

**EXECUTIVE SUMMARY OF THE  
PATIENT PROTECTION AND AFFORDABLE CARE ACT, AS AMENDED BY  
THE HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010  
(COLLECTIVELY, THE “ACT”)**

**(Note: The provisions of Title X of the Patient Protection and Affordable Care Act have been incorporated into the summary as Title X reflects amendments to the first 9 Titles. References herein to the “Reconciliation Act” are to the Health Care and Education Reconciliation Act of 2010.)**

**TITLE I – QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS**

**SUBTITLE A – IMMEDIATE IMPROVEMENTS TO HEALTH CARE COVERAGE**

- **§1001.** The following sections are added to the Public Health Service Act:
  - **§2711.** No lifetime limits on the value of health benefits for plan years beginning on or after September 23, 2010 and beginning in 2014, no annual limits on the value of benefits. Until 2014, annual limits will be restricted.
  - **§2712.** No rescission of an individual’s health care coverage unless the individual has committed fraud or made an intentional misrepresentation for plan years beginning on or after September 23, 2010.
  - **§2714.** Dependant coverage, if offered, must be available for an adult child until such adult child reaches age 26, provided that such adult child is not eligible to enroll in an employer-sponsored health plan for plan years beginning on or after September 23, 2010.
  - **§2715.** A standardized summary of benefits and explanation of coverage is to be developed for distribution to all enrollees.
  - **§2716.** A plan sponsor cannot establish coverage eligibility rules based on the salary of an employee or otherwise establish rules that discriminate in favor of higher wage employees for plan years beginning on or after September 23, 2010.
  - **§2717.** Beginning 2 years from the Act’s effective date, health insurance issuers will be required to make quality reports to the Secretary of HHS for the purposes of improving outcomes, preventing readmission, improving patient safety and implementing wellness and health promotion activities.
  - **§2718.** Each health insurance issuer must report to the Secretary of HHS the amount of premiums used to pay claims versus those used to pay administrative costs. Excess administrative percentages must be returned to the insured through annual rebates. This effectively caps administrative costs beginning January 2, 2011.
  - **§2719.** Health insurance issuers must improve internal appeals processes, including providing for continuing coverage pending an appeal, and must offer external appeals processes that are binding on the insurer.
  - **§2719A.**
    - (1) Beneficiaries, if required or allowed to select a participating provider as a primary care provider, must be allowed to select any participating provider able to accept the beneficiary.
    - (2) Emergency services must be provided without need for prior approval, regardless of whether the provider is a participating provider, and if provided out-of-network, the cost sharing percentage must be the same as if provided in-network and without regard to any other terms or conditions.

(3) A beneficiary with a child may select a pediatrician as the primary care provider for the child.

(4) No referral or prior approval shall be needed for a beneficiary to seek initial treatment from an obstetric or gynecology specialist.

- §1002. The following section is added to the Public Health Service Act:
  - §2793. Grants are to be awarded to states to expand health care coverage consumer assistance programs that handle complaints, enrollment and educational issues. \$30 million is appropriated for the first year.
- §1003. The following section is added to the Public Health Service Act:
  - §2794. Beginning with the 2010 plan year, the Secretary of HHS and the states must establish a process to annually review unreasonable increases in health insurance premiums. Justification for such increases must be made public.

#### SUBTITLE B – IMMEDIATE ACTIONS TO PRESERVE AND EXPAND COVERAGE

- §1101. A temporary high-risk pool will provide coverage for those individuals who cannot currently find coverage. This program will run from not later than 90 days following the effective date of the Act until January 1, 2014 (presumably when state exchanges will be in existence to take over this type of coverage). To be eligible for the high-risk pool, a participant must have a pre-existing condition, must be without creditable coverage for six months and must be a citizen, national or legal alien. Any issuer or employer will be liable to reimburse this program if such issuer or employer is found to have encouraged an enrollee to disenroll from the issuer's employee coverage in order to enroll in the temporary high-risk pool.
- §1102. A temporary reinsurance program (to be established not later than 90 days following the effective date of the Act) will reimburse employment-based plans for 80% of expenses related to claims made by early retirees under the plan exceeding \$15,000. Such reimbursement ends when the qualified expenses reach \$90,000. The purpose of this plan is to reduce costs for the pool of beneficiaries and to equalize premiums.
- §1103. A website is to be created (no later than July 1, 2010) by the Secretary of HHS, in consultation with the states, to allow consumers immediate access to affordable health care coverage options.
- §1104. Uniform standards will be created for use in health care transactions. Health plans will be required to certify compliance with these new HIPAA requirements or face significant penalties.

#### SUBTITLE C – QUALITY HEALTH INSURANCE COVERAGE FOR ALL AMERICANS

- §1201. The following sections are added to the Public Health Service Act:
  - §2702. Beginning in 2014, health insurance issuers must accept all employers and individuals in the applicable state who apply for coverage.
  - §2703. Beginning in 2014, health insurance issuers must renew or continue coverage at the option of a plan sponsor or individual.
  - §2704. For plan years beginning September 23, 2010, all health insurers are prohibited from excluding children on the basis of pre-existing conditions and beginning in 2014, group health plans and health insurers cannot impose pre-existing condition exclusions for any patient.
  - §2705. Beginning in 2014, group health plans and insurance issuers cannot discriminate against plan participants based on a participant's health status or claims experience. However, plan sponsors can offer up to a 30% discount on premium rates for employees to participate in certain health programs.

- §2708. Beginning in 2014, group health plans cannot apply any waiting periods greater than 90 days.

#### SUBTITLE D – AVAILABLE COVERAGE CHOICES FOR ALL AMERICANS

- Subtitle D generally establishes state exchanges for the purchase of a qualified health plan by January 1, 2014. Subtitle D also lays out general certification requirements for qualified health plans and provides for the Secretary of HHS to establish criteria for the certification of qualified health plans.
- §1334. The Office of Personnel Management is to oversee multi-state plans' entering into contracts with health insurance issuers. This section outlines the terms for such contracts, the administration of such contracts, the eligibility of health insurance issuers to enter into such contracts, the requirements for multi-state qualified health plans, the certification of such plans and a phase-in schedule for such plans. (This section was added by Section 10104.)

#### SUBTITLE E – AFFORDABLE COVERAGE CHOICES FOR ALL AMERICANS

- §1401. Beginning in 2014, a taxpayer with household income between 100% and 400% of the federal poverty line will be able to take a refundable “premium assistance credit” for the taxable year. This section outlines how the tax credits are calculated. Additionally, the Comptroller General is to conduct a study on the affordability of health insurance coverage.
- §1402. Individuals who enroll in a qualified health plan in an exchange at a specific coverage level may be eligible for cost-sharing reductions (i.e., subsidies) if their household income does not exceed 400% of the federal poverty line. This section provides a formula for determining how to reduce cost-sharing amounts.
- §1411. This section establishes procedures for determining eligibility for exchange participation, premium tax credits, cost-sharing reductions and individual responsibility exemptions. Additionally, this section outlines the information required to be provided by the applicant, how that information is verified, the appeals process, the confidentiality of information and penalties for individuals who fail to provide correct information. An applicant's citizenship/immigration status, income and family size will be verified against federal records.
- §1412. Advance determinations may be made regarding whether an individual is eligible for premium tax credits and cost-sharing reductions, upon the request of a particular exchange. Procedures are established for the payment of premium tax credits and the implementation of cost-sharing reductions. The Secretary of the Treasury may make an advance payment to an exchange based upon the number of eligible individuals in the particular program; the exchange would then reduce the premiums charged to enrolled individuals based upon pre-payments received from the government.
- §1413. A general process is outlined for streamlining application to and enrollment in applicable state health plans, including state exchanges.
- §1414. The IRS can make disclosures to the Department of HHS (“DHHS”) regarding taxpayer information where necessary to determine an individual's eligibility for various programs. The Secretary of HHS and exchanges are authorized to collect and use names and social security numbers to administer programs created under the Act. There are requirements to maintain confidentiality.
- §1415. Premium assistance tax credits and cost-sharing reductions are to be disregarded for purposes of determining an individual's income or qualifications for other federal programs.
- §1421. Certain credits are made available beginning in 2010 for employee health insurance expenses of small businesses (defined as businesses with no more than 25 employees where the average compensation is not greater than \$50,000). This section outlines the credit amount, the phase out of credits based on number of employees and average wages and other various rules. Credits are also available to tax-exempt eligible small employers.

- §1416. The Secretary of HHS is to study the implications of adjusting federal poverty levels and/or cost of living levels with regard to health care. (This section was added by Section 10105).

#### SUBTITLE F – SHARED RESPONSIBILITY FOR HEALTH CARE

- §1501. Beginning in 2014, individuals will be required to maintain minimum essential coverage for themselves and their dependents. If an individual does not maintain essential coverage, penalties known as the “shared responsibility payment” will be assessed. These penalties are based upon a variety of rules (i.e., family size, household income, etc.). There are certain exemptions from coverage. This section provides minimum essential coverage amounts and outlines certain administrative procedures. (Section 10106 modifies Section 1501(b) with regard to penalties for taxpayers who do not obtain health care).
- §1502. Beginning with the calendar year 2014, any person who provides minimum essential coverage to an individual must file a return reporting such coverage to the IRS. This section outlines the form of the required returns and statements to be given to individuals with respect to whom information is reported.
- §1511. Employers with more than 200 full-time employees and that offer one or more health benefit plans must provide for automatic enrollment of new employees. Employees must be given the opportunity to opt-out.
- §1512. Beginning in 2014, employers will be subject to requirements to provide notice to employees about health benefits.
- §1513. Beginning in 2014, certain large employers will have to pay assessments if they do not offer health care coverage.
- §1514. Beginning in 2014, certain large employers will have to report on health insurance coverage matters. This section outlines the form and manner of returns to be filed, statements to be furnished to individuals with respect to whom information is reported and other miscellaneous provisions.
- §1515. Beginning in 2014, employers cannot offer exchange-participating qualified health plans through cafeteria plans unless they are qualified employers for purposes of the exchange.
- §10108. Employers who offer minimum essential coverage must provide free choice vouchers to any qualified employee who is not subject to the individual mandate, but who meets certain income and expense requirements. The mandates are not effective until 2014 – as such, it is arguable that this provision is not effective until 2014; however, there is no effective date provided.

#### SUBTITLE G – MISCELLANEOUS PROVISIONS

- §1551. Definitions are to be the same as those set forth in Section 2791 of the Public Health Service Act.
- §1552. Certain “transparency in government” requirements are established whereby the Secretary of HHS shall publish specified information on its website within 30 days after passage of the Act.
- §1553. There is a prohibition on discrimination against a health care provider who refuses to assist in causing the death of any individual or in any assisted suicide, euthanasia or mercy killing.
- §1554. This section contains a general statement regarding access to health care services.
- §1555. This section outlines certain rights not to participate in federal health insurance programs.
- §1556. This section amends the Black Lung Benefits Act.

- §1557. This section addresses non-discrimination with regard to providing health care.
- §1558. This section prohibits retaliation against employees who receive health care benefits or seek coverage through exchanges.
- §1559. The Inspector General of the Department of Health and Human Services is given oversight authority.
- §1560. This section outlines certain rules of construction with regard to antitrust laws, Hawaii's Prepaid Health Care Act, student health insurance plans and state agencies.
- §1561. The Public Health Service Act is amended with respect to certain technology enrollment standards and protocols.
- §1562. The GAO is to perform certain studies on the rate of denial of coverage and enrollment by health insurance issuers and group health plans. (This section was added by Section 10107).
- §1563. Any laws or regulations that establish procurement requirements relating to certain small businesses may not be waived with respect to any contract awarded under the Act. Health care plans or health insurers may continue to use existing utilization management techniques. Most of the market reforms added by the Act's amendments to the Public Health Service Act also apply to group health plans and issuers. Group health plans are subject to new requirements, including (among other things) extension of dependent coverage, mandatory coverage of preventive health services, prohibition of lifetime or annual limits on the dollar value of benefits, unreasonable annual limits, and rescission. Additionally, congressional findings with regard to the Act's impact on the federal deficit are described in this section. (This section was renumbered per Section 10107).

