
- By family enrollment (as long as the ratio of premium for family to individual is uniform)

QHBP will provide for rebates to enrollees for any medical loss ratio less than 85%.

***Essential Benefits***

QHBP must offer at least the standard benefits as set forth in the “essential benefits package.” Plans offered outside of the Exchange can offer benefits above the standard, while those inside the Exchange must provide specified levels of benefits, unless it’s a premium plan, which can offer additional benefits. Minimum services include:

- Hospitalization;
- Outpatient hospital and outpatient clinic services (including emergency);
- Physician and other health professional services;
- Services, equipment and supplies necessary to physician or health professional’s delivery of care in institutional settings, physician offices; patient homes/residences; or other setting;
- Prescription drugs;
- Rehabilitative and habilitative services;
- Mental health and substance use disorder;
- Preventive services, including those graded A or B by the U.S. Preventive Services Task Force and vaccines recommended by the CDC;

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- Maternity benefits;
- Well baby and well child care and oral health, vision, hearing services, equipment, and supplies for those under 21 years of age.

No limits aside from cost-sharing will be imposed if they are unrelated to “clinical appropriateness.” There will be no cost sharing for preventive services. There will be a limit of \$5,000 for an individual and \$10,000 for a family, adjusted by the Consumer Price Index each year, on the amount of cost sharing under the essential benefits plan. The cost-sharing for the essential benefits package will be designed so that it will provide benefits that are actuarially equivalent to 70% of the full actuarial value of the benefits provided if there were no cost-sharing.

There should be a use of copayments rather than coinsurance for the tiered plans.

Eliminates lifetime and/or annual limits on coverage.

### ***Health Benefits Advisory Committee***

A Health Benefits Advisory Committee will be established as a private-public advisory committee, made up of a panel of medical and experts, to recommend covered benefits and an essential benefits package. The Surgeon General will serve as the Chair of the Committee, which will be composed of 9 non-Federal employees or officers appointment by the President, 9 non-Federal employees appointed by the Comptroller General of the U.S. (similar to MedPAC), an even number of not more than 8 members who are Federal employees and officers, as the President may appoint. Appointments will be made within 60 days of enactment. The Committee will reflect providers, consumer representatives, employers, labor, health insurance issuers, experts in health care financing and delivery, individuals knowledgeable about disparities relating to race, ethnicity, and disabilities, representatives of relevant governmental agencies, and at least one practicing physician or other health professional and an expert on children’s health, with a balance among various sectors of the health care system.

The Committee will recommend benefit standards and updates within one year of enactment with public input. Recommendations will include the essential benefits package, cost-sharing levels for both enhanced and premium plans, and for those plans whose benefits are actuarially equivalent to 85% of the essential plan.

### ***Adoption of Recommendations and Benefit Standards***

The Secretary will review the Committee’s recommendations within 45 days and will make a determination of whether to adopt them. Within 18 months of enactment the Secretary will use the rulemaking process to adopt benefit standards.

### ***Consumer Protections***

The Commissioner will establish fair grievance and appeals mechanisms and standards for information transparency and plan disclosure that all QHBPs must comply with.



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For QHBPs not offered through the Exchange, all standards and requirements apply.

### ***Health Choices Commissioner***

The legislation sets up a Health Choices Administration as an independent agency of the federal government, headed by a Health Choices Commissioner, appointed by the President and confirmed by the Senate. In addition to the responsibilities outlined above, the Commissioner will establish and operate the Health Insurance Exchange, collect data to promote quality and value in addressing disparities, and impose sanctions on noncompliant QHBPs. The Commissioner will consult with the National Association of Insurance Commissioners, State attorneys general and State insurance regulators, along with appropriate state and federal agencies.

The Commissioner will also appoint a Qualified Health Benefits Plan Ombudsman who will receive complaints, grievances, and requests for information, as well as to provide assistance to individuals seeking an appeal, with problems arising from disenrollment, and choosing a plan.

### ***Other Requirements***

Requirements applicable under title XXXII and XXVII of the Public Health Service Act (PHSA) are not superseded by this legislation for coverage offered outside of the Exchange. Nothing in this legislation is meant to prevent the application of State laws with respect to private rights of action.

## **Medicaid and CHIP**

### ***Medicaid***

Expands Medicaid to 133.5% of the federal poverty level and provides for coverage upon birth.

States will enter into a Medicaid memorandum of understanding with the Commissioner to coordinate enrollment of individuals in Exchange-participating plans and will determine eligibility for Medicaid when the individual applies for coverage.

For those individuals who are Medicaid eligible but enrolled in a plan through the Exchange, they are entitled to wrap around benefits for coverage not available under the Exchange plan but otherwise covered under Medicaid, at the expense of the State.

The Secretary is required to submit a report to Congress on how health care reforms have reduced the number of uninsured individuals and whether there is a continued role for Medicaid DSH.

Extends transitional Medicaid assistance offered through the ARRA to December 31, 2012 (from December 31, 2010).



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## *CHIP*

Sets a CHIP maintenance of effort requirement so that States cannot set eligibility requirements that are more restrictive than those in effect June 16, 2009. This maintenance of effort does not prohibit states from limiting expenditures for a given fiscal year as long as Federal financial participation is available. Similar maintenance of effort requirements are included for Medicaid.

## *Prevention/Wellness Coverage*

Requires coverage of preventive services graded A or B by the U.S. Preventive Services Task Force and for vaccines recommended for use as appropriate by the Director of the CDC.

Includes public health clinics under the vaccines for children program.

Eliminates the exception of tobacco cessation products from outpatient drug coverage, and includes tobacco cessation counseling as a covered service for pregnant women.

## *Optional Coverage*

Provides for optional coverage of nurse home visitation services for children less than two years of age and women who are pregnant for the first time.

Provides for optional coverage of family planning services including medical diagnosis and treatment services provided pursuant to a family planning service in a family planning setting after cervical cancer.

Provides for optional coverage of freestanding birth center services.

Provides for optional Medicaid coverage of low-income HIV-infected individuals.

## *School-based Health Clinics*

States must implement procedures for payments to school-based health clinics, if payment is made under a State plan for services otherwise provided by a physician's office or other outpatient clinic.

## *Primary Care Practitioners*

Sets a floor for the payment rate for primary care physicians or other primary health care professionals) of not less than 80% of the rate in 2010, 90% in 2011 and 100% in 2012 and beyond.

Allows the Secretary to approve a medical home pilot program that will last 5 years.



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### ***Electronic Eligibility Systems***

Provides for the upgrading and/or design of electronic eligibility systems, which may include the development of an online application system. To receive payments for such systems, States must prove to the Secretary that the system is adequate to provide efficient, economical and effective administration; is compatible with eligibility, enrollment and information retrieval systems already in use; provides accurate and timely data; any contractors used meet federal requirements set by the Secretary; allows States to conduct paperless verification for renewal; is compatible with electronic databases for TANF, CHIP, vital records, food stamps, Head Start, National School Lunch, Child Nutrition Act, CCDBG, homeless assistance, Native American Housing Assistance, unemployment insurance, Federal and/or State wage databases, Social Security data, and other public benefit programs and databases.

### ***Payments to Pharmacists***

The upper payment limit will be calculated at no less than 130% of the weighted average of the most recent average manufacturer prices for pharmaceutically and therapeutically equivalent multiple source drug products that are available for purchase by retail community pharmacies nationally. The Secretary will implement a process for AMPs to ensure that the limits do not vary significantly from month to month.

### ***Prescription Drug Rebates***

Rebates for drugs that are new formulations, such as extended-release versions or innovator multiple source drugs, will be computed as if it were a new drug or the amount for the original single source or innovator multiple source drug if greater. Increases the minimum rebate percentage for single source drugs to 22.1% after December 31, 2009.

Extends prescription drug discounts to Medicaid managed care organization enrollees.

States will report to HHS quarterly on the amount of rebates received from pharmacy manufacturers for drugs for those enrolled with Medicaid managed care organizations.

### ***GME***

States will submit information to the Secretary to be reviewed by the Advisory Committee on Health Workforce Evaluation and Assessment, on how GME payments are being used, including information on what institutions receive funding, how payments are calculated, the types and fields of education being supported, the workforce or other goals to which the funding is being applied, and that goals and requirements are being met.

Goals and requirements will be specified by the Secretary by a rule published prior to December 31, 2011.



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## *Waste Fraud and Abuse*

Prevents payments for certain healthcare-acquired conditions, and requires providers and suppliers to adopt programs to reduce waste, fraud and abuse.

## *Puerto Rico and Territories*

Increases the Medicaid FMAP cap for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands and American Samoa, effective January 1, 2011.

## **Health Insurance Exchange**

Establishes a national Health Insurance Exchange (the Exchange), to facilitate access of individuals and employers to choices of coverage, including a public insurance option. All individuals are eligible for coverage through the Exchange.

Phases in small employers over the course of 3 years: those with fewer than 10 eligible employees will be eligible in year 1, fewer than 20 in year 2, and those larger will be eligible in year 3.

## *Four tiers*

At least one basic plan must be offered through the Exchange for each service area, and if the service area offers an enhanced plan, a premium plan must also be offered. Finally, if a premium plan is offered, a premium-plus plan must also be offered. Standards for these plan tiers will be set by the Commissioner.

- Basic plan: will offer the essential benefits package, with no cost sharing.
- Enhanced plan: a lower level of cost-sharing and an additional level of benefits from the basic plan
- Premium plan: provides additional benefits to the enhanced plan and higher level of cost-sharing.
- Premium-plus plan: provides additional benefits (e.g. adult oral health and vision); the portion of premiums attributable to such additional benefits are separately specified.

The range of cost-sharing is set by the Commissioner, with no cost-sharing permitted under the basic plan. Any State coverage mandates above these will remain in place.

To offer a QHBP through the Exchange, plans must be licensed, provide for data reporting as specified by the Commissioner, provide for the implementation of affordability credits, accept all enrollment subject to exceptions (such as capacity limits), beginning in year 5 provide wrap-around services to Medicaid eligible individuals who elect to enroll in the Exchange, participate in pooling mechanisms, contract with essential community providers, offer culturally and linguistically appropriate services and communications, and comply with any other requirements as set forth by the Commissioner.



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## *Enrollment*

The Commissioner will also conduct outreach activities and information dissemination for individuals and employers offering insurance through the Exchange. The Commissioner will establish the enrollment process for the Exchange, and coordinate the distribution of affordability premium and cost sharing credits.