## **TITLE II – ROLE OF PUBLIC PROGRAMS**

### **SUBTITLE A – IMPROVED ACCESS TO MEDICAID**

- §2001. Beginning in 2014, state plans for medical assistance must make benchmark coverage (or benchmark equivalent coverage) available to individuals whose income does not exceed 133% of the poverty line ("newly eligible individuals"). Furthermore, this section outlines the Federal Medical Assistance Percentage ("FMAP"). From the date of enactment through the date the exchange is established, states cannot have eligibility standards more restrictive than those in effect on the date of enactment (this continues until 2019 for determining the eligibility of children). Also beginning in 2014, states can make coverage available to individuals with income greater than 133% over the poverty line. Parents of children under 19 cannot be enrolled unless the child is enrolled. Additionally, as of 2014, the basic services for benchmark equivalent coverage are expanded to include coverage of prescription drugs and mental health services. Beginning in 2015 and annually thereafter, each state must submit a report on its medical assistance plans summarizing the number of newly enrolled individuals and other related information.
- §2002. Beginning in 2014, states must use modified adjusted gross income to determine Medicaid eligibility. Each state must submit its income eligibility thresholds, methodologies and procedures to the Secretary of HHS for approval.
- §2003. Beginning in 2014, states must offer (if cost-effective as provided in Section 10203) a premium assistance subsidy for qualified employer-sponsored coverage (employer contribution must be greater or equal to 40% and it can't be a high deductible health plan) to all individuals (and parents of individuals) who are entitled to medical assistance. The subsidy is to be the amount of the employee's contribution for enrollment.
- §2004. Beginning in 2014, state plans for medical assistance must cover individuals under 26 who were in foster care when they turned 18 and were enrolled in the state plan while in foster care.

- §2005. Beginning July 1, 2011 and continuing through September 30, 2019, Medicaid payments to Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands and American Samoa are increased by 30%. Also starting July 1, 2011, and thereafter, FMAP to U.S. territories is increased to 55%. Beginning in 2014, payments made to U.S. territories with respect to amounts expended for medical assistance for newly eligible individuals will not count against the spending caps.
- §2006. Beginning in 2011, states that have declared a major disaster during the preceding 7 years will use a different FMAP percentage to avoid a sharp decrease in Medicaid funding that would otherwise occur in 2011.
- §2007. The Medicaid Improvement Fund is rescinded beginning 2014 and continuing through 2018.

#### SUBTITLE B – ENHANCED SUPPORT FOR THE CHILDREN’S HEALTH CARE PROGRAM

- §2101. Beginning in 2015 and continuing through September 2019, the enhanced FMAP for a state is to be increased by 23% (not to exceed 100%) for the CHIP match rate. Children that are ineligible for Medicaid because of the revised income requirements are to be treated as targeted low-income children and provided with health assistance under the state child health plan. Section 10203 extends and significantly increases allotments to states for CHIP (approximately \$17.4 million for 2013, \$19.1 million for 2014, and \$5.7 million for 2015).
- §2102. Minor technical corrections are made to the Children’s Health Insurance Program Reauthorization Act of 2009 and the American Recovery and Reinvestment Act of 2009. Section 10203 implements a hardship exception under which children are not excluded from the definition of “targeted low-income child” if the annual amount of premiums and cost-sharing imposed for coverage of the family of the child under an employer plan would exceed 5% of such family’s income for that year.

#### SUBTITLE C – MEDICAID AND CHIP ENROLLMENT SIMPLIFICATION

- §2201. Beginning in 2014, states must establish a secure website at which eligible individuals can apply for and enroll in Medicaid, CHIP or health exchange. There must be coordination between the three programs and streamlined procedures for enrollment. States must conduct outreach to underserved populations.
- §2202. Beginning in 2014, a hospital that is a participating provider under the state Medicaid plan may elect to be a qualified entity for purposes of determining, on the basis of preliminary information, whether an individual is eligible for medical assistance under the state Medicaid plan.

#### SUBTITLE D – IMPROVEMENTS TO MEDICAID SERVICES

- §2301. As of the date of enactment of the Act (extension given for states that require legislation to effect this addition), state medical assistance programs must cover freestanding birth center services.
- §2302. As of the date of enactment of the Act, children with terminal illnesses can receive payment for hospice care concurrently with payment for treatment.
- §2303. As of the date of enactment of the Act, non-pregnant individuals whose income does not exceed eligibility levels are eligible for family planning services and supplies. Services can be provided during a presumptive eligibility period.
- §2304. As of the date of enactment of the Act, the term “medical assistance” means payment of part or all of the cost of care and services or the care and services themselves, or both.

#### SUBTITLE E – NEW OPTIONS FOR STATES TO PROVIDE LONG-TERM SERVICES AND SUPPORTS

- §2401. Beginning October 1, 2011, states may amend their Medicaid plan to provide medical assistance for home and community-based attendant services and support for individuals for whom there has been a determination that, but for the provision of such services, the individuals would require the level of care provided in a hospital, nursing home, or facility for mental disease, the cost of which would be reimbursed under the state Medicaid plan. States must also establish a quality assurance system. Such an amendment to the state Medicaid plan must be developed and implemented in collaboration with a Development and Implementation Council established by the state that includes a majority of members with disabilities, elderly individuals and their representatives.
- §2402. The Secretary of HHS must promulgate regulations to govern states' provision of home and community-based attendant services. Beginning on the first day of the first fiscal year quarter that begins after the date of enactment, states may provide home and community-based attendant services to those that satisfy the needs-based criteria who have income over the otherwise established caps.
- §2403. Beginning 30 days after the date of enactment of the Act, individuals are eligible to participate in the Money Follows the Person Rebalancing Demonstration (which is extended through September 2016) if they reside in an inpatient facility for not less than 90 consecutive days.
- §2404. From 2014 through 2018, states must apply spousal impoverishment rules to individuals eligible for medical assistance for home and community-based attendant services.
- §2405. An appropriation of \$10 million for each year from 2010 through 2014 is made to the Secretary of HHS to carry out provisions of the Older Americans Act of 1965.
- §2406. This section states the Senate's opinion that long-term care has yet to be adequately addressed.

#### SUBTITLE F – MEDICAID PRESCRIPTION DRUG COVERAGE

- §2501. Beginning in 2010, the minimum rebate for single source and innovator multiple source prescription drugs is increased from 15.1% to 23.1% (17.1% for certain drugs). The minimum rebate percentage for multi-source, non-innovator drugs is increased from 11% to 13%. For new formulations, the rebate obligation is calculated from the average manufacturer price. The maximum rebate can not exceed 100% of the average manufacturer price of the drug.
- §2502. Beginning in 2014, smoking cessation drugs, barbiturates and benzodiazepines can not be excluded from coverage under the state Medicaid plan.
- §2503. The federal upper reimbursement limit can not be no less than 175% of the weighted average of the most recently reported monthly average manufacturer prices for pharmaceutically and therapeutically equivalent multiple source drug products that are available for purchase by retail community pharmacies on a nationwide basis. This begins the first day of the first calendar year quarter at least 180 days after the date of enactment of the Act.

#### SUBTITLE G – MEDICAID DISPROPORTIONATE SHARE PAYMENTS

- §2551. Beginning October 1, 2011, the Disproportionate Share Hospital ("DSH") payments to states are reduced through a formula that provides a benefit to states that reduce their percentage of uncovered individuals. Section 10201 provides for allotment and adjustment thereof for Hawaii.

#### SUBTITLE H - IMPROVED COORDINATION FOR DUAL ELIGIBLE BENEFICIARIES

- §2601. Waivers for dual eligible individuals may be conducted for a period of 5 years (extended for additional 5-year periods upon request of state unless the Secretary of HHS determines that

the conditions for the waiver have not been met or it would no longer be cost-effective and efficient or consistent with the purposes of the Title).

- §2602. On or before March 1, 2010, the Secretary of HHS must establish a Federal Coordinated Health Care Office to more effectively integrate Medicare and Medicaid and coordinate between the federal government and the states with respect to benefits for individuals eligible under both programs.

#### SUBTITLE I – IMPROVING THE QUALITY OF MEDICAID FOR PATIENTS AND PROVIDERS

- §2701. On or before January 1, 2011, the Secretary of HHS must identify and publish for comment a recommended core set of adult health quality measures for Medicaid eligible adults. These initial measures must be disseminated on or before January 1, 2012. On or before January 1, 2013, the Secretary of HHS must develop a standardized format for reporting information on these measures. Not later than 12 months after the release of the recommended core set of health quality measures, the Secretary of HHS must establish a Medicaid Quality Measurement Program. There is an appropriation of \$60 million per year from 2010 through 2014 for carrying out this section.
- §2702. The Secretary of HHS must identify current state practices that prohibit payment for health-care acquired conditions (medical conditions that could be identified by certain secondary diagnostic codes) and must incorporate the best state provisions into regulations to apply to the Medicaid program beginning in July 2011.
- §2703. Beginning in 2011, states may allow eligible individuals with chronic conditions to select a designated provider or health team to provide those individuals with comprehensive care management and coordinated care. The Secretary of HHS must contract with an independent entity to evaluate and assess states that have elected the option to provide coordinated care through a health home.
- §2704. From 2012 to 2016, the Secretary of HHS must conduct a demonstration project in up to 8 states selected by the Secretary of HHS to evaluate the use of bundled payments for the provision of integrated care for Medicaid patients with respect to hospitalization and concurrent physicians services during that hospitalization.
- §2705. From 2010 through 2012, the Secretary of HHS must conduct the Medicaid Global Payment System Demonstration Project in up to 5 states selected by the Secretary of HHS that would allow the participating states to adjust the payments made to an eligible safety net hospital system or network from a fee-for-service payment structure to a global capitated payment model. There is an appropriation of such sums as are necessary to carry out this section.
- §2706. From 2012 to 2016, the Secretary of HHS must conduct the Pediatric Accountable Care Organization Demonstration Project under which participating states can allow pediatric medical providers that meet specified requirements to be recognized as an accountable care organization that would receive incentive payments in the amount of the savings achieved in excess of the annual minimal savings level established by the state. There is an appropriation of such sums as are necessary to carry out this section.
- §2707. The Secretary of HHS must establish a 3-year demonstration project in which participating states (chosen by application to the Secretary) must provide Medicaid payments to an institution for mental diseases that is not publicly owned or operated for eligible adults who require medical assistance to stabilize an emergency medical condition (expressing suicidal or homicidal thoughts or gestures). States will be reimbursed for the FMAP of expenditures for medical assistance for these services in exchange for the state reporting requested information to the Secretary of HHS. There is an appropriation of \$75 million for 2011. Funds are available through 2015.

#### SUBTITLE J – IMPROVEMENTS TO THE MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSIONER

- §2801. Additional responsibilities are created for Medicaid and the CHIP Payment and Access Commission (“MACPAC”), including (1) review of policies, processes, regulations, state-specific reports, (2) coordination with the Medicare Payment Advisory Commission (“MedPAC”) for dually eligible individuals, (3) consultation with states, and (4) coordination and consultation with the Federal Coordinated Health Care Office. There is an appropriation of \$9 million for 2010 (plus a transfer of another \$2 million to MACPAC to comply with this section).

#### SUBTITLE K – PROTECTIONS FOR AMERICAN INDIANS AND ALASKA NATIVES

- §2901. Cost sharing is prohibited for certain Indians enrolled in a qualified health plan through an exchange. Indian health programs are payors of last resort. Health programs operated by the Indian Health Service, Indian tribes, tribal organizations and Urban Indian organizations qualify as Express Lane agencies that can make eligibility determinations for enrollment in CHIP or Medicaid. This section is effective as of the date of enactment of the Act.
- §2902. The sunset provision on reimbursement to Indian hospitals and clinics under Medicare Part B is removed, effective as of the date of enactment of the Act.

#### SUBTITLE L – MATERNAL AND CHILD HEALTH SERVICES

- §2951. Within 6 months after the date of enactment of the Act, each state must conduct a statewide needs assessment identifying communities with concentrations of premature birth, infant mortality, poverty, crime, domestic violence, high rates of high-school dropouts, substance abuse, unemployment or child maltreatment and evaluate the quality and capacity of existing programs or initiatives for early childhood home visitation in the state and the state’s capacity for providing substance abuse treatment and counseling services. States are to submit their assessment to the Secretary of HHS; the Secretary of HHS may make grants to eligible entities for home visitation to promote improvements in maternal and prenatal health, infant and child health and parenting. There are appropriations of \$100 million for 2010, \$250 million for 2011, \$350 million for 2012, \$400 million for 2013 and \$400 million for 2014 (3% reservation of the appropriated amounts for Indian Tribes, Tribal Organizations or Urban Indian Organizations).
- §2952. The Secretary of HHS “is encouraged” to continue activities, including research, on postpartum depression or postpartum psychosis. “It is the sense of Congress” that the Director of the National Institute of Mental Health “may” conduct a longitudinal study of postpartum issues. The Secretary of HHS may make grants to eligible entities for projects for the establishment, operation, and coordination of effective and cost-efficient systems for the delivery of essential services to individuals with or at risk for postpartum conditions and their families. There is an appropriation of \$3 million for 2010 and of “such sums as may be necessary” for 2011 and 2012.
- §2953. From 2010 to 2014, the Secretary of HHS must allot an annual amount (minimum \$250,000) to each state equal to the product of a base appropriated amount and the state youth population percentage. These allotments are to be used to enable the state to carry out personal responsibility education (education on abstinence and contraception and other youth-focused life skills, including healthy relationships). There is an appropriation of \$75 million for each year (reservation of \$10 million for grants to implement innovative youth pregnancy prevention strategies and target high-risk, vulnerable and culturally under-represented youth; reservation of 5% of remainder for grants to Indian tribes or tribal organizations).
- §2954. This section restores an appropriation of \$50 million per year for 2010 through 2014 for abstinence education.
- §2955. Beginning October 1, 2010, children leaving the foster care program are to be educated on health insurance options and the importance of designating a health care power of attorney.

- §10201. A process is provided for the application or renewal of an experimental, pilot or demonstration project that would result in an impact on eligibility, enrollment, benefits, cost-sharing or financing of a state Medicaid program.
- §10202. A balancing incentive payment is made to states (1) in which less than 50% of the total expenditures for medical assistance for long-term services and supports are non-institutionally-based (nursing home or intermediate care facility) and (2) that submit an application with a plan to expand and diversify medical assistance for non-institutionally-based long-term services such as home health care services and personal care services.
- §§10211 to 10214. The Secretary of HHS (with the Secretary of Education) must establish a Pregnancy Assistance Fund to award grants to states to assist pregnant and parenting teens and women. States may (1) use the Pregnancy Assistance Fund grants made available in Section 10212 to assist pregnant and parenting teens and women; (2) make funds available to institutions of higher education to establish, maintain or operate pregnant and parenting student services (institutions must provide 25% matching non-federal funds); (3) make funds available to eligible high schools and community service centers to establish, maintain or operate pregnancy and parenting services; (4) make funds available to state Attorney General to provide intervention services or social services for eligible pregnant women who are victims of domestic violence, sexual violence, sexual assault or stalking; or (5) make funds available to increase public awareness and education concerning any services available to pregnant and parenting teens and women. There is an appropriation of \$25 million for each year 2010 through 2019.
- §10221. This section amends and enacts into law a bill related to the Indian Health Care Improvement Act.
- §1202 of the Reconciliation Act. State Medicaid plans must pay for primary care services by a family medicine, general internal medicine, or pediatric medicine physician in 2013 and 2014 at not less than the same rates as Medicare covers.
- §1206 of the Reconciliation Act. This section provides for the line extension of single source drugs.

### **TITLE III – IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE**

#### **SUBTITLE A – TRANSFORMING THE HEALTH CARE DELIVERY SYSTEM**

- §3001. For hospital discharges occurring on or after October 1, 2012, the Secretary of HHS will establish a hospital value-based purchasing program for hospitals participating in Medicare under which value-based incentive payments will be made to hospitals that meet certain performance standards established by the Secretary of HHS. A portion of a hospital's Medicare payment will be linked to the hospital's performance on quality measures related to common and high-cost conditions. Starting in fiscal year 2014, the measures will also include efficiency measures. From these assessments, the Secretary of HHS will distribute value-based incentive payments among hospitals achieving different levels of hospital performance scores, with hospitals achieving the highest hospital performance scores receiving the largest value-based incentive payments. Within two years of the enactment of the Act, the Secretary of HHS will also establish a value-based purchasing program under the Medicare program for inpatient critical access hospitals and inpatient hospital services. This program will be conducted for a 3-year period.
- §3002. With respect to covered professional services furnished by an eligible professional during 2015 or any subsequent year, if the eligible professional does not satisfactorily submit data on quality measures for covered professional services for the quality reporting period for the year, the Medicare fee schedule amount for such services furnished by such professional during the year will be reduced by 1.5% for 2015 and 2% for 2016 and each subsequent year of the fee schedule amount that would otherwise apply to such services. Per Section 16327, payments under the Physician Quality Reporting Initiative are extended through 2014.

- §3003. Medicare’s Physician Resource Use Feedback Program will be expanded to provide for the development of individualized reports by 2012. Reports will compare the per capita use of physicians to other physicians who see similar patients. Per Section 10331, the Secretary of HHS will create a Physician Compare Website on physicians enrolled in Medicare or who participate in the Physician Quality Reporting Initiative.
- §3004. For rate year 2014 and each subsequent rate year, each long-term care hospital, inpatient rehabilitation facility and hospice program is required to submit to the Secretary of HHS data on quality measures (to be established by the Secretary of HHS by October 1, 2012). If such data is not submitted to the Secretary of HHS, with respect to such rate year, any annual update to a standard Federal rate for discharges for the hospital during the rate year will be reduced by 2%. This may result in payment rates under the system for a rate year being less than such payment rates for the preceding rate year. Per Section 10322, these rules also apply to inpatient psychiatric hospitals.
- §3005. For fiscal year 2014, a PPS-exempt cancer hospital must submit data to the Secretary of HHS on quality measures (as specified by the Secretary of HHS by October 1, 2012). The Secretary of HHS must establish procedures for making data submitted in this section available to the public. Cancer hospitals that do not participate will be subject to a reduction in their annual payment update rate.
- §3006. The Secretary of HHS is to implement a value-based purchasing program for skilled nurses facilities, home health agencies and ambulatory surgical centers (per Section 10301).
- §3007. The Secretary of HHS must establish a payment modifier that provides for differential payments to a physician or a group of physicians under the fee schedule established yearly by the Secretary of HHS based upon the quality of care furnished compared to the cost during a performance period. The Secretary of HHS will establish the appropriate measures of the quality care furnished by a physician or group of physicians and will evaluate costs based on a composite of appropriate measures of costs established by the Secretary of HHS. The initial performance period is to be 2015. The program will be extended to all physicians and groups of physicians beginning in 2017.
- §3008. There are incentives for hospitals to reduce hospital-acquired conditions (a condition an individual acquires during a stay in a hospital) with respect to discharges from a hospital occurring during fiscal year 2015 or a subsequent fiscal year. Hospitals in the top 25<sup>th</sup> percentile of rates of hospital-acquired conditions for certain high-cost procedures will be subject to a 1% payment penalty applied to the hospital discharge payments.
- §3011. The Secretary of HHS must establish a national strategy to improve the delivery of health care services, patient health outcomes and population health and will identify national priorities for improvement to develop such strategies. The Secretary of HHS will also collaborate, coordinate and consult with state agencies responsible for administering the Medicaid program and CHIP with respect to developing and disseminating strategies, goals, models and timetables that are consistent with the national priorities identified. The national strategy is to be initially submitted to Congress by January 1, 2011.
- §3012. The President will convene an Interagency Working Group on Health Care Quality that will develop health care goals and priorities.
- §3013. Quality measures conforming with the national strategy will be developed.
- §§3014 to 3015. The Secretary of HHS will consult with the Director of the Agency of Healthcare Research and Quality and the Administrator of the Centers for Medicare & Medicaid Services to identify, not less than triennially, gaps where no quality measures exist and existing quality measures that need improvement, updating or expansion. “Quality measure” means a standard for measuring the performance and improvement of population health or of health plans, providers of services and other clinicians in the delivery of health care services. The

Secretary of HHS will also award grants, contracts or intergovernmental agreements to eligible entities for purposes of developing, improving, updating or expanding quality measures identified under this part. The Secretary of HHS has been provided with \$20 million for each of fiscal years 2010 through 2014 to support an entity to facilitate input on quality measures. Per Section 10332, non-patient identifiable claims data under Medicare Parts A, B, and D will be made available to qualified entities.

- §3021. No later than January 1, 2011, there will be created, within the Centers for Medicare & Medicaid Services, a Center for Medicare and Medicaid Innovation (“CMI”) to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals. In selecting such models, the Secretary of HHS will give preference to models that also improve the coordination, quality, and efficiency of health care services furnished to applicable individuals. CMI is to consult representatives of relevant Federal agencies, and clinical and analytical experts with expertise in medicine and health care management, as well as use open door forums and other mechanisms to seek input from interested parties. The Secretary of HHS will test the models developed, will have the power to terminate or modify the design and implementation of a model, and may, through rulemaking, expand the duration and scope of a model that is being tested or a demonstration project to the extent appropriate if such expansion is determined to reduce spending or improve the quality of care and reduce spending.
- §3022. No later than January 1, 2012, the Secretary of HHS must establish a shared savings program that promotes accountability for a patient population and coordinates items and services, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery. Under such program, groups of providers of services and suppliers meeting criteria specified by the Secretary of HHS may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an accountable care organization (“ACO”) and ACOs that meet quality performance standards established by the Secretary of HHS are eligible to receive payments for shared savings. An ACO will continue to receive the original Medicare fee-for-service program payments and will also be eligible to receive payment for shared savings if the ACO meets the quality performance standards and requirements set forth by the Secretary of HHS and if the estimated average per capita Medicare expenditures under the ACO for the Medicare fee-for-service beneficiaries is below the applicable benchmark, as established by the Secretary of HHS for each agreement period.
- §3023. No later than January 1, 2013, the Secretary of HHS must establish a pilot program for integrated care during an episode of care provided to an applicable beneficiary around a hospitalization in order to improve the coordination, quality and efficiency of health care services. The program is to last 5 years, and the goal of the program is to improve patient care and achieve savings in the Medicare program through bundled payments.
- §3024. Starting no later than January 1, 2012, the Secretary of HHS is to conduct a demonstration program to test a payment incentive and service delivery model that utilizes physicians and nurse practitioner directed home-based primary care teams designed to reduce expenditures and improve health outcomes in the provision of items and services to chronically ill Medicare beneficiaries. Certain incentive payments may be made if actual expenditures for the applicable beneficiaries are less than the estimated spending target.
- §3025. Starting on or after October 1, 2012, with respect to payment for discharges from an applicable hospital, in order to account for excess readmissions to the hospital, the Secretary of HHS will reduce the payments that would otherwise be made to such hospital. In addition, the Secretary of HHS will make available a program for eligible hospitals to improve their readmission rates through the use of patient safety organizations.
- §3026. The Secretary of HHS will establish a Community Based Care Transitions Program to provide funding to eligible entities that furnish improved care transition services to high-risk

Medicare beneficiaries who are at high-risk for readmission. This program begins January 1, 2011 and lasts for 5 years.