For children who are not covered for any portion of their first year of life they shall be deemed a non-traditional Medicaid eligible individual. A child who is CHIP eligible the day before the end of the first year of life is automatically Exchange-eligible. Mechanisms will be in place whereby individuals who are eligible for Medicaid will be automatically enrolled. For those individuals in the Exchange who are eligible for Medicaid, they will have the option of either Medicaid enrollment or a plan through the Exchange.

## *Other Functions*

The legislation establishes a Special Inspector General for the Health Insurance Exchange, appointed by the President with confirmation by the Senate.

## *Health Insurance Exchange Trust Fund*

Creates a Health Insurance Exchange Trust Fund, which will include payments made by the Commissioner to the Fund for the Exchange's operating costs. Dedicated payments to the Fund include:

- Taxes on individuals who do not obtain qualified coverage
- Taxes on employers to providing qualified coverage
- Excise taxes on failures to meet health coverage requirements
- Appropriations to cover government contributions

## *State-based Exchanges*

States can apply to the Commissioner to establish its own Exchange either by itself or as a group of States. The state must be able to provide assurances that the State Exchange will carry out the functions of the Exchange, including contracting with QHBPs, establishing local offices, and it is the sole Exchange in the state. Funding for assistance to the state for operating the Exchange will be provided.

## ***Public plan***

Establishes a public health insurance option as an Exchange-qualified health benefits plan, only available through the Exchange. The public option will offer basic, enhanced, and premium plans and could offer premium-plus, although it is not required to do so. The Secretary can contract out to administer the public plan.

An ombudsman's office will be established for the public option.



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Geographically-adjusted premiums will be established for the public option. Additionally, an account will be established within the Treasury for receipts and disbursements attributable to the operation of the public plan.

Payment rates will be established by the Secretary, at similar rates as services and providers under Medicare Part A & B, with the exception of practitioners' services (including pediatricians and others not currently participating in Medicare) and any adjustments the Secretary deems necessary will be set at Medicare rates plus 5%. The Secretary has authority to set new rates for services that are not covered under Medicare, such as well child visits, prescription drugs not covered under Medicare part A or B. Incentives will be set by the Secretary at such rates as will promote payment accuracy, ensure adequate beneficiary access to providers and promote affordability and the efficient delivery of medical care.

The Secretary is encouraged to utilize innovative payment mechanisms and policies to determine the payment for items and services under the public option, including patient-centered medical homes, care management payment, accountable care organizations, value-based purchasing, differential payment rates, performance or utilization based payments, partial capitation, and direct contracting with providers. Innovative payments should seek to improve health outcomes, reduce health disparities, address geographic variation, prevent or manage chronic illnesses, and promote coordinated and integrated care that is patient-centered.

The Secretary will establish conditions of participation for providers under the public option.

The same fraud and abuse provisions that apply with respect to Medicare apply to the public option.

*This legislation provides for a public option, but we are still waiting for the Finance Committee proposal, which is likely to be the most conservative proposal we will see on this topic.*

### ***Individual affordability credits***

Individuals participating in the Exchange may apply to the Commissioner for affordability credits, which will be applied as a reduction of the cost-sharing otherwise applicable to the individual's chosen plan. The Commissioner will reimburse a state for the costs of conducting a Medicaid eligibility determination.

Affordability credits can only be used toward purchasing the basic plan through the Exchange in years 1 and 2. Beginning in year 3 the Commissioner will establish a process whereby affordability credits can be used for enhanced or premium plans.

"Affordable credit eligible individual" is an individual who is lawfully present in a state in the U.S., enrolled in an Exchange-participating plan, with income below 400% of the Federal poverty level (FPL) for the size family involved.

The Commissioner will conduct a study on income disregards with respect to affordability credit eligibility.



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Affordability credit amounts are based on premium percentage limits on a sliding scale. For those at or below 133% FPL the limit is 1%, and for those at 400% FPL the limit is 10%.

The affordability cost-sharing credit is based on the individual family's income, at tiered levels from 133% FPL to 400% FPL, based on a sliding scale. For year 1, the amount is \$250 for an individual and \$500 for a family. The amount is increased each year based on the Consumer Price Index for All Urban Consumers. Cost-sharing amounts are also based on a sliding scale by income.

The Commissioner will study the feasibility of adjusting the application of FPL for different geographic areas to reflect variation in cost of living.

There will be penalties for the intentional misrepresentation of family or individual income.

Includes a provision that prohibits Federal payments for affordability credits on behalf of undocumented aliens.

### **Employer Responsibility**

If an employee declines an offer of qualified individual and family coverage from their employer, the employer must make a contribution to the Exchange in the amount proportional to the average weekly hours of employment of the employee to the minimum weekly hours specified by the Commissioner for an employee to be a full-time employee.

The employer must comply with the Commissioner's process for proving that they either provide qualified coverage to their employees or contribute to the Exchange.

The contribution made by the employer in lieu of coverage is equal to 8% of the wages paid by the employer to employee and will be paid to the Commissioner for payment into the Exchange Trust Fund.

Civil penalties of \$100 per day for each day the employer is in violation will be imposed for any employer who fails to satisfy health coverage participation requirements. Failures corrected within 30 days are not subject to penalties, with limits on those unintentional failures.

Small businesses will be exempt, although the provisions for this are currently under discussion.

### **Individual Responsibility**

Individuals without qualified coverage will be imposed a tax. The tax amount will not exceed the national premium amount for self-only or family coverage under a basic plan. This tax does not apply to dependents, nonresident aliens, individuals residing outside of the U.S., anyone taking a religious conscience exemption, or any exemption otherwise granted by the Secretary.



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The legislation provides for Medicare, Medicaid, TRICARE, and coverage through the VA to be grandfathered into the plan.

Determination regarding coverage will be disclosed on an individual's tax return.

## Small Business Employee Coverage

Small businesses will receive a health coverage credit for qualified health coverage expenses, phased out based on a sliding scale by number of employees (fewer than 25 employees per year who received at least \$5,000 per year) with exemption for employees who make over \$125,000 per year.

## Revenue Provisions

Other revenue provisions are currently under discussion.

## IMMEDIATE INVESTMENTS

Before the implementation of health reform there will be immediate investments for improving efficiency and value in health care. These immediate investments will include:

- Administrative simplification measures including standardized language and forms, operating rules and companion guides for health care transactions, increasing the consistency of claims edits and code corrections across plans, electronic exchange of administrative and clinical data, and standardizing quality reporting requirements;
- Implementation of a minimum loss ratio of not less than 85%;
- Additional programs including reinsurance for early retirees, promotion of the issuance of smart cards (electronic insurance cards), cards for preventive care.

## MEDICARE AND MEDICAID IMPROVEMENTS

### Improving Health Care Value

#### *Medicare Part A*

Provides an update to the skilled nursing facility payment, the inpatient rehabilitation facility payment, includes productivity improvements to market basket updates that do not already have them (inpatient acute hospitals, skilled nursing facilities, long term care hospitals, inpatient rehabilitation facilities, psychiatric hospitals, and hospice care).

The Secretary will conduct an analysis of payments for skilled nursing facilities, and adjust case mix adjusters accordingly. The payment system for costs of skilled nursing facilities for non-therapy ancillary services and therapy services will also be revised. A separate payment component for nontherapy ancillary services and therapy services will also be established.



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The Secretary will submit a report to Congress on Medicare DSH, making recommendations on the appropriate amount, targeting and distribution of Medicare DSH payments to hospitals given their continued uncompensated care costs and the amount, targeting and contribution of Medicare DSH to compensate for higher Medicare costs associated with serving low-income beneficiaries.

### Provisions Related to Part B

#### Physicians Services

##### ***Sustainable Growth Rate Reform***

The legislation provides for a transitional update to the SGR for 2010. The update to the single conversion factor will be the percentage increase in the MEI for the year. To determine the update in 2011 and subsequent years, the SGR will be rebased by setting the allowed expenditures for 2009 equal to the amount of actual expenditures during 2009.

The legislation establishes separate target growth rates for categories of services. For services provided on or after January 1, 2009, the following categories of services will be treated as separate service categories: (1) E/M services and Medicare covered preventive services and (2) all other services. In 2011, separate conversion factors will be established for these categories; they will be updated annually based upon an adjustment factor for the category. The Secretary will be responsible for computing the allowed expenditures for a service category based on a formula outlined in the legislation.

For the accountable care organization (ACO) pilot program, the Secretary will develop a method for application in 2012 that allows each organization to have its own expenditure targets and updates with respect to beneficiaries attributable to that ACO and that the target growth rate applicable to other physicians does not apply to physicians to the extent that their services are provided through the ACO. The Secretary has the discretion to apply the difference on a claim-by-claim or lump sum basis.

*The Senate Finance Committee Options Paper did not provide for permanent reform of the SGR. This proposal for two separate spending targets was based on the House passed CHAMP Act of 2007, which set out multiple spending targets. This takes a step towards addressing the payment inequity facing primary care by separating the spending target for E/M services.*

##### ***Misvalued Codes Under the Physician Fee Schedule***

The Secretary will identify potentially misvalued services, will review them and make appropriate adjustments to their relative values. The Secretary will examine codes and families of codes that experienced the fastest growth, substantial changes in practice expense, codes for new technologies or services within an appropriate period after the relative values are initially established, multiple codes that are frequently billed in conjunction with furnishing a single



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service, codes with low relative values, codes that have not been reviewed since the implementation of the RBRVS, and other codes as the Secretary deems appropriate.

To conduct this review, the Secretary may use existing processes, including surveys and the use of analytic contractors, to receive recommendations on the review and appropriate adjustment of potentially misvalued services.

The Secretary will also establish a process to validate and make appropriate adjustments relative value units under the fee schedule, which may include the validation of work elements and the pre, post and intra-service components of work.

The legislation provides \$20 million for FY 2010 and each subsequent year for identifying potentially misvalued codes and validating relative value units.

### ***Payments for Efficient Areas***

Suppliers paid under the physician fee schedule who provide services in an efficient area between January 1, 2011 and January 1, 2013 will be paid an additional 5 percent of the payment amount for the services. The Secretary will identify the counties or equivalent areas in the United States in the lowest fifth percentile of utilization based on per capita spending for services provided in the most recent year for which data is available. The proposed and final physician fee schedule rule will identify the counties and areas to which this section is applicable.

*Depending on where DOs end up practicing, they may be eligible to collect this bonus if enacted into law.*

### ***Modifications to the Physician Quality Reporting Initiative (PQRI)***

By January 1, 2011, the Secretary will develop a mechanism to provide timely feedback to participating providers. The feedback will include the extent to which the provider is reporting successfully and any recommendations to correct reporting inconsistencies and interim assessments on the probability of the provider receiving an incentive payment. The section also establishes an appeals process in which the provider can request a review of the disputed payment amounts and errors the provider believes were made by the contractor.