- §3027. The gainsharing demonstration project set to end on December 31, 2009 has been extended until September 30, 2011 for projects in operation as of October 1, 2008.

#### SUBTITLE B – IMPROVING MEDICARE FOR PATIENTS AND PROVIDERS

- §3102. The floor on geographic index adjustments to the work portion of the physician fee schedule is extended through calendar year 2010. Also, the Secretary of HHS is directed to improve the methodology for calculating practice expense adjustments no later than January 1, 2012.
- §3103. The process allowing exceptions to limitations on medically necessary therapy is extended until December 31, 2010.
- §3104. The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 is amended, through 2010, to provide an exception to a payment rule that permits certain clinical laboratories at qualified rural hospitals to receive direct Medicare reimbursement when providing the technical component of certain physician pathology services that had been outsourced by certain hospitals.
- §3105. Bonus and increased payments made by Medicare for ground and air ambulance services in rural areas are extended through 2010.
- §3106. The Medicare, Medicaid and SCHIP Extension Act of 2007 is amended to extend for 2 years payment rules for long term care hospital services and a moratorium on the establishment of certain types of hospitals and other facilities.
- §3107. The 5% increase in payment rates for psychiatric services has been extended through December 31, 2010.
- §3108. A physician assistant who does not have a direct or indirect employment relationship with a skilled nursing facility, but is working in collaboration with a physician, is allowed to order skilled nursing care services for Medicare payment purposes.
- §3109. Effective January 1, 2011, pharmacies with less than 5% of revenues from specific Medicare billings (and that meet other criteria set forth in this section) are permitted to be exempt from accreditation requirements until the Secretary of HHS develops pharmacy specific standards.
- §3110. A special 12 month enrollment period is provided for military retirees, their spouses (including widows/widowers) and dependent children, who are otherwise eligible for TRICARE (the healthcare plan under the Department of Defense) and entitled to Medicare Part A based on disability or end stage renal disease, but who have declined Medicare Part B.
- §3111. Payments are set for dual energy x-ray absorptiometry services furnished during 2010 and 2011 at 70% of the 2006 Medicare reimbursement rates.
- §3112. The remaining funds (\$22.3 billion) in the Medicare Improvement Fund are eliminated.
- §3113. The Secretary of HHS is to conduct a demonstration project under Medicare Part B to test the impact of direct payments for certain complex laboratory tests on Medicare quality and costs. The direct payment will be a payment made to a laboratory (including a hospital based or independent laboratory) that performs the complex diagnostic laboratory tests. The demonstration project is to begin on July 1, 2011 and continue for a period of 2 years thereafter.
- §3114. The payment rate for a certified nurse midwife for covered services is increased from 65% to 100% of the rate that would be paid if a physician were performing the service. This rate change goes into effect on January 1, 2011.

- §3121. The hold harmless provisions under the prospective payment system for rural hospital outpatient department services are extended through calendar year 2010. The 100 bed limitation for sole community hospitals is removed so that all such hospitals receive an 85% increase in the payment difference during calendar year 2010.
- §3122. The reasonable cost reimbursement for clinical diagnostic laboratory services under Medicare Part B for qualifying rural hospitals with fewer than 50 beds is extended from July 1, 2010 until July 1, 2011.
- §3123. This section extends the Rural Community Hospital Demonstration Program for one additional year through 2010, expands the minimum number of participating hospitals to 30 and expands the number of demonstration states with low population densities to 20. (This section was amended by Section 10313).
- §3124. The Medicare Dependent Hospital Program for certain small rural hospitals is extended through October 1, 2012. The Medicare in-patient hospital payment adjustment for low volume hospitals is modified through fiscal year 2012.
- §3125. The program providing a temporary adjustment to in-patient hospital services for certain low volume rural hospitals is extended through fiscal year 2012. This section modifies the eligibility requirements regarding distance from another facility. Additionally, this section modifies the requirements regarding the number of eligible discharges of individuals entitled to, or enrolled for, benefits under Medicare Part A.
- §3126. Additional counties, as well as physicians, will be allowed to participate in the Demonstration Project on Community Health Integration Models in Certain Rural Counties which otherwise allows rural entities to test new models for the delivery of health care services in rural areas.
- §3127. The Medicare Payment Advisory Commission is required to study the adequacy of payments for items and services furnished by service providers and suppliers in rural areas under the Medicare Program.
- §3128. Critical access hospitals are allowed to continue to be eligible to receive 101% of reasonable costs for providing out-patient care and qualifying ambulance services.
- §3129. The “FLEX Grant” program is extended through fiscal year 2012. FLEX grants are allowed to be used to support rural hospitals’ efforts to implement delivery system reform programs such as value based purchasing programs, bundling and other quality programs.
- §3131. The Secretary of HHS is directed to improve payment accuracy through rebasing the home health prospective payment system starting in 2014 by an appropriate percentage to reflect the number, mix and level of intensity of home health care services and the average cost of providing care. This section also establishes a 10% cap on the amount of reimbursement a home health care provider can receive from outlier payments and reinstates an add on payment for rural home health care providers from April 1, 2010 through fiscal year 2015. The Secretary of HHS is directed to study home health agency costs involved with providing ongoing access to care to low income Medicare beneficiaries in medically underserved areas. A Medicare demonstration project based on the results of the Secretary’s study is authorized.
- §3132. The Secretary of HHS is required to update Medicare hospice claim forms and cost reports by January 1, 2011 and to implement changes to the hospice payment system to improve payment accuracy not earlier than October 1, 2013. The Secretary of HHS must also impose new requirements on hospice providers participating in Medicare, including requirements for a hospice physician or nurse practitioner to have a face-to-face encounter with the individual regarding eligibility and re-certification and a medical review of any stays exceeding 180 days where the number of such cases exceeds a specified percentage for all hospice programs.

- §3133. Reductions to Medicare Disproportionate Share Hospital (“DSH”) payments are specified beginning in fiscal year 2014. Subsection “D” hospitals (acute care hospitals) are particularly affected. Per Section 1104 of the Reconciliation Act, the Secretary of HHS will update hospital payments to better account for hospitals’ uncompensated care costs. The reductions are to reflect lower uncompensated care costs relative to increases in the number of insured.
- §3134. The Secretary of HHS is directed to periodically identify physician services as being potentially misvalued and to make appropriate adjustments under the Medicare physician fee schedule. For purposes of identifying misvalued services, the Secretary of HHS is to examine codes for which there has been the fastest growth, codes that have experienced substantial changes in practice expenses, codes for new technologies or services within an appropriate period after the relative values were initially established for such codes, multiple codes that are frequently billed in conjunction with furnishing a single service, codes with low relative values, particularly those that are often billed multiple times for a single treatment, codes which have not been subject to review since implementation of the Harvard-Valued codes and such other codes determined to be appropriate by the Secretary of HHS.
- §3135. The presumed utilization rate for calculating the payment for advanced imaging equipment other than low tech imaging (i.e., ultrasound, x rays and EKGs) is increased. The technical component discount on single session imaging studies on contiguous body parts is increased. These changes apply to services provided in 2011 and subsequent years.
- §3136. This section eliminates the option for Medicare to purchase power driven wheelchairs (other than complex rehabilitative power wheel chairs) with a lump sum payment at the time the chair is supplied. The payments will now be made over a 13-month period.
- §3137. “Section 508” hospital reclassifications are extended until September 30, 2010. “Section 508” refers to Section 508 of the Medicare Modernization Act of 2003, which allows the temporary reclassification of a hospital with a low Medicare area wage index for reimbursement purposes to a nearby location with a higher Medicare area wage index so that the first hospital will receive the higher Medicare reimbursement rate. The Secretary of HHS is directed to provide a plan to Congress to reform the hospital wage index system.
- §3138. The Secretary of HHS is directed to conduct a study to determine whether existing cancer hospitals which are exempt from the in-patient perspective payment system have costs under the out-patient perspective payment system that exceed costs of other hospitals and to make an appropriate payment adjustment under the out-patient perspective payment system based on that analysis for services furnished on or after January 1, 2011.
- §3139. A biosimilar biological product is allowed to be reimbursed at a rate equal to the sum of the average sales price of the brand biological product plus 6%. Biosimilar biological products are biological products approved under an abbreviated application for a license of a biological product that relies in part on data or information and an application for another biological product licensed under Section 351 of the Public Health Service Act.
- §3140. The Secretary of HHS is directed to establish a Medicare Hospice Concurrent Care demonstration program at participating hospice programs under which Medicare beneficiaries are furnished, during the same period, hospice care and any other items or services covered under the Social Security Act from funds otherwise paid under the Social Security Act to such hospice programs. The demonstration program is to be conducted for a 3-year period.
- §3141. Beginning on October 1, 2010, budget neutrality associated with the effect of the imputed rural and rural floor must be applied on a national, rather than a state-specific basis, through a uniform national adjustment to the area wage index.
- §3142. The Secretary of HHS is directed to conduct a study on the need for an additional Medicare payment for urban Medicare dependent hospitals for inpatient hospital services.

- §3143. Nothing in the Act is to result in the reduction of guaranteed home health benefits under the Medicare program.
- §1102 of the Reconciliation Act. The comparative cost adjustment program (Section 1860C-1 of the Social Security Act) is repealed.
- §1301 of the Reconciliation Act. Community mental health centers that provide Medicare partial hospitalization services must provide a significant share of their services to individuals who are not eligible for benefits under Medicare.

#### SUBTITLE C – PROVISIONS RELATING TO PART C

- §3202. Medicare Advantage plans are prohibited from charging beneficiaries cost sharing for covered services that is greater than what is charged under the traditional fee for service program. Plans that provide extra benefits are required to give priority in the following order: (1) reduction of cost sharing, (2) coverage of preventative care and wellness benefits, and (3) other benefits not covered under the traditional fee for service program. These changes are effective on January 1, 2011.
- §3204. Beneficiaries may disenroll from a Medicare Advantage plan and return to the traditional fee for service program from January 1 to March 15 of each year.
- §3205. The Special Needs Plan Program is extended through 2014. Special needs plans must be approved by the National Committee for Quality Assurance. DHHS may apply a frailty payment adjustment to fully integrated, dual eligible special needs plans that enroll frail populations.
- §3206. This section extends the length of time reasonable cost plans may continue operating regardless of any other Medicare Advantage plans serving in the area. The extension is through calendar year 2012.
- §3207. An employer-sponsored private fee-for-service plan with enrollment as of October 1, 2009 is allowed to use a Centers for Medicare & Medicaid Services service area waiver normally available only to Medicare Advantage coordinated care plans, beginning in fiscal year 2011.
- §3208. Demonstration plans that serve residents in continuing care retirement communities are allowed to operate under the Medicare Advantage Program.
- §3209. Beginning in 2011, the Secretary of HHS is allowed to deny bids submitted by Medicare Advantage and Medicare Part D prescription drug plans that propose to significantly increase beneficiary cost sharing or decrease benefits offered under the plan.
- §3210. The Secretary of HHS is directed to request that the National Association of Insurance Commissioners develop new standards for certain Medigap plans so that such plans include nominal cost sharing that encourages use of appropriate Medicare Part B physician services.
- §1102 of the Reconciliation Act. Medicare Advantage payment rates in 2011 will be the same as in 2010. Beginning in 2012, a new “Blended Benchmark” will be used to determine all Medicare Advantage payments except for those under PACE. Quality measures will impact the blended benchmark calculation and the beneficiary rebate starting in 2012.
- §1103 of the Reconciliation Act. A Medicare Advantage plan will incur penalties if it fails to have a medical loss ratio of at least 85%, beginning in contract year 2014.

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

- §3301. Beginning January 1, 2011, drug manufacturers must participate in the Medicare coverage gap discount program which provides a 50% discount to Medicare Part D beneficiaries for brand name drugs and biologics that fall into the coverage gap known as “the donut hole.” The “donut hole” will be partially closed in 2010 with a \$250 rebate.

- §3302. The Medicare Advantage rebate amounts and quality bonus payments are excluded from the calculation of the regional low income subsidy benchmark premium for Medicare Advantage monthly prescription drug beneficiaries.
- §3303. For plan years beginning January 1, 2011 or later, the Secretary of HHS is directed to permit a prescription drug plan or a Medicare Advantage prescription drug plan to waive the beneficiary premium for a subsidy eligible individual if the amount of such premium is de minimis.
- §3304. The surviving spouse of a low-income eligible couple is permitted to delay low income subsidiary re-determination for one year after the death of the spouse.
- §3305. Beginning in 2011, the DHHS is directed to transmit formulary and coverage determination information to subsidy eligible beneficiaries who have been automatically reassigned to a new Medicare Part D low-income subsidy plan. The information is to include information on formulary differences between the individual's former plan and the new plan with respect to the individual's drug regimens and a description of the individual's right to request a coverage determination, exception or reconsideration, bring an appeal or resolve a grievance.
- §3306. The Medicare Improvements for Patients and Providers Act is amended to provide additional funding of \$45 million for fiscal years 2010, 2011 and 2012 for outreach and education activities related to specified Medicare low-income assistance programs.
- §3307. The Secretary of HHS is authorized to identify classes of clinical concern through rule making, including anticonvulsants, antidepressants, antineoplastics, antipsychotics, antiretrovirals and immunosuppressants for the treatment of transplant rejection. Prescription drug plan sponsors must include all drugs in these classes in their formularies under Medicare Part D and Medicare Advantage. These changes are effective for plan year 2011 and subsequent years.
- §3308. Medicare Part D enrollees who exceed certain income thresholds are required to pay higher premiums. Additionally, this section revises the authority of the IRS to disclose certain income information to the Social Security Administration for purposes of adjusting the Medicare Part B subsidy.
- §3309. Cost sharing under Medicare Part D is eliminated for certain dual eligible individuals receiving care under a home and community based waiver program who would otherwise require institutional care in a facility for the mentally disabled.
- §3310. The Secretary of HHS is directed to require sponsors of prescription drug plans to utilize specific uniform techniques for dispensing covered Medicare Part D drugs to enrollees who reside in long term care facilities in order to reduce waste associated with 30 day refills. These changes are effective on January 1, 2012.
- §3311. The Secretary of HHS is directed to develop and maintain a plan complaint system to handle complaints regarding Medicare Advantage and Medicare Part D plans or their sponsors.
- §3312. Prescription drug plan sponsors must (1) use a single, uniform exceptions and appeals process for determination of an enrollee's prescription drug coverage and (2) provide instant access to this process through a toll free telephone number and an Internet website.
- §3313. The Office of Inspector General must conduct a study and report to Congress on the inclusion and formularies of drugs commonly used by dual eligibles and on prescription drug prices under Medicare Part D and Medicaid.
- §3314. Costs incurred by AIDS drug assistance programs and by the Indian Health Service are allowed to count toward the annual out of pocket threshold.

#### SUBTITLE E – ENSURING MEDICARE SUSTAINABILITY

- §3401. As amended by Sections 10319 and 10322, a productivity adjustment is incorporated into the market basket updates for several different types of providers, additional market basket reductions for certain providers are implemented and a productivity adjustment is incorporated into payment updates for Part B providers who do not already have such an adjustment. Entities impacted by this section include inpatient acute hospitals, skilled nursing facilities, long-term care hospitals, inpatient rehabilitation facilities, home health agencies, psychiatric hospitals, hospice care providers, dialysis providers, outpatient hospitals, ambulance service providers, ambulatory surgical centers, laboratory service providers, certain durable medical equipment providers and certain prosthetic device, orthotic and prosthetic providers. These changes begin in various years, depending on the type of provider. Section 10322 amends this section by imposing certain penalties on psychiatric hospitals for failing to submit data in accordance with the requirements under this section.
- §3402. Premiums paid under Part B of the Social Security Act are calculated based on an individual's income level. The income thresholds used to calculate these premiums are frozen at 2010 levels. This freeze is effective from January 1, 2011 through December 31, 2019.
- §3403. An Independent Medicare Advisory Board (as amended and renamed by Section 10320) ("Board") is established. The Board is established for the purpose of reducing the per capita rate of growth of Medicare spending. The Board will attempt to achieve this purpose by projecting the per capita growth rate under Medicare for an upcoming year, and if such projected rate exceeds the target growth rate for that year, then the Board will develop and submit to the President and Congress a proposal containing recommendations to reduce the Medicare per capita growth rate to the extent required under this section.

#### SUBTITLE F – HEALTH CARE QUALITY IMPROVEMENTS

- §3501. The Center for Quality Improvement and Patient Safety of the Agency for Healthcare Research and Quality ("Center") is given additional responsibilities related to quality improvement practices in the delivery of health care services. Specifically, the Center is required to perform additional research with respect to health care delivery system improvement and the development of tools to facilitate adoption of best practices that improve the quality, safety and efficiency of health care delivery services. The Center will make the results of such research available to the public through multiple media and appropriate formats. Furthermore, the Center shall award certain technical assistance and implementation grants to eligible entities to help identify, develop, evaluate, disseminate and provide training in innovative methodologies and strategies for quality improvement practices in the delivery of health care services.
- §3502. As amended by Section 10321, the Secretary of HHS is required to establish a program to provide grants to or enter into contracts with eligible entities to establish community-based interdisciplinary, interprofessional teams to support primary care practices within the hospital service areas of the eligible entities, as well as to develop and support patient-centered medical homes. Patient-centered medical homes are defined as a mode of care that includes personal physicians, nurse practitioners and other primary care providers, whole person orientation, coordinated and integrated care, safe and high-quality care through evidence-informed medicine, appropriate use of health information technology, continuous quality improvements, expanded access to care and payment that recognizes added value from additional components of patient-centered care. The goal of such programs is to increase access to comprehensive, community-based, coordinated care.
- §3503. The Secretary of HHS must establish a program to provide grants or contracts to eligible entities (1) to implement medication management services provided by licensed pharmacists as a collaborative, multidisciplinary, interprofessional approach to the treatment of chronic disease of targeted individuals, (2) to improve the quality of care and (3) to reduce the overall cost in the treatment of such diseases.

- §3504. Funding is provided to the Assistant Secretary for Preparedness and Response to award a certain number of multi-year contracts or competitive grants to states or groups of states to support pilot projects that design, implement and evaluate innovative models of regionalized, comprehensive and accountable emergency care and trauma systems. The Secretary of HHS is required to support emergency medical research and pediatric emergency medical research efforts.
- §3505. Grants must be awarded to a number of eligible entities, including qualified public, nonprofit Indian Health Service, Indian tribal and urban Indian trauma centers, in an effort to (1) assist in defraying substantial uncompensated care costs, (2) further the core missions of such trauma centers and (3) provide emergency relief to ensure the continued and future availability of trauma services. The grants are targeted to assist those centers susceptible to funding and workforce shortages due to their presence in underserved areas.
- §3506. A program is established to award grants or contracts to entities to develop, update and produce patient decision aids for preference sensitive care to assist health care providers in educating patients, caregivers and authorized representatives concerning the relative safety, effectiveness and cost of treatment options. A “patient aid” is an educational tool that helps patients understand their treatment options and assists in the patient’s decision as to a preferred course of treatment. “Preference sensitive care” means medical care for which the clinical evidence does not clearly support one treatment option such that the appropriate course of treatment depends on the values or preferences of the patient.
- §3507. The FDA must determine whether the addition of quantitative summaries of the benefits and risks of prescription drugs in a standardized format (such as a table or drug facts box) to the promotional labeling or print advertising of such drugs would improve health care decision-making by clinicians, patients and consumers.
- §3508. The Secretary of HHS is allowed to award grants to certain academic institutions to develop and implement academic curricula that integrate quality improvement and patient safety in the clinical education of health professionals.
- §3509. Women’s health offices are established within various Federal agencies with the goal of improving prevention, treatment and research for women in health programs.
- §3510. Section 340A of the Public Health Services Act is amended by limiting the periods of a grant provided under this section to 4 years, requiring certain minimum core proficiencies of the entities to which grants are awarded and reauthorizing future demonstration programs to provide patient navigator services within communities to assist patients in overcoming barriers to health services.
- §3511. This section authorizes the appropriation of such sums as may be necessary to carry out this subtitle and amendments thereto.

#### SUBTITLE G – PROTECTING AND IMPROVING GUARANTEED MEDICARE BENEFITS

- §3601. Nothing in the Act is to result in a reduction of guaranteed Medicare benefits. The Medicare savings generated under the Act are to extend the solvency of Medicare trust funds, reduce Medicare premiums and other cost-sharing for beneficiaries, improve or expand the guaranteed Medicare benefits and protect access to Medicare providers.
- §3602. Nothing in the Act is to reduce or eliminate any guaranteed benefits to participants in Medicare Advantage plans.
- §10323. The Secretary of HHS must establish a pilot program to provide innovative approaches to furnishing comprehensive, coordinated and cost-effective health care (including medical screening services) under Medicare to environmentally exposed individuals, as such term is defined in this section.