The Secretary is directed to develop a plan to integrate clinical reporting on quality measures with the reporting requirements relating to the meaningful use of electronic health records by January 1, 2012. The integration will include the development of measures for which reporting would demonstrate the meaningful use of an electronic health record and the clinical quality of care provided to the patient; it will also require the collection of health data to identify deficiencies in the quality and coordination of care for patients and other activities as specified by the Secretary.

Incentive payments for PQRI are extended through 2012.



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## Market Basket Updates

### *Incorporating Productivity Adjustment Into Market Basket Updates that Do Not Already Incorporate Such Adjustment*

This provision eliminates the 1 percent cut scheduled for 2012 for the market basket update for dialysis. Instead the market basket will be subject to the productivity adjustment, which is defined as a 10 year moving average of changes in annual economy-wide private non-farm business multi-factor productivity.

## Other Provisions

### *Home Infusion Therapy Report to Congress*

The Secretary will submit a report to Congress within a year after enactment on the scope of coverage for home infusion therapy services in traditional fee-for-service Medicare, Medicare Advantage, and the veteran's health care program, the benefits and costs of providing these services, recommendations on the structure of a payment system under Medicare for home infusion therapy services, and recommendations for legislative action relating to coverage for these services.

### *Require Ambulatory Surgical Centers to Submit Cost Data and Other Data*

As a condition of coverage, the Secretary will require the submission of a report on the costs of the facility. No later than 2 years after enactment, the Secretary will develop a cost report form. The Secretary will also provide for periodic auditing of these cost reports.

### *Treatment of Certain Cancer Hospitals*

A study will be conducted by the Secretary to determine if the costs incurred by these hospitals for ambulatory payment classification groups exceed those costs incurred by other hospitals. If the Secretary determines the costs incurred exceed those of other hospitals, an appropriate adjustment will be made to reflect those higher costs for services provided on or after January 1, 2011.

### *Payments for Imaging Services*

An adjustment will be made in practice expense to reflect the higher presumed utilization. The Secretary will adjust the relative value units so it reflects a 75, rather than 50, percent presumed rate of utilization.

The Secretary will increase the reduction in expenditures attributable to the multiple procedure payment reduction applicable to the technical component for imaging from 25 to 50 percent.

## Provisions Related to Medicare Parts A and B



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### ***Reducing Potentially Preventable Hospital Readmissions***

The Secretary will reduce the payments to a hospital that would have been made to account for excess readmissions during a fiscal year on or after October 1, 2010. The reduction will be an amount equal to the product of the base operating DRG payment and the adjustment factor for the hospital for the fiscal year.

The excess readmissions ratio means with respect to an applicable period the ratio of the risk adjusted readmissions based on actual readmissions for an applicable hospital for such condition with respect to the applicable period to the risk adjusted expected readmission for such hospital for such condition with respect to the applicable period. Readmissions for conditions for which there are fewer than a minimum number of discharges will be excluded. Beginning with discharges in FY 2013, the Secretary may provide for the excess readmissions ratio to be based on a ranking of hospitals by readmissions ratios normalized to a benchmark that is lower than the 50<sup>th</sup> percentile. The Secretary will have the authority to expand the number of applicable conditions.

The Secretary will monitor the activities of hospitals to determine if steps have been taken to avoid patients at risk in order to reduce the likelihood of increasing readmissions for applicable conditions. If it is determined a hospital has taken such steps, after notice to the hospital and opportunity for the hospital to take action to alleviate such steps, the Secretary may impose appropriate sanctions.

Beginning on or after FY 2011, the Secretary will increase the DSH payments to targeted hospitals for transitional care activities designed to address the patient noncompliance issues that result in higher than normal readmission rates. These activities include care coordination services, hiring translators, increasing services offered by discharge planners, ensuring individuals receive a summary of care and medication orders upon discharge, developing a quality improvement plan, and assigning discharged individuals to a medical home. The GAO will submit a report to Congress on the use of these funds.

The Secretary will conduct a study to determine how the readmissions policy can be applied to physicians.

### ***Post Acute Care Services Payment Reform Plan***

The Secretary will develop a detailed plan to reform payment for Medicare post acute care services to improve the coordination, quality and efficiency of such services and to improve outcomes for individuals. The plan will include specifications for a bundled payment for post acute services.

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

Each entity provided covered items or services will provide the Secretary with information about its ownership, investment and compensation arrangements. Hospitals with physician ownership



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or investment will submit an initial report and periodic updates to the Secretary containing a detailed description of the identity of each physician owner and physician investor. It will be required that any referring physician owner or investor discloses to the individual being referred the ownership or investment interest as applicable. On any public website or form of advertising, a hospital that is partially or wholly owned by physicians or physician investors must disclose that fact. Failure to disclose will result in a penalty of not more than \$10,000 for each case in which disclosure was not made.

### **Medicare Advantage Reforms**

#### **Payment and Administration**

##### ***Phase-in of Payment Based on Fee-for-Service Costs***

A blended benchmark rate will be determined annually for each area. The amount takes into account the phase-out in the indirect costs of medical education from capitation rates and sets a fee-for-service payment floor. This will not apply to PACE programs.

##### ***Quality Bonus Payments***

For years beginning with 2011, a Medicare Advantage plan designated as a high quality MA plan will have its blended benchmark amount increased by 1 percent in 2011, 2 percent in 2012 and 3 percent in subsequent years. For those MA plans designated as improved quality MA plans will have their blended benchmark amount increased by .33 percent in 2011, .66 percent in 2012 and by 1 percent in subsequent years. The Secretary will provide for the computation of quality performance scores by a formula outlined in the section.

By 2013, the Secretary will implement reporting requirements for quality designed to reflect the outcomes of care experienced by those in MA plans. These measures may include measures of rates of admission and readmission to a hospital, measures of prevention quality, measures of patient mortality and morbidity following surgery, measures of health functioning and survival for patients with chronic diseases and measures of patient safety. These measures will be risk-adjusted as appropriate.

##### ***Extension of Reasonable Cost Contracts***

Extends reasonable cost contracts until January 1, 2012.

##### ***Limitation of Waiver Authority for Employer Group Plans***

The Secretary may waive requirements that may hinder enrollment in MA plans only if 90 percent of the MA eligible individuals enrolled reside in a county in which the MA organization offers a MA local plan. This provision takes effect January 1, 2011.



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### ***Improving Risk Adjustment for MA Payments***

Within a year of enactment, the Secretary will submit a report to Congress that evaluates the need and feasibility of improving the adequacy of the risk adjustment system in predicting costs for non-Medicaid eligible low-income beneficiaries.

### ***Elimination of MA Regional Plan Stabilization Fund***

The fund is eliminated, and any amount contained in it on the date of enactment will be transferred to the Federal Supplementary Medical Insurance Trust Fund.

### **Consumer Protections and Anti-Fraud**

### ***Limitations on Out-of-Pocket Costs for Individual Health Services***

MA plans are prohibited from using a flat copayment or per diem rate in lieu of the cost-sharing that would be imposed under part A or B as long as the amount of the cost-sharing imposed does not exceed the amount of the cost-sharing that would be imposed under the respective part if the individual was not enrolled in a MA plan.

### **Treatment of Special Needs Individuals; Medicaid Integration**

### ***Limitation on Enrollment Outside Open Enrollment Period of Individuals into Chronic Care Specialized MA Plans for Special Needs Individuals***

The MA plan will not enroll an individual on or after January 1, 2011 other than during an open enrollment period except when at the time of the diagnosis of the disease or condition that qualifies the individual as a special needs individual.

### ***Extension of Authority of Special Needs Plans to Restrict Enrollment***

Special needs plans may continue to restrict enrollment until January 1, 2013.

### ***Fully Integrated Dual Eligible Special Needs Plans***

The Secretary will designate MA plans as fully integrated dual eligible special needs plans for the purposes of advancing fully integrated Medicare and Medicaid benefits and services for dual eligibles, during the 5 year period beginning in 2011.

### ***Improved Coordination for Dual Eligibles***

The Secretary will provide a focused effort to provide for improved coordination between Medicare and Medicaid through a specific office or program within CMS for dual eligibles. Improved coordination will include efforts to simplify access to benefits, improve care continuity, harmonize regulatory conflicts and improve total cost and quality performance.

### **Improvements to Medicare Part D**



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### ***Requiring Drug Manufacturers to Provide Drug Rebates for Certain Full Premium Subsidy Eligible Individuals***

A rebate agreement will require the manufacturer to provide the Secretary a rebate for each rebate period ending after December 31, 2010 for any covered outpatient drug to any full premium subsidy Medicare drug plan enrollee for which payment was made by a PDP sponsor under Part D.

The rebate will be equal to the total number of units of dosage form and strength of the drug provided and dispensed and the average Medicare drug program full subsidy discount amount. The Medicaid rebate amount will be computed under its own formula.

PDP sponsors will be required to report information on the total number of each dosage, form and strength of each drug dispensed to full premium subsidy Medicare drug plan enrollees, information on the price discounts, price concessions and rebates for such drugs, information on the extent to which such discounts, concessions and rebates apply equally to full premium subsidy Medicare drug plan enrollees who are not full premium subsidy Medicare drug plan enrollees and any additional information deemed necessary by the Secretary. Penalties will be imposed for failure to provide timely information and the provision of false information.

### ***Phased-in Elimination of Coverage Gap***

Beginning in 2011, the Secretary will progressively increase the initial coverage limit and decrease the annual out-of-pocket threshold until there is a continuation of coverage from the initial limit for expenditures incurred through the total amount of expenditures at which benefits are available. In 2011, the initial coverage limit will be increased by ½ of the cumulative phase-in percentage of 4 times the out-of-pocket gap amount for the year. The annual out-of-pocket threshold will be decreased by ½ of the cumulative phase-in percentage of the out-of-pocket gap for the year.

### ***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***

Costs incurred through the above mention programs count toward the annual out of pocket threshold in part D on or after January 1, 2011.

### ***Permitting Mid-Year Changes in Enrollment for Formulary Changes Adversely Impact an Enrollee***

An individual enrolled in a prescription drug plan in which the formulary of the plan is materially changed to reduce the coverage if the drug under the plan will be permitted to change his enrollment mid-year. However, if a drug is removed from the formulary because of a recall, withdrawn by the FDA or replaced by a generic equivalent, the enrolled individual will not be permitted to change his enrollment. This provision will be effective on January 1, 2011.