- §10324. Minimum floors are established for hospital wage indexes and geographic practice expenses for hospitals and physicians. The minimum floor for the hospital wage index begins in October 2010 for inpatient services and in January 2011 for outpatient services and applies only to physicians and hospitals in states in which at least 50 percent of the counties are frontier. The minimum floor for geographic practice expenses begins in January 2011 and applies to the same physicians and hospitals. A “frontier county” is one in which the population per square mile is less than 6.
- §10325. The implementation of Version 4 of the Resource Utilization Groups (entitled “Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2010; Minimum Data Set, Version 3.0 for Skilled Nursing Facilities and Medicaid Nursing Facilities” 74 Fed. Reg. 40288) in the skilled nursing facility prospective payment system is delayed until no earlier than October 1, 2011.
- §10326. By no later than January 1, 2016, the Secretary of HHS is to conduct a pilot program for certain Medicare providers (certain psychiatric hospitals and psychiatric units, long-term care hospitals, rehabilitation hospitals, PPS-exempt cancer hospitals and hospice programs) to test the implementation of a value-based purchasing program for payments under Title XVIII of the Social Security Act. The Secretary of HHS, at any point after January 1, 2018, may expand the duration and scope of the pilot program if it determines that expansion would reduce Medicare spending without reducing the quality of care or improve the quality of care.
- §10327. For 2011 through 2014, an additional incentive payment for quality reporting is to be paid to physicians that satisfy certain requirements.
- §10328. For Part D plans beginning on or after 2 years from the enactment of the Act, prescription drug plan sponsors must offer medication therapy management services to targeted beneficiaries in an effort to increase adherence to prescription medications. Such services include the following: (1) an annual comprehensive medication review furnished in person or via telehealth technologies by a licensed pharmacist or other qualified provider; and (2) follow-up interventions, as needed, on the findings of the annual medication review. The sponsor must also assess, at least quarterly, the medication use of individuals who are at risk but not enrolled in the medication therapy management program.
- §10329. The Secretary of HHS is to work with insurance companies, consumers, employers, providers and other relevant stakeholders to develop a methodology to measure health plan value, considering cost, quality of care, efficiency, risk and value.
- §10330. The Secretary of HHS is to develop a detailed plan and budget to modernize the computer and data systems of the Centers for Medicare and Medicaid Services.
- §10331. By January 1, 2011, the Secretary of HHS must develop a Physician Compare Internet website with information on physicians enrolled in the Medicare program and other eligible professionals who participate in the Physician Quality Reporting Initiative. Beginning no later than January 1, 2013, and with respect to reporting periods beginning no earlier than January 1, 2012, the Secretary of HHS must implement a plan for making available on the website information on physician performance that provides comparable information for the public on quality and patient experience measures with respect to physicians enrolled in the Medicare program, so long as such information provides an accurate portrayal of physician performance. The Secretary of HHS is given the power to establish a demonstration program, not later than January 1, 2019, to provide financial incentives to Medicare beneficiaries who are furnished services by high quality physicians.
- §10332. The Secretary of HHS must make available to certain qualified public and private entities standardized extracts of claims data under parts A, B and D of Medicare for items and services furnished under such parts for one or more specific geographic areas and time periods requested by a qualified entity. The purpose of this is to measure the performance of providers and suppliers in ways that protects patient privacy. This provision is effective January 1, 2012.

- §10333. This section is to promote the establishment of “community-based collaborative care networks” through the issuance of grants. A community-based collaborative care network is a consortium of health care providers with a joint governance structure (including providers within a single entity) that provides comprehensive coordinated and integrated health care services for low-income populations.
- §10334. The Office of Minority Health is transferred to the Office of the Secretary of HHS.
- §10335. The hospital value-based purchasing program must not include measures of hospital readmissions.
- §10336. The Comptroller General is to conduct a study on the impact on Medicare beneficiaries’ access to high-quality dialysis services including specified oral drugs that are furnished to such beneficiaries for treatment of end stage renal disease in the bundled prospective payment system.
- §1109 of the Reconciliation Act. Qualifying “subsection (d) hospitals” are entitled to payments from the Federal Hospital Insurance Trust Fund for fiscal years 2011 and 2012.

## **TITLE IV – PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH**

### **SUBTITLE A – MODERNIZING DISEASE PREVENTION AND PUBLIC HEALTH SYSTEMS**

- §4001. The President must establish a council known as the National Prevention, Promotion and Public Health Council comprised of the chief officers of a number of executive departments. The Council is required, among other things, to develop a national prevention, health promotion, public health and integrative strategy to improve the health status of Americans and reduce the incidence of preventable illness and disability in the United States. An Advisory Group on Prevention, Health Promotion, and Integrative and Public Health is established to be composed of a diverse group of licensed health care professionals for the purpose of making policy and program recommendations and advising the Council on lifestyle-based chronic disease prevention and management, integrative health care practices and health promotion.
- §4002. A Prevention and Public Health Fund is established to provide for expanded and sustained national investment in prevention and public health programs to improve health and restrain the growth rate of private and public sector health care costs. The Fund is intended to fund programs authorized by the Public Health Service Act for prevention, wellness and public health activities including prevention research, health screenings and initiatives.
- §4003. This section establishes the independent Preventive Services Task Force which will review scientific evidence related to the effectiveness, appropriateness and cost effectiveness of clinical preventive services for the purpose of developing recommendations for the health care community and updating previous clinical preventive recommendations for individuals and organizations delivering clinical services. A Community Preventive Services Task Force is established to review scientific evidence related to the effectiveness, appropriateness and cost effectiveness of community preventive interventions for the purpose of developing recommendations to affect health at the population level.
- §4004. This section provides for the implementation of a national public-private partnership for prevention and health promotion outreach and education to raise public awareness of health improvement across the lifespan. This section also outlines certain mechanisms to disseminate such information (e.g., media campaign, website, dissemination of information through providers, etc.).

### **SUBTITLE B – INCREASING ACCESS TO CLINICAL PREVENTIVE SERVICES**

- §4101. A program is established to award grants to eligible entities to support the operation and development of school based health centers. The funds from the grant program may be used for expenditures for facilities, acquiring and leasing equipment, providing training relating to the provision of required comprehensive primary health care health services and additional

services, the management and operation of health care programs and the payment of salaries of physicians, nurses and other personnel of the school based health center. There is a preference for applicants that serve populations of children and adolescents eligible for Medicaid or child health assistance. Funds may not be used to provide abortions.

- §4102. This section establishes (1) a national public health campaign focused on oral health care prevention and education including prevention of oral disease such as early childhood and other periodontal disease and oral cancer and (2) a program to award grants to eligible entities to demonstrate the effectiveness of research-based dental caries disease management activities.
- §4103. Medicare coverage is to be provided for an annual wellness visit and a personalized prevention plan, which would include elements such as a five to 10 year screening schedule, a list of identified risk factors and conditions and a strategy to address them, health advice and referrals to education and preventative counseling and community-based interventions to modify risk factors such as physical activity, smoking and nutrition. No deductible or co-insurance is required.
- §4104. Medicare beneficiary coinsurance requirements are to be waived for most preventative services including personalized prevention plan services and any covered preventative service if it is recommended with the grade A or B by the U.S. Preventive Service Task Force.
- §4105. The Secretary of HHS is authorized to modify or eliminate the coverage of any currently covered preventive service in the Medicare program to the extent such change is consistent with the U.S. Preventive Services Task Force recommendations and the services are not used for diagnostic or treatment.
- §4106. The current Medicaid state option is expanded to provide other diagnostic, screening, preventive and rehabilitation services to include (1) any clinical preventive service recommended with a grade of A or B by the U.S. Preventive Services Task Force, (2) with respect to adults, immunizations recommended by the Advisory Committee on Immunization Practices and their administration and (3) certain medical or remedial services for the reduction of physical or mental disability and the restoration of the disabled individual. States that elect to cover these additional services and vaccines, and also prohibit cost sharing for such services and vaccines, would receive an increased Federal medical assistance percentage of 1% for these services.
- §4107. States will be required to provide Medicaid coverage for counseling and pharmacotherapy to pregnant women for cessation of tobacco use, beginning on October 1, 2010.
- §4108. A grant program is established for states to carry out initiatives to provide incentives to Medicaid beneficiaries who successfully participate in programs designed to help individuals achieve one or more of the following: (1) ceasing use of tobacco products, (2) controlling or reducing their weight, (3) lowering their cholesterol or blood pressure or (4) avoiding the onset of diabetes (or mitigating the effects from diabetes).

#### SUBTITLE C – CREATING HEALTHIER COMMUNITIES

- §4201. Competitive grants to state and local government agencies and community based organizations are authorized for the implementation, evaluation and dissemination of evidence-based community preventative health activities in order to reduce current disease rates, prevent the development of secondary conditions, address health disparities and develop a stronger evidence base of effective prevention programming.
- §4202. A program is created to award grants to states or large local health departments to establish 5-year pilot programs to provide public health community interventions, screenings and necessary clinical referrals relating to chronic diseases for individuals who are between 55 and 64 years of age in order to reduce chronic diseases and Medicare costs related thereto.

- §4203. Minimal technical criteria are established for medical diagnostic equipment used in physicians' offices, clinics, emergency rooms, hospitals and other medical settings. Among other things, such equipment is required to be accessible to, and usable by, individuals with accessibility needs.
- §4204. States are authorized to purchase adult vaccines under CDC contracts. In addition, a program is created to award grants to states to improve the provision of recommended immunizations for children, adolescents and adults through the use of evidence-based population intervention for high-risk populations.
- §4205. When food is a standard menu item and is offered for sale in a restaurant or similar retail food establishment that is part of a chain of 20 or more locations doing business under the same name and offering for sale substantially the same menu item, the restaurant or similar retail food establishment must disclose information regarding the nutritional content of such food, the number of calories in such food and other related information.
- §4206. A pilot program is established to test the impact of providing at risk populations that utilize community health centers individualized wellness plans designed to reduce risk factors for preventable conditions as identified by a comprehensive risk factor assessment.
- §4207. Employers must provide (1) a reasonable break time for an employee to express breast milk for her nursing child for 1 year after the child's birth each time such employee has the need to express the milk and (2) a place other than a bathroom that is shielded from view and free from intrusion from coworkers and the public which may be used for an employee to express breast milk. An employer is not required to compensate an employee receiving reasonable break time. An employer that employs less than 15 employees is not subject to these requirements if such requirements would impose an undue hardship by causing the employer significant difficulty and expense when considered in relation to the size, financial resources or nature or structure of the employer's business. These requirements do not preempt state law that provides greater protection to employees than the protection that is provided for under this section.

#### SUBTITLE D SUPPORT FOR PREVENTION AND PUBLIC HEALTH INNOVATION

- §4301. Funding is allocated for research in the area of public health services and systems, including examining evidence-based practices relating to prevention, analyzing the translation of interventions from academic settings to real world settings and identifying effective strategies for organizing, financing or delivering public health services in real world community settings. Research under this section is to be coordinated through the Community Preventative Services Task Force.
- §4302. Data collection is required with respect to any federally conducted or supported health care or public health program, activity or survey with respect to applicants, recipients or participants involved with any such program.
- §4303. The CDC must provide employers with technical assistance and other resources to promote the benefits of worksite health promotion. The CDC is also required to evaluate employer-based wellness programs.
- §4304. A program is created to award grants to state, local and tribal public health agencies to improve surveillance for, and responses to, infectious diseases and other conditions of importance.
- §4305. The Secretary of HHS is authorized to enter into an agreement with the Institute of Medicine at the National Academies to convene a conference on pain in order to increase recognition of pain as a significant public health problem in the United States, evaluate the adequacy of assessment, diagnosis and management of acute and chronic pain in the general population and in identified racial, gender, age and other demographic groups, identify barriers to appropriate pain care and establish an agenda for action of both public and private sectors

that will reduce such barriers and improve data pain research. The Pain Consortium at the National Institute of Health is authorized to enhance and coordinate clinical research on pain, causes and treatments. Finally, a grant program is established for health professions, schools, hospices and other public and private entities providing education and training to improve pain care provided by health professionals.

- §4306. There is an appropriation of \$25 million for fiscal years 2010 through 2014 for the childhood obesity demonstration project.

#### SUBTITLE E – MISCELLANEOUS PROVISIONS

- §4402. The Secretary of HHS must conduct an evaluation of programs relating to existing federal health and wellness initiatives.
- §10407. This section outlines measures to gather additional diabetes statistics to create “diabetes report cards,” which would address preventive care, risk factors and aggregate health outcomes for diabetes patients.
- §10408. Grants will be awarded to small employers to provide their employees with a comprehensive workplace wellness program. The program will be conducted from 2011 to 2015 with an authorized allocation of \$200 million for such program.
- §10409. The Cures Acceleration Network program is established to award grants and contracts to eligible entities that promote innovation in and support the development of high-need cures.
- §10410. The Secretary of HHS must award competitive grants to qualified institutions that establish and maintain centers for the treatment of depression disorders.
- §10411. A National Congenital Heart Disease Surveillance System is established to track the epidemiology of congenital heart disease.
- §10412. States that receive grants under the public access defibrillation program are allowed to use the funds to establish an information clearinghouse to develop and implement public access defibrillation programs in schools.
- §10413. The Secretary of HHS and the CDC must conduct an evidence-based educational campaign designed to create awareness in young women of breast cancer and other breast health issues.