## **Medicare Rural Access Protections**



## SUMMARY OF THE HOUSE HEALTH REFORM BILL

### ***Telehealth Expansion and Enhancements***

The Secretary will undertake activities to expand and enhance Medicare beneficiary access to telehealth services.

### ***Extension of Outpatient Hold Harmless Provisions***

The outpatient hold harmless provision is extended until January 1, 2012.

### ***Extension of Section 508 Hospital Reclassifications***

Section 508 Hospital reclassifications are extended through September 30, 2011.

### ***Extension of Payment for Technical Component of Certain Physician Pathology Services***

This provision is extended for 2009, 2010 and 2011.

## MEDICARE BENEFICIARY IMPROVEMENTS

### **Improving and Simplifying Financial Assistance for Low Income Medicare Beneficiaries**

#### ***Improving Asset Tests for Medicare Savings Program and Low-Income Subsidy Program***

Articulates an annual increase in low-income subsidy program. The low-income subsidy test will be applied under the Medicare savings program. As of January 1, 2012, eligibility determinations for income-related subsidies and Medicare cost-sharing will apply.

#### ***Elimination of Part D Cost-Sharing for Certain Non-Institutionalized Full Benefit Dual Eligible Individuals***

The cost-sharing requirement will be eliminated for drugs dispensed on or after January 1, 2011.

#### ***Eliminating Barriers to Enrollment***

Individuals will be permitted to apply for the low-income subsidy program on the basis of self certification of income and resources; this information will be verified without having the individual provide additional documentation except in extraordinary circumstances. Eligible individuals will be automatically reenrolled without the need for annual or periodic application unless notified. Individuals who are eligible for low income assistance under the Medicare Part D will be identified by the Social Security Administration.



## **SUMMARY OF THE HOUSE HEALTH REFORM BILL**

### ***Enhanced Oversight Relating to Reimbursements for Retroactive Low Income Subsidy Enrollment***

A retroactive LIS enrollment beneficiary is entitled to reimbursement by the plan for covered drug costs incurred by the beneficiary during the retroactive coverage period.

### ***Intelligent Assignment in Enrollment***

The Secretary will have the authority to use intelligent assignment in PDPs to maximize the access of an individual to necessary prescription drugs while minimizing costs to such individual and to the program to the maximum extent possible. This provision is effective as of November 1, 2011.

### ***Automatic Enrollment Process for Certain Subsidy Eligible Individuals***

Subsidy eligible individuals who fail to enroll in a PDP or MA-PD plan during the special enrollment period will be subject to an intelligent assignment process in a plan most appropriate for the individual. Nothing will prohibit an individual from declining enrollment in the chosen plan. This provision is effective beginning January 2011.

## **Reducing Health Disparities**

### ***Ensuring Effective Communication in Medicare***

The Secretary will conduct a study on Medicare payments for language services that examines the extent to which Medicare service providers utilize, offer or make available language services for beneficiaries who are limited English proficient and ways that Medicare should develop payment systems for language services. The report will be due to Congress no later than one year after enactment.

### ***Demonstration to Promote Access for Medicare Beneficiaries with Limited English Proficiency by Providing Reimbursement for Culturally and Linguistically Appropriate Services***

Six months after the completion of the study on effective communication in Medicare, CMS will run a demonstration program under which the Secretary will award no fewer than 24 3 year grants to eligible Medicare service providers to improve effective communication between the providers and Medicare beneficiaries who are living in communities where racial and ethnic minorities are underserved with respect to such services.

### ***IOM Report on Impact of Language Access Services***

The IOM will prepare and publish within 3 years of enactment a report on the impact of language access services on the health and health care of limited English proficient populations. The report will recommend the development and implementation of policies and practice by health care organizations and providers for limited English proficient patient populations; a



## SUMMARY OF THE HOUSE HEALTH REFORM BILL

description of the effect of providing language access services on the quality of health care; and a description of the costs associated with or savings related to provision of language access services.

### Miscellaneous Improvements

#### *Extended Months of Coverage of Immunosuppressive Drugs for Kidney Transplant Patients*

This provision extends Medicare coverage of immunosuppressive drugs for kidney transplant patients for the life of their transplant; previously patients not of Medicare age only were eligible for 36 months of coverage of these drugs.

### PROMOTING PRIMARY CARE, MENTAL HEALTH SERVICES, AND COORDINATED CARE

#### *Accountable Care Organizations (ACOs) Pilot Program*

A pilot program will be established to test different payment incentive models, including the specific payment incentive models designed to reduce the growth of expenditures and improve health outcomes. This pilot will examine whether ACOs promote accountability for a patient population and coordinate items and services under parts A and B; encourage investment in infrastructure and redesigned care processes for high quality and efficient service delivery; and reward physician practices for the provision of high quality and efficient health care services.

A qualifying ACO is a group of physicians that is organized in part for the purpose of providing physicians' services and meets criteria determined appropriate by the Secretary. Nothing in this legislation will prevent a qualifying ACO from including a hospital or any other provider of services or supplier.

The pilot will include a performance target model, which is a payment incentive model. A qualifying ACO will qualify to receive an incentive payment if expenditures for applicable beneficiaries are less than a target spending level or a target rate of growth. The incentive payment will be made only if savings are greater than would result from normal variation in expenditures for items and services covered under parts A and B.

The Secretary may also incorporate reporting requirements, incentive payments and penalties related to the PQRI, electronic prescribing, electronic health records and other similar initiatives.

Besides the performance target model, the pilot may also include a partial capitation model under which a qualifying ACO would be at financial risk for some, but not all, of the items and services covered under parts A and B. This model may be limited to ACOs that are highly integrated systems of care and capable of bearing risk.

Beneficiaries who are eligible to participate in the pilot are enrolled under part B and entitled to part A benefits, are not enrolled in MA or a PACE program and meets other criteria determined by the Secretary.



## SUMMARY OF THE HOUSE HEALTH REFORM BILL

The pilot will begin by January 1, 2012m and a qualifying ACO may participate between 3 to 5 years. The Secretary may extend the duration of an agreement with an ACO if the ACO receives incentive payments with respect to any of the first 4 years of the pilot agreement and is consistently meeting quality standards or the ACO is consistently exceeding quality standards and is not increasing spending. The Secretary has the authority to implement, on a permanent basis, the components of the pilot program that are beneficial to the program.

*At this point, it is unclear how effective ACOs may be at improving quality and coordination of care. What is also unclear is how ACOs will affect physician payment. This is an issue we will continue to monitor.*

### **Medical Home Pilot Program**

The Secretary is directed to establish a medical home pilot program to evaluate the feasibility and advisability of reimbursing qualified patient-centered medical homes for furnishing medical home services. The pilot will include urban, rural and underserved areas. Two models of medical homes will be evaluated: the independent patient-centered medical home and the community-based medical home. The legislation explicitly states that nothing will prevent a nurse practitioner from leading a patient centered medical home so long as all the requirements of this provision are met and the nurse practitioner is acting consistently with state law.

Patient-centered medical home services means the following:

- Beneficiaries are provided with direct and ongoing access to a primary care or principal physician or nurse practitioner who accepts responsibility for providing first contact, continuous and comprehensive care;
- Care is coordinated by a team of individuals at the practice level across office, institutional and home settings led by a primary care or principal physician or nurse practitioner;
- All of the patient's health care needs are provided for or appropriate care with other qualified providers is arranged;
- Continuous access to care is provided;
- Readily accessible, clinically useful information on participating patients is available to allow them to be treated comprehensively and systematically; and
- Evidence-based guidelines are implemented and applied to the identified needs of the beneficiary.

The independent patient-centered medical home will require the Secretary to make payments for medical home services furnished to targeted high needs beneficiaries who are based on measures of the number and severity of the beneficiary's chronic illnesses and need for regular medical monitoring, advising or treatment. The high needs beneficiary is generally within the upper 50<sup>th</sup> percentile of Medicare beneficiaries and must agree to participate in the pilot project.

The Secretary must establish a methodology for payment; it can be a per beneficiary per month payment paid prospectively. In determining the amount of the fee, the Secretary is directed to



## SUMMARY OF THE HOUSE HEALTH REFORM BILL

consider the clinical work and practice expenses involved in providing the medical home services and may allow for differential payments based on capabilities of the medical home.

Under this independent patient centered medical home model, a variety of practices, including those with fewer than 10 physicians, large practices, practices in underserved and rural communities and community health centers, will be encouraged to participate.

A community based medical home is a nonprofit community-based or State-based organization that meets the following requirements:

- It provides beneficiaries with medical home services;
- It provides medical home services under the supervision of the primary care or principal care physician or nurse practitioner designated by the beneficiary as his or her community based medical home provider;
- The organization employs community health workers that assist the primary or principal care physician or nurse practitioner in chronic care management activities such as teaching self-care skills for managing chronic illnesses, medication therapy management, or helping beneficiaries access the health care and community-based resources in their local geographic area; and
- The organization meets other criteria outlined by the Secretary.

For the purposes of this section, a high need beneficiary is one with multiple chronic illnesses that require regular medical monitoring, advising or treatment.

The Secretary will establish standards for the certification of community-based medical homes, and provide for the review and certification of community-based medical homes. The demonstration for community-based medical homes will operate for up to 5 years. Sites for this model will be given preference if they are from geographic areas that propose to coordinate health care services across a variety of health care settings, from States that propose to use networks to coordinate health care services for chronically ill Medicare, Medicaid and dual eligible individuals.

The Secretary retains the discretion to determine how to pay for this model, but a per member per month payment may be made on a prospective basis to the community or State based organization or to the primary or principal care practice for the beneficiary. To determine the amount of the payment, the Secretary will consider the clinical work and practice expense involved in providing the medical home services and use appropriate risk-adjustment.

The Secretary will be required to evaluate the extent to which there is an improvement in the quality and coordination of health care services, the reduction in health disparities, the reduction in preventable hospitalizations, prevention of readmissions, reductions in emergency room visits, improvement in health outcomes, improvements in patient satisfaction, improved efficiency of care, reductions in health care expenditures, and the feasibility and advisability of reimbursing for medical home services on a permanent basis.

The legislation explicitly states that there will be no effect on payment for evaluation and management services. \$2.5 million will be available in FYs 2010 through 2012 for this project.



## SUMMARY OF THE HOUSE HEALTH REFORM BILL

*The medical home has the potential to impact how primary care is practiced, possibly improving outcomes for patients with multiple chronic conditions. We will continue to monitor proposals related to the medical home.*

### ***Rate Increase for Selected Primary Care Services***

For primary care services furnished on or after January 1, 2011 by a primary care physician, a 5 percent (10 percent in areas designated as HPSAs) will be paid to the practitioner. Primary care services are defined as evaluation and management services and other services deemed by the Secretary to be associated with ensuring accessible, continuous, coordinated, and comprehensive care. The section defines a primary care practitioner as one who specializes in family medicine, general internal medicine, general pediatrics or geriatrics and has allowed charges for primary care services that account for at least 50 percent of their total allowed charges.