### **TITLE V – HEALTH CARE WORKFORCE**

#### SUBTITLE A – PURPOSE AND DEFINITIONS

- §5001. The purpose of this Title is to improve access to and the delivery of health care services to all individuals, particularly the low income, underserved, uninsured, etc. by (1) gathering and assessing comprehensive data, (2) increasing the supply of a qualified health care workforce, (3) enhancing health care workforce education training and (4) providing support to the existing health care workforce. Section 5002 contains definitions used in this Title.

#### SUBTITLE B – INNOVATIONS IN THE HEALTH CARE WORKFORCE

- §5101. A National Health Care Workforce Commission is created to (1) serve as a national resource, (2) communicate and coordinate with DHHS and various departments, (3) develop evaluations of education and training activities to determine if the demand for health care workers is being met and (4) identify barriers to improved coordination at the federal, state and local levels.
- §5102. A competitive health care workforce development grant program is established. This program will enable state partnerships to complete comprehensive planning with respect to comprehensive health care workforce development strategies. This section outlines eligibility for receiving a grant, the amount of the grant, the required activities related to the grant and the state requirements of matching 15% of the amount of the grant.

- §5103. The National Center for Health Workforce Analysis is established. This center will gather information on the health care workforce and evaluate benchmarks under the Act.
- §5104. A temporary task force is created to assess health care access for federal health care beneficiaries in Alaska. (This section was added by Section 10501).

#### SUBTITLE C – INCREASING THE SUPPLY OF THE HEALTH CARE WORKFORCE

- §5201. The federal student loan program for primary care is modified to limit the service obligation to a maximum of 10 years, lower the penalty for noncompliance with the loan agreement and lift the requirement for parental financial information for independent students. Repaid loan funds must stay within the program.
- §5202. Maximum loan amounts under the federal nursing student loan program are increased. Dates relating to the financial need requirements and loan cancellations are updated.
- §5203. A loan repayment program is established that pays up to \$35,000 per year toward qualified health professional's education loans, in exchange for at least 2 years of full-time pediatric subspecialty work in a shortage area.
- §5204. A loan repayment program is established that pays up to \$35,000 per year toward the educational loans of a public health student or worker, in exchange for 3 or more years of full-time work at a federal, state, local or tribal public health agency.
- §5205. The federal student loan forgiveness program for service in areas of national need is expanded to cover allied health professionals.
- §5206. The Secretary of HHS may make grants or contract with eligible entities to award scholarships for degree or professional training programs to enable mid-career professionals in the public health and allied health workforce to receive additional training in public health and allied health.
- §5207. Approximately \$4.1 billion from non-appropriated Treasury funds is authorized for fiscal year 2010 through fiscal year 2015 for National Health Service Corps programs. A formula for calculating appropriations for fiscal years after 2016 and beyond is established.
- §5208. The development and operation of nurse-managed health clinics is funded through operating costs grants awarded by the Secretary of HHS to qualifying nurse-managed health clinics.
- §5209. The 2,800 cap on commissioned officers in the Regular Corps of the U.S. Public Health Service Commissioned Corps is eliminated.
- §5210. The Public Health Service's Reserve Corps is replaced by the Ready Reserve Corps, with active-duty officers in the Reserve Corps assimilated into the Regular Corps. Funding is authorized through fiscal year 2014.

#### SUBTITLE D – ENHANCING HEALTH CARE WORKFORCE EDUCATION AND TRAINING

- §5301. The Secretary of HHS may make grants to or enter into contracts with private hospitals, medical schools and related programs to establish a variety of primary care training programs.
- §5302. The Secretary of HHS may award grants to eligible entities (institutions of higher education) that provide training opportunities for direct care workers who are employed in long term care settings, such as nursing homes. Grants are also provided for training in various areas including general, pediatric and public health dentistry, geriatric education and training, mental and behavior health education and training, cultural competency, prevention and public health and individuals with disabilities training, advance nursing education, nurse retention, as well as, programs to repay student loan payments for individuals in the health arena.

- §5303. Grants and contracts may be awarded to conduct approved professional training programs in general dentistry, pediatric dentistry or public health dentistry programs, including oral hygiene, and to individuals participating in these programs as students or faculty.
- §5304. In an effort to increase access to dental care in rural and other underserved communities, the Secretary of HHS will establish a demonstration program to award grants to eligible entities to create training programs to train or to employ alternative dental health care providers.
- §5305. Geriatric education centers are eligible for grant funds to offer short-term courses in geriatrics, chronic care management and long-term care to faculty in medical schools and other health professions schools. Grant recipients must also provide training courses to direct care providers, including instruction on dementia and medication use, or develop curriculum on these issues for use in training courses. Incentive grant programs for physicians in academic careers are expanded to include faculty in other health fields. Additional career incentive funds are provided for nonphysician health professionals. Grants to nursing schools for activities relating to geriatric care education may be used to establish traineeships for those seeking advanced nursing degrees specializing in geriatric care.
- §5306. Institutions of higher education and other accredited programs are eligible for grants to support the recruitment, education and clinical experiences of students in social work programs, psychology graduate programs and field placement programs in child and adolescent mental health. Mental health organizations may also receive funding to pay for pre-service or in-service training of paraprofessional child and adolescent mental health workers. Grant recipients must meet diversity requirements and prioritize cultural and linguistic competency.
- §5307. The Secretary of HHS is authorized to award grants, contracts or cooperative agreements to public and nonprofit entities to develop, evaluate and disseminate research, demonstration projects and model curricular for cultural competency, prevention, public health proficiency, reducing health disparities and aptitude for working with individuals with disabilities training for use in health professions schools and continuing education programs, and for other purposes that the Secretary of HHS may deem appropriate.
- §5308. The advanced nursing education grant program is modified to strengthen requirements for nurse midwifery grants by requiring eligible programs to be accredited by the American College of Nurse-Midwives Accreditation Commission for Midwifery Education. The cap on doctorate degree traineeship programs is eliminated.
- §5309. Grants for nursing education, practice and retention are supported with necessary appropriations. Retention grants may be awarded to eligible entities to promote career advancement for individuals with nursing-related licenses and credentials to become baccalaureate prepared registered nurses or advanced education nurses.
- §5310. Faculty at nursing schools are eligible for loan repayment and scholarship programs.
- §5311. The Secretary of HHS may enter into agreements with accredited schools of nursing to establish and operate a student loan fund to repay educational loans in exchange for employment as a faculty member of an accredited school of nursing. Loans made to individuals through schools of nursing may not exceed \$35,500 for any academic year during fiscal years 2010 and 2011, and thereafter may be adjusted to provide cost-of-attendance increases. The Secretary of HHS is also authorized to provide individual educational loan repayment in exchange for at least 4 years of service in the aggregate as a full-time faculty member at an accredited school of nursing during a 6-year period.
- §5312. Appropriations in the amount of \$338 million are authorized to carry out nursing workforce development programs for fiscal year 2010, and such amounts as are necessary are authorized for fiscal years 2011 through 2016.

- §5313. A new training program is established for community health workers to promote positive health behaviors and improve risky behaviors (e.g., improved nutrition, decreased tobacco use) among medically underserved populations. The program is appropriated such sums as may be necessary for fiscal years 2010 through 2014.
- §5314. The Secretary of HHS may expand existing fellowships operated through the CDC, applied epidemiology training programs and the Epidemic Intelligence Service, or otherwise act, to address documented workforce shortages in the critical areas of applied public health epidemiology and public health laboratory science and informatics in state and local health departments.
- §5315. The United States Public Health Sciences Track is established. This Track has authority to grant appropriate advanced degrees in a manner that uniquely emphasizes team-based service, public health, epidemiology and emergency preparedness and response.
- §5316. The Secretary of HHS will award grants to eligible entities to operate nurse practitioner primary care programs as part of a training demonstration program. The entities must enroll and employ graduates of nurse practitioner programs and provide 1-year training for careers as primary care providers in federally qualified health centers and nurse-managed health clinics. (This section was added by Section 10501).

#### SUBTITLE E – SUPPORTING THE EXISTING HEALTH CARE WORKFORCE

- §5401. Compensation is to be continued for various grants under the Public Health Service Act, including training for diversity and continuing education for health professionals serving underserved communities for the purpose of assisting schools that are supporting programs of excellence in health professions education for under-represented minority individuals.
- §5402. The federal government, through programs established by the Secretary of HHS, may contract to provide educational loan repayment to disadvantaged individuals who agree to serve as faculty members of health professions schools. For each year of service as a faculty member, an amount not to exceed \$30,000 of the principal and interest on the loans of such individuals may be repaid.
- §5403. Grants are to be continued under the Public Health Service Act for the purpose of assisting eligible entities in providing community-based training and education in order to increase the number of primary-care physicians and other primary care providers that provide health services in underserved areas and health disparity populations.
- §5404. The ways through which increased nursing education opportunities for individuals from disadvantaged backgrounds may be provided pursuant to grants and contracts under the Public Health Service Act are expanded to include stipends for diploma or associate degree nurses to enter a bridge or degree completion program, student scholarships or stipends for accelerated nursing degree programs and advanced education preparation.
- §5405. A Primary Care Extension Program is established. This program will provide support and assistance to primary care providers to educate providers about preventive medicine, health promotion, chronic disease management, mental behavioral health services, etc. The Secretary of HHS must award competitive grants to states that establish primary care extension program hubs.

#### SUBTITLE E – STRENGTHENING PRIMARY CARE AND OTHER WORKFORCE IMPROVEMENTS

- §5501. In the case of primary care services furnished on or after January 1, 2011, and before January 1, 2016, by a primary care practitioner, in addition to the amount of payment that would otherwise be made for such services under this part, there is also to be paid (on a monthly or quarterly basis) an amount equal to 10% of the payment amount for the service under this part. In addition, in the case of major surgical procedures furnished on or after January 1, 2011 and before January 1, 2016, by a general surgeon in an area that is designated as a health

professional shortage area, there also is to be paid in addition to the amount of payment that would otherwise be made, an amount equal to 10% of the payment amount for this service.

- §5502. Improvements are to be made to the Medicare federally-qualified health centers. The Secretary of HHS is allowed to develop a prospective payment system for payment for federally-qualified health services furnished by federally-qualified health centers.
- §5503. The DHHS is directed to redistribute residency positions that have been unfilled for the prior 3 cost reports. The redistributed slots would go to training primary care physicians. DHHS also will be required to redistribute residency slots from closed hospitals to other hospitals in the same state.
- §5504. Hospitals can receive indirect medical education and direct graduate medical education funding for residents who train in a nonprovider setting so that any time spent by the resident in a nonprovider setting will be counted toward hospital reimbursement for medical education if the hospital incurs the costs of the stipends and fringe benefits.
- §5505. Current law is modified to allow hospitals to count resident time spent in teaching conferences toward indirect medical education costs in the teaching or hospital setting and toward direct graduate medical education in the nonprovider (non-hospital) setting.
- §5506. This section addresses the re-distribution of unused medical residency positions.
- §5507. A demonstration grant program is established through competitive grants to provide aid and supportive services to low-income individuals, including recipients of assistance under State Temporary Assistance for Need Families programs, to obtain education and training for occupations in health care fields that pay well and are expected to experience labor shortages and/or are in high demand. The program may award grants for up to 6 states for up to 3 years to develop core training competencies and certification programs for personal and home care aids and extend funding for family-to-family health information centers.
- §5508. Grants are to be provided to teaching health centers for the purpose of establishing new accredited or expanded primary care residency program support of graduate medical education at qualified teaching health centers for 2010, 2011, and 2012.
- §5509. The Secretary of HHS is to establish a graduate nurse education demonstration program under which an eligible hospital may receive payment for the hospital's reasonable costs for the provision of qualified clinical training to advance practice nurses.