*Unlike the Senate Finance Options Paper, the House bill does not phase out the primary care bonus payment. While ACP, AAFP and AOA advocated for 10 percent bonus payment in the first year, this provision may address the needs of primary care physicians better than the Finance option. We will wait to see what the Finance Committee includes in its legislation.*

### ***Coverage and Waiver of Cost Sharing for Preventive Services***

A Medicare covered preventive service includes prostate cancer screening tests, colorectal cancer screening tests, diabetes self management training services, screening for glaucoma, medical nutrition therapy services, an initial preventive physical exam, cardiovascular screening blood tests, diabetes screening tests, ultrasound screening for abdominal aortic aneurysm, pneumococcal and influenza vaccines and their administration and hepatitis B vaccine and its administration, screening mammography, screening pap smear and screening pelvic exam, bone mass measurement, kidney disease education services, and additional preventive services. For any covered preventive services for which the payment rate provided is less than 100 percent of an actual charge, fee schedule rate, or other rate, this section increases it to 100 percent.

The section eliminates coinsurance for sigmoidoscopies and colonoscopies.

### ***Coverage of Marriage and Family Therapist Services and Mental Health Counselor Services***

This section provides for coverage of marriage and family therapist services for the diagnosis and treatment of mental illness, which the marriage and family therapist is legally authorized to perform and would otherwise be covered if provided by a physician or as incident to a physician's service. Medicare Part B will cover 80 percent of the lesser of the actual charge for the services or 75 percent of the amount determined for payment of a psychologist. Mental health counselor services will also be paid for at the same rate as for marriage and family therapist services.

### ***Extension of Physician Fee Schedule Mental Health Add On***

The mental health add on is extended through December 31, 2011.



# SUMMARY OF THE HOUSE HEALTH REFORM BILL

## *Expanding Access to Vaccines*

This section expands access to “federally recommended vaccines,” which with respect to an adult is recommended by the Advisory Committee on Immunization Practices and with respect to a child, a vaccine on list in § 1928(e) of the Social Security Act. This provision is effective for vaccines administered on or after January 1, 2011.

## *Elimination of 190-Day Lifetime Limit on Psychiatric Hospital Stays*

The limit is lifted for inpatient psychiatric hospital services furnished on or after January 1, 2010.

## QUALITY

### Comparative Effectiveness Research

#### ***Comparative Effectiveness Research***

This section establishes the Center for Comparative Effectiveness Research within AHRQ to conduct, support and synthesize research on the outcomes, effectiveness and appropriateness of health care services and procedures to identify the manner in which diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated and managed clinically. *We anticipate that the Finance Committee will take a different approach and create a new center for CER rather than placing it within AHRQ. We will continue to monitor this issue.*

The Center is charged with the following:

- Conducting, supporting and synthesizing comparative effectiveness research of the full spectrum of health care items and services;
- Conducting and supporting systematic reviews of clinical research;
- Continuously developing rigorous scientific methodologies for conducting CER;
- Submitting to the CER Commission, the Secretary and Congress appropriate reports; and
- Encouraging the development and use of clinical registries and the development of clinical effectiveness research data networks from electronic health records, post marketing drug and medical device surveillance efforts and other forms of electronic data.

An independent Comparative Effectiveness Research Commission is established to oversee and evaluate the activities of the Center. The Commission will determine national priorities for research, monitor the appropriateness of use of the comparative effectiveness research trust fund, identify credible research methods and standards of evidence, review the methodologies developed by the Center, enter into an arrangement with IOM to evaluate and report on the standards of evidence, support forums to increase stakeholder awareness, make recommendations for policy to make this data public, appoint a clinical perspective advisory



## SUMMARY OF THE HOUSE HEALTH REFORM BILL

committee, recommend the priority for periodic reviews of CER, review processes of the Center, make recommendations for the dissemination of the research findings, provide for public disclose and report to Congress annually.

The Commission will include the Director of AHRQ, the Chief Medical Office of CMS and 15 additional members who will represent broad constituencies of stakeholders. The Secretary will appoint members of the Commission, including a Chairman and Vice Chairman, to terms of 4 years, except 7 of the initial appointees will be to 3 year terms. Any potential appointee will be excluded if he or she has a financial interest that could be affected by the advice of the Commission. Members of the Commission will be entitled to receive a per diem equivalent of the rate provided for level IV of the Executive Schedule and travel expenses when appropriate. All Commission reports will be submitted to the Secretary and made available to the public.

Any research conducted will be transparent, credible accessible to all stakeholders. It will also meet a national research priority and be conducted in a way that considers the advice of the clinical perspective advisory panel. The Commission will consider research questions and methodology and consult with patients, health care providers, health care consumer representatives and other appropriate stakeholders. The section also requires that research will be designed to take potential differences into account.

No later than 90 days after receipt by the Center or Commission, appropriate information in the reports will be posted on the official public website of the Center and of the Commission. According to the section, a relevant report is an interim progress report, a draft final comparative effectiveness review, a final progress report on the new research submitted for publication by a peer reviewed journal, Stakeholder comments or a final report.

The Center will also disseminate appropriate research findings to health care providers, patients, vendors of HIT focused on clinical decision support, appropriate professional associations and Federal and private health plans as well as any other relevant stakeholders. Besides conveying the findings, the Center will discuss them with respect to specific sub-populations, risk factors and comorbidities, include the limitations of the research, not include data that would violate the privacy of research participants, and assist the users of HIT focused on clinical decision support.

The Director of AHRQ will be responsible for providing an annual report on the activities of the Center and Commission to Congress. By December 31, 2013, the Secretary will submit a report to Congress on all the activities supported and conducted by this section, including an evaluation of the overall costs and whether Congress should expand the Center and Commission's responsibilities.

For FY 2010 and each subsequent FY, the CER Trust Fund will contain funds without the need for further appropriations and without fiscal year limitation to carry out the activities outlined. Transfers to the fund will be made as follows:

- \$90 million in FY 2010
- \$100 million in FY 2011
- \$110 million in FY 2012



## SUMMARY OF THE HOUSE HEALTH REFORM BILL

- Beginning in FY 2013, an amount from the fees on health insurance and self-insured plans with some limitation by the Secretary will be transferred.

### Quality Measurements

#### *Establishment of National Priorities and Performance Measures for Quality Improvement*

The Secretary is directed to establish and update at least triennially national priorities for performance improvement. The Secretary will solicit and consider recommendations from outside entities, including consensus-based entities, providers, payors, government agencies, nonprofit organizations and other public and private entities. Priority will be given to health care services that:

- Contribute to a large burden of disease;
- Have the greatest potential to decrease morbidity and mortality;
- Have the greatest potential for improving the performance, affordability and patient centeredness of health care;
- Address health disparities; and
- Have the potential for rapid improvement due to existing evidence, standards of care or other reasons.

The Secretary will transfer \$7 million from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund for these activities in FYs 2010 through 2014.

Through the Director of AHRQ, the Secretary will enter into agreements through contract or grant with qualified entities to develop quality measures. The Secretary will seek public input and consider recommendations of consensus-based entities under contract when determining areas in which measures should be developed. Also, acting through the Director of AHRQ, in a manner consistent with the national priorities and in consultation with CMS, the Secretary will determine areas in which to develop and test measures. Patient centered and population based measures will be designed with the following aims:

- To assess outcomes and functional status of patients;
- To assess continuity and coordination of care and care transitions;
- To assess safety, effectiveness and timeliness of care;
- To assess health disparities;
- To assess efficiency and resource use in the provision of care;
- To be collected as part of HIT supporting better delivery of services;
- To be available free of charge to users of such measures; and
- To access delivery of health care services to individuals regardless of age.

The Secretary may also use funds available under this section to update quality measures that have already been endorsed. For FYs 2010 through 2014, \$35 million is provided for these activities.

The GAO will conduct periodic evaluations of the data collection process for quality measurement.



# SUMMARY OF THE HOUSE HEALTH REFORM BILL

## Physician Payments Sunshine Provisions

### *Reports on the Financial Relationships Between Manufacturers and Distributors of Covered Drugs, Devices, Biologicals, or Medical Supplies Under Medicare, Medicaid, or CHIP and Physicians and Other Health Care Entities and Between Physicians and Other Health Care Entities*

By March 31 of each year (beginning in 2011), each applicable manufacturer or distributor who provides a payment or transfer of value to a covered recipient will submit to the Secretary the following information for the previous year:

- The covered recipient's name, business address, physician specialty and NPI;
- The value and date of the payment, the name of related drug, device or supply, a description of the form of the payment or transfer and the description of its nature; and
- With respect to a drug sample, the name, number, date and dosage units of the sample.

By March 31 of each year (beginning in 2011), each hospital or other health care entity that bills Medicare under part A or B must report on the ownership shares of each physician who owns an interest in the equity.

The information regarding transfers of value and ownership interests must be made publicly available on the Internet. Penalties will be levied for noncompliance with the above reporting requirements. The Secretary will also be required to report the information disclosed and enforcement actions taken to Congress annually.

### *Limitation on Tax Deductions for Advertising by Certain Manufacturers of Drugs, Devices or Medical Supplies*

No deduction will be allowed for any expenditure for advertising, promotion or marketing of any covered drug, device or medical supply if a penalty is imposed relating to quarterly transparency reports.

## MEDICARE GRADUATE MEDICAL EDUCATION

### *Distribution of Unused Residency Positions*

If a hospital's reference resident level is less than the applicable resident limit, the applicable resident limit will be reduced by 90 percent of the difference between the two for cost reporting periods on or after July 1, 2011. The reference resident level for a hospital is the highest resident level for any of the 3 most recent cost reporting periods of the hospital for which a cost report has been settled.

If a hospital submits a request to increase its resident level due to the expansion of an existing residency training program that is not reflected on the most recent cost report, the reference



## SUMMARY OF THE HOUSE HEALTH REFORM BILL

resident level will be the level that includes the additional residents from the expansion as determined by the Secretary who is authorized to determine an alternative reference level.

The Secretary will increase the applicable resident limit for each qualifying hospital that submits an application for cost reporting periods on or after July 1, 2011. The estimated aggregate number of increases may not exceed the Secretary's estimate of the aggregate reductions in limits outlined under this section.

To qualify, hospitals must maintain the number of primary care residents at a level that is not less than the base level of primary residents increased by the number of additional primary care resident positions provided to the hospital. This base level for the hospital is the level of residents determined without regard to whether such positions were in excess of the otherwise applicable resident limit. Also, the hospital must assign all additional resident positions for primary care residents. The hospital's primary care resident programs must be fully accredited or the hospital must be actively pursuing the accreditation.

When determining which hospitals will have their residency limit increased, the Secretary will consider the likelihood of the hospital filling the positions within the first 3 cost reporting periods beginning on or after July 1, 2011. The Secretary will also consider the following five criteria:

- (1) Preference will be given to hospitals that had a reduction in residency positions;
- (2) Preference will be given to hospitals with 3 year primary care training programs, such as family practice and internal medicine;
- (3) Preference will be given to hospitals with formal arrangements that place greater emphasis on training in Federally qualified health centers, rural health clinics, off-campus provider-based outpatient departments and other non-provider settings;
- (4) Preference will be given to hospitals with formal arrangements that place emphasis on training in a health professional shortage areas; and
- (5) Preference will be given to hospitals in States that have low resident-to-population ratios.

However, no more than 20 full time equivalent additional residency positions will be made available.

For additional residency positions created under this section, the approved FTE resident amounts are deemed to be equal to the hospital per resident amounts for primary care and nonprimary care. Positions will be distributed no later than July 1, 2011.

Hospitals that receive additional resident positions will be required to maintain records and report on the number of primary care residents in its residency training programs and as a condition of continued payment they must maintain the level of positions at no less than the sum of the level of primary care resident positions before receiving the additional positions and the number of additional positions.

The IME payment for discharges occurring on or after July 1, 2011 will be adjusted to reflect the redistribution of resident positions.



## SUMMARY OF THE HOUSE HEALTH REFORM BILL

*While this would not create as many new GME slots as the Nelson bill, it does ensure that new slots will be added for primary care. However, at this point, we do not know if these new and reallocated slots coupled with the payment reforms in this bill would be sufficient to address the primary care workforce shortage.*

### ***Increasing Training in Non-Provider Settings***

For direct GME, all the time spent by a resident will be counted towards the determination of full time equivalency without regard to the setting in which the activities were performed, if the hospital incurs the costs of the stipends and fringe benefits of the resident during the time spent by the resident in that setting as of July 1, 2009. Hospitals claiming time spent in non-provider settings will maintain records and make them available to the Secretary. The IME payments will also be adjusted accordingly. The Inspector General will analyze the data to assess the extent to which there is an increase in time spent by medical residents training in non-provider settings.

The Secretary may conduct a demonstration project under which an approved teaching center would be eligible for payment for its direct costs of graduate medical education activities for primary care residents and the direct costs of graduate medical education activities of its contracting hospital for such residents. Approved teaching centers would contract with an accredited teaching hospital to carry out the inpatient responsibilities of the primary care residency program for the hospital's costs of the salary and fringe benefits of the residents in the program. The hospital's full time equivalent resident amount will not affect the contracting hospital's resident limit, and the contracting hospital will agree not diminish the number of residents in its primary care residency training program.

An approved teaching health center is defined as a non-provider setting, including Federally qualified health center or rural health center, that develops and operated an accredited primary care residency program for which funding would be available if it were operated by a hospital

*This appears to address the non-hospital training issue.*

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

All the time spent by an intern or resident in an approved medical residency training program in non-patient care activities, including didactic conferences and seminars but not including research not associated with the treatment or diagnosis of particular patient, will be counted towards the determination of full time equivalency.

All the time spent by an intern or resident in an approved medical residency training program on vacation, sick leave or other approved leave that does not prolong the total time of the resident is participating in the approved program will count toward the determination of full time equivalency.



## SUMMARY OF THE HOUSE HEALTH REFORM BILL

### ***Preservation of Resident Cap Positions From Closed Hospitals***

The Secretary will establish a process to increase the applicable resident limit for other hospitals in the State where a hospital with an approved medical residency program closes on or after the date that is 2 years before the date of enactment of this section. This will be a redistribution of the residency slots held by the closed hospital.

### ***Improving Accountability for Approved Medical Residency Training***

The goals of medical residency training programs are to foster a physician workforce so that physicians are trained to do the following:

- Work effectively in various health care delivery settings;
- Coordinate patient care within and across settings relevant to their specialties;
- Understand the relevant cost and value of various diagnostic and treatment options;
- Work in inter-professional teams and multi-disciplinary team-based models in provider and non-provider settings to enhance safety and improve the quality of patient care;
- Be knowledgeable in methods of identifying systematic errors in health care delivery and in implementing systematic solutions in the case of errors; and
- Be meaning EHR users in the delivery of care and in improving the quality of the health of the community and the individuals served by the hospital.

The GAO will conduct a study to evaluate the extent to which medical residency programs are meeting these goals and have the appropriate faculty expertise to teach the topics required to meet the stated goals.

## **Medicaid and CHIP**

### ***Medicaid***

Expands Medicaid to 133.5% of the federal poverty level and provides for coverage upon birth.

States will enter into a Medicaid memorandum of understanding with the Commissioner to coordinate enrollment of individuals in Exchange-participating plans and will determine eligibility for Medicaid when the individual applies for coverage.

For those individuals who are Medicaid eligible but enrolled in a plan through the Exchange, they are entitled to wrap around benefits for coverage not available under the Exchange plan but otherwise covered under Medicaid, at the expense of the State.

The Secretary is required to submit a report to Congress on how health care reforms have reduced the number of uninsured individuals and whether there is a continued role for Medicaid DSH.



## SUMMARY OF THE HOUSE HEALTH REFORM BILL

Extends transitional Medicaid assistance offered through the ARRA to December 31, 2012 (from December 31, 2010).

### *CHIP*

Sets a CHIP maintenance of effort requirement so that States cannot set eligibility requirements that are more restrictive than those in effect June 16, 2009. This maintenance of effort does not prohibit states from limiting expenditures for a given fiscal year as long as Federal financial participation is available. Similar maintenance of effort requirements are included for Medicaid.

### ***Prevention/Wellness Coverage***

Requires coverage of preventive services graded A or B by the U.S. Preventive Services Task Force and for vaccines recommended for use as appropriate by the Director of the CDC.

Includes public health clinics under the vaccines for children program.

Eliminates the exception of tobacco cessation products from outpatient drug coverage, and includes tobacco cessation counseling as a covered service for pregnant women.

### ***Optional Coverage***

Provides for optional coverage of nurse home visitation services for children less than two years of age and women who are pregnant for the first time.

Provides for optional coverage of family planning services including medical diagnosis and treatment services provided pursuant to a family planning service in a family planning setting after cervical cancer.

Provides for optional coverage of freestanding birth center services.

Provides for optional Medicaid coverage of low-income HIV-infected individuals.

### ***School-based Health Clinics***

States must implement procedures for payments to school-based health clinics, if payment is made under a State plan for services otherwise provided by a physician's office or other outpatient clinic.

### ***Primary Care Practitioners***

Sets a floor for the payment rate for primary care physicians or other primary health care professionals) of not less than 80% of the rate in 2010, 90% in 2011 and 100% in 2012 and beyond. *Another provision that attempts the primary care reimbursement issue.*



## SUMMARY OF THE HOUSE HEALTH REFORM BILL

Allows the Secretary to approve a medical home pilot program that will last 5 years.

### *Electronic Eligibility Systems*

Provides for the upgrading and/or design of electronic eligibility systems, which may include the development of an online application system. To receive payments for such systems, States must prove to the Secretary that the system is adequate to provide efficient, economical and effective administration; is compatible with eligibility, enrollment and information retrieval systems already in use; provides accurate and timely data; any contractors used meet federal requirements set by the Secretary; allows States to conduct paperless verification for renewal; is compatible with electronic databases for TANF, CHIP, vital records, food stamps, Head Start, National School Lunch, Child Nutrition Act, CCDBG, homeless assistance, Native American Housing Assistance, unemployment insurance, Federal and/or State wage databases, Social Security data, and other public benefit programs and databases.

### *Payments to Pharmacists*

The upper payment limit will be calculated at no less than 130% of the weighted average of the most recent average manufacturer prices for pharmaceutically and therapeutically equivalent multiple source drug products that are available for purchase by retail community pharmacies nationally. The Secretary will implement a process for AMPs to ensure that the limits do not vary significantly from month to month.

### *Prescription Drug Rebates*

Rebates for drugs that are new formulations, such as extended-release versions or innovator multiple source drugs, will be computed as if it were a new drug or the amount for the original single source or innovator multiple source drug if greater. Increases the minimum rebate percentage for single source drugs to 22.1% after December 31, 2009.

Extends prescription drug discounts to Medicaid managed care organization enrollees.

States will report to HHS quarterly on the amount of rebates received from pharmacy manufacturers for drugs for those enrolled with Medicaid managed care organizations.

### **GME**

States will submit information to the Secretary to be reviewed by the Advisory Committee on Health Workforce Evaluation and Assessment, on how GME payments are being used, including information on what institutions receive funding, how payments are calculated, the types and fields of education being supported, the workforce or other goals to which the funding is being applied, and that goals and requirements are being met.

Goals and requirements will be specified by the Secretary by a rule published prior to December 31, 2011.



## SUMMARY OF THE HOUSE HEALTH REFORM BILL

### *Waste Fraud and Abuse*

Prevents payments for certain healthcare-acquired conditions, and requires providers and suppliers to adopt programs to reduce waste, fraud and abuse.

### *Puerto Rico and Territories*

Increases the Medicaid FMAP cap for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands and American Samoa, effective January 1, 2011.

## PUBLIC HEALTH AND WORKFORCE DEVELOPMENT

### *Public Health Investment Fund*

The fund is established and will be funded as follows:

- \$4.7 billion in FY 2010;
- \$5.6 billion in FY 2011;
- \$6.9 billion in FY 2012;
- \$7.7 billion in FY 2013; and
- \$8.8 billion in FY 2014.

Amounts in the fund are authorized to be appropriated by the House and Senate Appropriations Committees to increase funding for carrying out activities included in the public health provisions.

## COMMUNITY HEALTH CENTERS

### *Increased Funding*

Authorizes appropriations as follows:

- \$1 billion in FY 2010;
- \$1.5 billion in FY 2011;
- \$2.5 billion in FY 2012;
- \$3 billion in FY 2013; and
- \$4 billion in FY 2014.

## WORKFORCE

### **Primary Care Workforce**

### *National Health Service Corps*

The Secretary may grant waivers allowing individuals to satisfy their clinical service requirement in the NHSC through part time service and extend the period of obligated service or reduce the amount of loan repayment to account for any decrease in the amount of service that would have



## SUMMARY OF THE HOUSE HEALTH REFORM BILL

been performed through full time service. The loan repayment amount is increased to \$50,000 beginning after FY 2011 and the Secretary can increase the amount for inflation annually.

### *Authorization of Appropriations*

\$75 million for FYs 2010 through 2014 is appropriated for the NHSC program from the Public Health Investment Fund. For scholarship and loan repayment, \$300 million for FYs 2010 through 2014 is appropriated from the Fund.

### **Promotion of Primary Care and Dentistry**

#### *Frontline Health Providers*

This section will address unmet health care needs in areas experiencing an insufficient capacity of health professionals or high needs for health services in one or more fields that is not addressed by the NHSC. Health professionals in this section include: physicians or other health professionals providing primary health services and other health professionals.

A health professional needs areas will be designated by the Secretary. For primary health services, the Secretary will determine if it is a rational area for the delivery of primary health services to have insufficient capacity of health professionals in a field for the population served or high needs for primary health services. The area will not include a health professional shortage area for the field and will have fewer than 1 physician or other health professional in such field per 2,000 residents in the area. For other providers, the Secretary will determine it is a rational area for the delivery of health services and have insufficient capacity of health professionals in a field for the population served or high needs for health services.

The Secretary will provide eligible individuals with scholarships for each school year in which the individual is enrolled as a full time student at an accredited school in a course of study or program leading to a degree in a health field. The individual must agree to maintain an acceptable level of academic standing, complete an internship or residency, if applicable and serve as a full time physician or other health professional in health professional needs area in a field for which the scholarship was provided for one year for each school year the individual received a scholarship or two years, whichever is longer. The amount of the scholarship will not be more than 50 percent of the tuition and other reasonable expenses for the school year and will not be no more than 50 percent of that paid under the NHSC Scholarship Program.

If there are not enough applicants to obligate the full amount of scholarship money available, the amount of the scholarship is raised from no more than 50 percent to no more than 75 percent of the tuition or that paid under the NHSC Scholarship Program.

This section creates a program where HRSA enters into contracts with eligible individuals under which the individual agrees to serve as a full time health care provider in a health professional needs area in a field for which the individual was provided loan repayment. For each year of service, the Secretary will pay an amount on the principal and interest of the undergraduate, or graduate educational or both of the individual that is not more than 50 percent of the average



## SUMMARY OF THE HOUSE HEALTH REFORM BILL

award made under the NHSC Loan Repayment Program in the previous fiscal year. The service requirement can be met through employment in a solo or group practice, a clinic, a public or private nonprofit hospital or any other health care entity deemed appropriate by the Secretary. Again, if there are more funds available than applications, the reference amount will be raised from 50 percent to 75 percent.

The Secretary will report to Congress 18 months after enactment; this report will include the impact of the program on application to and participation in the NHSC and an evaluation of the program.

Ninety percent of the funds available under this program will be for physicians and other health professionals providing primary care services, and ten percent will be for other health professionals, half of which are in generalist physician specialties. *This section is another attempt to address the primary care shortage in areas of high need.*

### **Primary Care Student Loan Funds**

This section states that interest will be computed on the unpaid balance of the loan only for period for which the loan is repayable at the rate of 2 percent less than the applicable interest rate in § 427(A)(1)(1) of the Higher Education Act of 1965. To be eligible for this interest rate, the student must practice for 10 years (including residency training in primary health care) or through the date on which the loan is repaid in full, whichever occurs first. If a student is noncompliant, the total interest which would have accrued over the course of the loan without the interest rate reduction will be repayable. The Secretary will require parental or student financial information to determine financial need under this section. *Note that this provision requires 10 years of primary care service. Some may argue that the required service period is too long to attract many people to participate.*

### **Training in Family Medicine, General Internal Medicine, General Pediatrics, Geriatrics and Physician Assistantship**

Sec. 747 Primary Care Training and Enhancement is amended such that the Secretary will award grants or enter into contracts with an accredited public or nonprofit private hospital, school of medicine or osteopathic medicine, accredited physician assistant training program, or a public or private nonprofit entity to do the following:

- To plan, develop, operate or participate in an accredited professional training program, including an accredited residency or internship program in the field of family medicine, general internal medicine, general pediatrics, or geriatrics for medical students, interns, residents or practicing physicians;
- To provide need-based financial assistance in the form of traineeships and fellowships to medical students, interns, residents, practicing physicians or other medical personnel specializing or working in family medicine, general internal medicine, general pediatrics or geriatrics;
- To plan, develop, and operate a program for the training of physicians who plan to teach in family medicine, general internal medicine, general pediatrics or geriatrics training programs;



## SUMMARY OF THE HOUSE HEALTH REFORM BILL

- To plan, develop, and operate a program for the training of physicians teaching in community-based settings;
- To provide financial assistance in the form of traineeships and fellowships to physicians who are participants in any such programs and who plan to teach or conduct research in family medicine, general internal medicine, general pediatrics, or geriatrics training program; and
- To plan, develop, and operate a program for physician assistant education, and for the training of individuals who will teach in programs to provide such training.

Grants or contracts awarded under this section will not exceed 5 years.

To build capacity in primary care, the Secretary will award grants or enter contracts with accredited schools of medicine or osteopathic medicine to establish, maintain or improve academic units or programs that improve clinical teaching and research. Preference will be given to applicants that plan to establish academic units or program in family medicine, general internal medicine, general pediatrics or geriatrics or plan to substantially expand such units or programs. Grants or contracts awarded under this section will not exceed 5 years.

Preference will be given to applicants who:

- Have a record of training the greatest percentage of providers or have demonstrated significant improvements in the percentage of providers who enter and remain in primary care practice;
- Have a record of training individuals from underrepresented minority groups or from disadvantaged backgrounds;
- Conduct teaching programs targeting vulnerable populations.

*Like the Senate HELP bill, the House bill separates the dentistry and primary care training programs in this reauthorization.*

***Training for General, Pediatric, and Public Health Dentists and Dental Hygienists***

### ***Authorization of Appropriations***

For FYs 2010 through 2014, \$200 million is authorized for the primary care student loan program, the training in family medicine, general internal medicine, general pediatrics, geriatrics and physician assistantship program, and the training for general, pediatric and public health dentists and dental hygienists program.

## **Public Health Workforce**

### ***Public Health Workforce Corps.***

This section establishes the Public Health Workforce Corps, consisting of officers of the Regular and Reserve Corps of the Service, United States civilian employees appointed by the Secretary, and other individuals not employed by the United States. The Corps will be used to ensure an adequate supply of public health professionals to eliminate critical public health workforce



## SUMMARY OF THE HOUSE HEALTH REFORM BILL

shortages. The Secretary will develop a method for placing and assigning Corps participants as public health professionals.

The Secretary will establish the Public Health Workforce Scholarship Program. To be eligible to participate, an individual must be accepted for enrollment or enrolled as a full or part time student in a graduate school or program of public health, health administration, management, or policy; preventive medicine; veterinary public health; or dental public health; or other program deemed appropriate by the Secretary. The individual may also be eligible or hold an appointment as a commissioned officer in the Regular or Reserve Corps to be eligible for selection, submit an application or sign and submit to the Secretary at the time of application a written contract to serve full time as a public health professional upon completion of the program.

Upon completion of his studies, the individual may postpone his obligated service until he completes an approved internship, residency or other relevant public health advanced training program.

The Secretary will establish the Public Health Workforce Loan Repayment Program in which individuals with graduate degrees in public health, health administration, management or policy, preventive medicine, veterinary public health or dental public health or those enrolled in those programs; are eligible for or hold an appointment in the Regular or Reserve Corps; submit an application; and sign a contract to serve as a public health professional for the applicable period of service. The Secretary will agree to pay the loans incurred pursuing the public health degree in exchange for the individual agreeing to serve 2 years or longer. Service can be postponed while the individual completes an approved residency, internship or other relevant public health advanced training program.

### ***Enhancing the Public Health Workforce***

In conjunction with HRSA and CDC, the Secretary will award grants or contracts to expand the public health workforce, increase the quality of the workforce and enhance the workforce to meet national, State and local health care needs. Health professions schools, State or local health departments or a public or private nonprofit entity are eligible to submit applications. In awarding grants and contracts, the Secretary will grant preference to entities that train individuals from disadvantaged or underrepresented minority backgrounds, graduate large proportions of individuals who serve in underserved communities, prepare individuals for future or continued employment at Federal, State, and local and tribal public health agencies. These awards may be used for programs designed to award traineeships to students in accredited schools of public health who enter educational programs in fields where there is a severe shortage of public health professionals. *COMs would be eligible for grants under this section; we will monitor this program as the health reform proposals are considered throughout the summer and fall.*

### ***Preventive Medicine and Public Health Training Grant Program***

Grants or contracts will be awarded to eligible entities to provide training to graduate medical residents in preventive medicine specialties. To be eligible, the entity will be a school of public health, public health department, school of medicine or osteopathic medicine, or public or private



## SUMMARY OF THE HOUSE HEALTH REFORM BILL

hospital and submit an application containing the information required by the Secretary. Preference will be given to entities that train individuals who are from disadvantaged or underrepresented minority backgrounds, graduate large proportions of individuals who serve in underserved communities, and prepare individuals for future or continued employment at Federal, State and local and tribal public health agencies. *COMs will also be eligible to receive these grants, and we will monitor this program as well.*

### ***Authorization of Appropriations***

For FYs 2010 through 2014, \$50 million is authorized for the public health workforce programs.

### **Adapting Workforce to Evolving Health System Needs**

#### **Health Professions Training for Diversity**

##### ***Centers of Excellence***

Reauthorizes the Centers of Excellence program. In the case that more than \$40 million is appropriated for this program, the section articulates how that money should be distributed. In cases where the Center of Excellence has received Federal funds besides a grant under this section, the other Federal monies should be expended prior to the grant unless the Secretary provides otherwise.

##### ***Scholarships for Disadvantaged Students, Loan Repayments and Fellowships Regarding Faculty Positions, and Educational Assistance in the Health Professions Regarding Individuals from Disadvantaged Backgrounds***

For loan repayment and fellowships for faculty positions, \$30,000 of the principal and interest of an individual's educational loan may be repaid under this section for entered into before or during FY 2011. For those entered into after FY 2011, the amount authorized to be paid will be adjusted by the Secretary annually to reflect inflation.

##### ***Nursing Workforce Diversity Grants***

##### ***Coordination of Diversity and Cultural Competency Programs***

The Secretary will coordinate these activities to enhance effectiveness and avoid duplication.

#### **Interdisciplinary Training Programs**

##### ***Cultural and Linguistic Competence Training for Health Care Professionals***

The sections provides for grants to be awarded to eligible entities to address health disparities by promoting cultural and linguistic competency. The grant may be used to test, develop, implement and evaluate models of cultural and linguistic competence training and to facilitate faculty and student research on culturally and linguistically competent health care. Eligible



## SUMMARY OF THE HOUSE HEALTH REFORM BILL

entities include accredited health professions schools, academic health centers, State or local governments, and appropriate public and private entities. Preference will be given to applicants who will use the grant to address more than one health profession discipline, specialty or subspecialty or will partner with an institution, professional association or community-based organization serving the relevant population. *This is another grant opportunity for COMs.*

### *Cultural and Linguistic Competence Training for Nurses*

#### ***Innovations in Interdisciplinary Training***

Grants will be awarded to eligible entities to develop and operate a program for innovations in interdisciplinary care training to promote interdisciplinary and team-based models to prepare and train health professionals to reduce health disparities or improve patient care and coordination within academic health centers and across health professions settings for training and practice. Models of care that may be funded under this section include the patient centered medical home model, medication therapy management, and models that address both physical and mental health. Grant terms will not exceed 5 years.

#### **Advisory Committee on Health Workforce Evaluation and Assessment**

##### ***Health Workforce Evaluation and Assessment***

An advisory committee will be established to advise and make recommendations to assess, evaluate, and advise on the adequacy and appropriateness of the health workforce and make recommendations on policies to ensure that the workforce is meeting the Nation's health and health care needs. The Secretary will appoint 15 members to serve on the Committee who will serve staggered 3 year terms.

#### **National Center for Health Workforce Analysis**

##### ***Health Care Workforce Program Assessment***

The National Center for Health Care Workforce Analysis will be established to evaluate the effectiveness of federal workforce programs. In coordination with the Advisory Committee on Health Workforce Evaluation and Assessment, the Center will collect, analyze and report data describing the health care workforce; develop and publish benchmarks for performance for Federal workforce programs; establish, maintain and make publicly available a national health workforce database; establish and maintain a registry of grants awarded; compile workforce information; and disseminate reports and workforce information to state, regional and national entities. Within 180 days after enactment, the functions of HRSA's National Center for Health Workforce Analysis will be transferred to this newly established Center.

*Both the Advisory Committee on Health Workforce and the National Center for Health Care Workforce Analysis will monitor workforce needs and programs, but neither is designed to review Title VII specifically.*



# SUMMARY OF THE HOUSE HEALTH REFORM BILL

## *Reports*

The Secretary will submit reports annually to Congress on the activities carried out under this section and their effectiveness. The Secretary may require those receiving funding to submit reports on their activities

## **Authorization of Appropriations**

### ***Authorization of Appropriations***

For FYs 2010 through 2014, \$90 million is authorized for the Health Professions Training for Diversity Programs. For FYs 2010 through 2014, \$70 million is authorized for the Interdisciplinary Training Programs, the Advisory Committee on Health Workforce Evaluation and Assessment, and the National Center for Health Workforce Analysis.

## **PREVENTION AND WELLNESS**

### **Prevention and Wellness Trust**

#### ***Prevention and Wellness Trust***

This section establishes the Prevention and Wellness Trust and authorized funds from the Public Health Investment Fund be appropriated to the Trust as follows:

- \$2.4 billion in FY 2010;
- \$2.8 billion in FY 2011;
- \$3.1 billion in FY 2012;
- \$3.4 billion in FY 2013; and
- \$3.5 billion in FY 2014.

The section authorizes \$30 million for FY 2010 through 2014 for the Prevention Task Forces. For Prevention and Wellness Research, the section authorizes \$100 million in FY 2010, \$150 million in FY 2011, \$200 million in FY 2012, \$250 million for FY 2013, and \$300 million for FY 2014.

To carry out the Community-Based Prevention and Wellness Services, the section authorizes \$1.1 billion in FY 2010, \$1.3 billion in FY 2011, \$1.4 billion in FY 2012, \$1.6 billion in FY 2013, and \$1.6 billion in FY 2014.

To carry out the Core Public Health Infrastructure and Activities for State and Local Health Departments, the section authorizes \$800 million in FY 2010, \$1 billion in FY 2011, \$1.1 billion in FY 2012, \$1.2 billion in FY 2013 and \$1.3 billion in FY 2014.

For FYs 2010 through 2014, \$350 million is authorized for Core Public Health Infrastructure and Activities.



# SUMMARY OF THE HOUSE HEALTH REFORM BILL

## National Prevention and Wellness Strategy

### *National Prevention and Wellness Strategy*

Within one year of enactment and every 2 years thereafter, the Secretary will submit a national strategy that is designed to improve the Nation's health through evidence-based clinical and community-based prevention and wellness activities. The strategy will identify specific national goals and objectives, establish national priorities, establish national priorities for prevention and wellness activities, identify health disparities in prevention and wellness activities and plan for implementation of the strategy. The Secretary is directed to consult with the heads of appropriate health agencies, other Federal departments as appropriate, nonprofit and for-profit health-related entities, and the Association of State and Territorial Health Officials and the National Association of County and City Health Officials.

### **Prevention Task Forces**

#### *Task Force on Clinical Preventive Services*

Acting through the Director of AHRQ, the Secretary will establish the Task Force on Clinical Preventive Services, which will review the scientific evidence related to clinical preventive services, identify gaps in those services and recommend priority areas for research, take health disparities into account when developing recommendations, consult with the clinical preventive stakeholders board, and consult with the Task Force on Community Preventive Services. The Secretary will appoint 30 members to staggered 6 year terms on the Task Force.

#### *Task Force on Community Preventive Services*

Acting through the Director of the CDC, the Secretary will establish the Task Force on Community Preventive Services to review the scientific evidence related to community preventive services, identify gaps in those service and recommend priority research areas, take health disparities into account when making recommendations, consult with community prevention stakeholders board, and consult with the Task Force on Clinical Preventive Services. The Secretary will appoint 30 members to staggered 6 year terms.

### **Prevention and Wellness Research**

#### *Prevention and Wellness Research Activity Coordination*

The Directors of CDC and NIH will take into consideration the national strategy and recommendations of the Task Forces on Clinical Preventive Services and Community Preventive Services when conducting or supporting research on prevention and wellness.



## SUMMARY OF THE HOUSE HEALTH REFORM BILL

### *Community-Based Prevention and Wellness Research Grants*

The Secretary shall award grants to conduct research on priority areas identified in the national strategy or by the Task Force on Community Preventive Services. State or local departments of health, a public or private nonprofit entity or consortium of 2 or more eligible entities will be eligible for grants under this section.

### **Delivery of Community-Based Prevention and Wellness Services**

#### ***Community-Based Prevention and Wellness Service Grants***

Grants will be awarded to provide evidence-based, community-based prevention and wellness services in areas identified by the national strategy and to plan such services. Of the funds awarded, at least 50 percent must be used for planning or implementing prevention and wellness services whose primary purpose is to achieve a measurable reduction in one or more health disparities. For FY 2013 and subsequent years, the Secretary may award grants under this section only for planning or implementing services recommended by the Task Force on Community Preventive Services. *This may present an opportunity for COMs.*

### **Core Public Health Infrastructure and Activities**

#### ***Core Public Health Infrastructure and Activities for State and Local Health Departments***

To address core public health infrastructure needs, 50 percent of grants each year will be awarded to each State health department and the other 50 percent may be awarded on a competitive basis to State, local or tribal health departments. A formula will be used to determine how the grants to State health departments will be allocated; it will take into account factors, including population size, burden of preventable disease and disability, and core public health infrastructure gaps, and application requirements established by the Secretary.

The Secretary will also develop a public health accreditation program to advance the performance of State or local health departments and public health laboratories.

#### ***Core Public Health Infrastructure and Activities for CDC***

The core public health infrastructure and activities of the CDC will be improved and expanded to address unmet and emerging public health needs.

## **QUALITY AND SURVEILLANCE**

#### ***Implementation of Best Practices in the Delivery of Health Care***

The Director of AHRQ will head the newly established Center for Quality Improvement. The Center will identify, prioritize and develop quality improvement activities. The Center will work with hospitals, clinical practices, and other health care facilities to assist in the implementation of



## SUMMARY OF THE HOUSE HEALTH REFORM BILL

quality improvement activities. The Center will provide for the measurement of patient outcome and satisfaction before, during and after implementation.

The Center will conduct or fund research on the factors that facilitate the behavior change necessary to improve quality and foster an environment of continual improvement. It will also conduct research to develop superior designs for the delivery of health services. Grants will be provided to regional qualified entities to enter into voluntary agreements with hospitals, health facilities and health practitioners in a State or region to implement quality improvement activities; these funds may be used to form collaborative multi-institutional teams, assess existing practices, develop an implementation plan for quality improvement activities, measure patient outcomes, and provide data and progress reports to the Center.

Until the Center has established initial priorities, it shall prioritize the following:

- Reducing health care-associated infections;
- Increasing hospital and outpatient perioperative patient safety;
- Improving emergency room care; and
- Improving the provision of obstetrical and neonatal care.

### *Assistant Secretary for Health Information*

Within the Bureau of Health Information, the Assistant Secretary for Health Information will ensure the collection, collation, reporting and publishing of statistics on key health indicators on the performance of the Nation's health and health care and other health information regarding performance as determined by the Secretary. Key health indicators must be identified and reassessed at least once every 3 years and information on them must be published quarterly. The Assistant Secretary will be responsible for identifying gaps in key health indicator data and ensure consistency with the national strategy. The Assistant Secretary must coordinate with the Office of the National Coordinator for Health Information Technology.

## OTHER PROVISIONS

### *Expanded Participation in 340B Program*

The 340B program for discount drugs is expanded to include children's hospitals meeting the DSH percentage requirement, critical access hospitals, entities receiving funds under title V of the SSA, entities receiving funds under part I of part B of title XIX of the Public Health Service Act (relating to comprehensive mental health services) for the provision of community mental health services, entities receiving funds under subpart II of such part B (relating to the prevention and treatment of substance abuse) for the provision of treatment services for substance abuse, Medicare-dependent, small rural hospitals as defined in SSA, sole community hospitals as defined by SSA and rural referral centers as defined by SSA. These entities are prohibited from obtaining covered outpatient drugs through a group purchasing organization or other group purchasing arrangement except for drugs purchased for inpatient use and reasonable exceptions established by the Secretary.