#### SUBTITLE G – IMPROVING ACCESS TO HEALTH CARE SERVICES

- §5601. Spending for federally-qualified health centers is addressed in this section. Grants are to be provided for qualified health centers. Community health centers are allowed to contract with outside entities to deliver primary health care services to people eligible for free or reduced cost care.
- §5602. The Secretary of HHS will use a negotiated rulemaking process to create a methodology and criteria for use in designating medically underserved populations and health professional shortage areas.
- §5603. The Emergency Medical Services for Children Program will be funded through 2014.
- §5604. To benefit adults with mental illnesses who have co-occurring primary care conditions as well as chronic diseases, grants and cooperative agreements will be awarded to eligible entities to provide coordinated and integrated services through the collocation of primary and specialty care services in community-based mental and behavioral health settings.
- §5605. A new commission will work with the National Academy of Sciences to determine how best to establish key national indicators systems that would identify issue areas, measures and data to populate the system.

## SUBTITLE H – GENERAL PROVISIONS

- §5701. The Secretary of HHS must make annual reports on this Title to Congress.
- §10501. The Secretary of HHS must develop a new prospective payment system for payments for services furnished by federally qualified health centers. This applies to payments to be made for periods on or after October 1, 2014.

## TITLE VI – TRANSPARENCY AND PROGRAM INTEGRITY

### SUBTITLE A – PHYSICIAN OWNERSHIP AND OTHER TRANSPARENCY

- §6001. The Stark Law exception for physician investment in hospitals is changed by prohibiting future physician investment in hospitals as of March 23, 2010. Current physician owned hospitals are grandfathered in; however, expansion (i.e., the hospital cannot increase the number of operating or procedure rooms nor the number of beds) is prohibited. In addition, the referring physician and treating physician who have ownership interests in the hospital must disclose such to the patient. The timing of such disclosure must be “by a time that permits the patient to make a meaningful decision” regarding their care. For those physician owned hospitals currently being built, the hospital must be up and running with a provider agreement in place by December 31, 2010, and the physician must have purchased his/her investment by December 31, 2010 (per Section 1106 of the Reconciliation Act) or will otherwise be prohibited from participating in Medicare. If the hospital is jointly owned by a hospital and physician group, the physician ownership percentage as a whole cannot increase after March 23, 2010. If the hospital does not have a physician on site at all times during which the patient is receiving services, this fact must also be disclosed to the patient prior to admission and the patient must sign an acknowledgement that the patient understands such fact. There is a detailed process provided whereby hospitals can apply for an exception to the moratorium on increasing operating and procedure rooms and beds.
- §6002. Any manufacturer of a covered drug, device, biological or medical supply is required to submit certain information to the Secretary of HHS regarding certain payments or other transfers of value to physicians and teaching hospitals. This section is effective as of January 1, 2012 so such payments need to be tracked starting in 2012 and reported 90 days after the end of each calendar year. These companies as well as group purchasing organizations are also required to disclose to the Secretary of HHS physician ownership, if any, in such entities at the same time it discloses payment made to physicians. There are penalties for failure to file the reports or for incorrect reports. The reports, in turn, will be made public on an annual basis. Prior to making the reports public, the entities will have 45 days to make corrections.
- §6003. As an additional requirement to the in-office ancillary exception, before a referring physician can provide MRI, CT or PET services in the physician’s office, the physician must inform the patient, in writing, that there are other “suppliers” from which to receive such imaging services and provide them with a listing thereof. (This provision is effective now although there is a debate as to whether it is effective now or only after regulations are issued).
- §6004. Drug manufacturers and distributors are required to report to the Secretary of HHS on an annual basis starting in 2012 (with 2011 information) the number of drug samples requested by a provider and distributed by a provider.
- §6005. A health benefits plan or an entity that provides pharmacy benefits management services on behalf of a health benefits plan that manages prescription drug coverage under a contract with a PDP sponsor of a prescription drug plan or an Medicare Advantage organization offering an MA-PD plan under Medicare Part D or a qualified health benefits plan offered through a state Exchange must provide certain information to the Secretary of HHS and in some cases to the plan.

## SUBTITLE B – NURSING HOME TRANSPARENCY AND IMPROVEMENT

- §6101. Skilled nursing facilities and nursing facilities will be required to disclose certain information to the Secretary of HHS and other entities regarding the ownership and organization structure of their facilities. This rule is effective after the Secretary of HHS promulgates final rules on the submission of the information.
- §6102. Skilled nursing facilities and nursing facilities must implement a compliance and ethics program.
- §6103. The Nursing Home Compare website must include staffing data based on collected information as well as summary information on complaints made against skilled nursing facilities and nursing facilities.
- §6104. Skilled nursing facilities must separately report expenditures for direct care services, indirect care services, capital assets, and administrative costs on cost reports for costs reporting periods.
- §6105. A complaint resolution process, including standardized complaint forms for nursing home residents, or persons acting on their behalf, is established.
- §6106. Skilled nursing facilities and nursing facilities must electronically report staffing information in a uniform format based on payroll data, including information on agency or contract staff.
- §6107. The GAO will conduct a study on the Five-Star Quality Rating System of nursing homes paid for Medicare and Medicaid services.
- §§6111 to 6114. These sections outline the enforcement mechanisms for this subtitle, the monitoring of nursing facilities and the implementation of best practices in nursing facilities. Section 10606 provides for the enhancement of fraud-related enforcement. Section 1302 of the Reconciliation Act provides for prepayment reviews.
- §6121. Skilled nursing facilities and nursing facilities must conduct dementia management and abuse prevention training for employees before employment. Ongoing training may be required at the Secretary's discretion.

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

- §6201. The Secretary of HHS must establish a nationwide program for background checks on direct patient access employees of long-term care facilities and providers to ensure patient safety. The program must be based on the background check pilot program created by the Medicare Modernization Act. Long-term care facilities must carry out national and state background checks on prospective long-term care facility employees who would likely have direct access to patients in their care. States will have the option to reimburse the facilities, along with matching federal funds, for the cost of the background checks.

## SUBTITLE D – PATIENT-CENTERED OUTCOMES RESEARCH

- §§6301 to 6302. A method is outlined for organizations to seek monies to conduct comparative clinical effectiveness research that evaluates and compares health outcomes and the clinical effectiveness, risks and benefits of two or more medical treatments, services and items. A new nonprofit corporation called the Patient-Centered Outcomes Research Institute is to be established. This Institute is to identify research priorities and contract with third parties to manage the funding and conduct the research. Funding is to be provided in part from fees imposed on insurers of health plans and employer sponsored or self-insured health plans.

## SUBTITLE E – MEDICARE, MEDICAID AND CHIP PROGRAM INTEGRITY PROVISIONS

- §6401. New and existing providers of medical or other items or services and suppliers participating in Medicare, Medicaid, and CHIP will be subject to new enrollment and revalidation requirements.
  - Background checks and other screening of providers and suppliers applying for Medicare Provider Numbers will be required. If enrolled in a federally funded program as of the date of enactment of the Act, the screening will begin on or after the date that is 2 years after enactment of the Act. If not enrolled in a federally funded program as of the date of enactment of the Act, the screening will begin on or after the date that is 1 year after enactment of the Act. The Secretary of HHS will be required to collect fees from certain institutional providers and suppliers to pay the costs of the background check (e.g., \$500 for institutional providers, to be adjusted annually based on CPI).
  - The Secretary of HHS will be required to implement provisional oversight of new providers or suppliers. The oversight period must be at least 30 days but no more than a year. Oversight might include pre-payment review and payment caps. There must be at least 90 days of increased oversight of initial claims from new DME suppliers.
  - There are increased disclosure requirements for providers and suppliers applying or re-applying for provider numbers. Beginning one year after enactment of the Act, they must disclose any previous or current affiliation with a provider or supplier that has uncollected debt (unknown at this time what “uncollected debt” means), has been or is subject to a payment suspension or an exclusion under a federally funded program, or has had its billing privileges denied or revoked.
  - The Secretary of HHS may adjust payments to any “applicable provider” necessary to recover past-due obligations from another provider. An applicable provider is a provider with the same tax ID number but a different provider number.
  - The Secretary of HHS may impose a moratorium on new providers and suppliers if determined to be necessary to combat fraud, waste and abuse. There will be no judicial review of a temporary moratorium under this provision.
  - All providers and suppliers within a particular industry sector or category will be required to implement compliance programs with specific core elements. The Secretary of HHS is to determine the core elements of the compliance program and determine the timeframe for implementing the compliance program.
- §6402. To combat fraud and abuse and to enhance program integrity, an integrated data repository is to be created. The data repository will combine data from health-related programs under Titles XVIII, XIX, XXI; Veteran Affairs; Defense; OASDI; Indian Health Service; and Contract Health Service. There will be an administrative penalty imposed for beneficiaries involved in health care fraud. Any person who receives an overpayment is required to report and return the overpayment within 60 days of discovery; any overpayment not returned becomes a debt due. No later than January 1, 2011, all providers and suppliers must include their NPI on all applications and claims for payment. The Civil Monetary Penalties Law and the Criminal False Claims Act are updated to reflect new agencies and organizations wherein false statements can be in violation of these laws; the knowledge of an overpayment, but failure to report and return, is added as a violation of the Civil Monetary Penalties Law. Actual knowledge of a violation, or intent to violate, are not required to establish a violation of the Criminal False Claims Act. The Secretary of HHS is allowed to impose surety bond requirements (of not less than \$50,000) on providers and suppliers the Secretary of HHS deems to be a risk for fraud and abuse. The Secretary of HHS may suspend payment to a provider or supplier pending an investigation if allegations of fraud arise.

- §6403. The data in the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank (“NPDB”) are to be combined. The Secretary of HHS must maintain a national health care fraud and abuse data collection program and submit the data to the NPDB.
- §6404. Beginning January 1, 2010, claims for payment under federal health care programs cannot be submitted more than 1 year following the date of service.
- §6405. Physicians ordering DME or home health services payable by federally funded programs must be enrolled in Medicare. The Secretary of HHS may expand this requirement to other items or services.
- §6406. Beginning January 1, 2010, ordering physicians and suppliers must keep records of all referrals to DME suppliers and home health services, or other items or services as directed by the Secretary of HHS. (There is no mention of how long records must be kept). The penalty for noncompliance is revocation of enrollment for no more than 1 year.
- §6407. Before a physician can refer a patient for DME or certify the patient for home health services, there must be a face-to-face encounter (including the use of telehealth). This requirement begins January 1, 2010 as a condition for payment.
- §6408. Penalties are created for false statements to a federal health care program as well as for not granting access to documents where appropriate. This is effective on January 1, 2010.
- §6409. The Secretary of HHS is directed to establish a self-disclosure protocol for violations of the Stark Law within 6 months of the enactment of the Act.
- §6410. The number of MSAs participating in round 2 of the competitive bidding program for DME and POS suppliers is increased.
- §6411. RAC audits are to be expanded to cover state Medicaid programs (states will be required to contract with RAC auditors by December 31, 2010) and Medicare Parts C and D (by December 31, 2010).
- §10603 as amended by §1304 of the Reconciliation Act. New and existing providers of Medicare, Medicaid and CHIP will be subject to new enrollment and revalidation requirements.

#### SUBTITLE F – ADDITIONAL MEDICAID PROGRAM INTEGRITY PROVISIONS

- §6501. A provider or supplier terminated under Medicare, or another state’s Medicaid program is automatically terminated under Medicaid by the state. This is effective on January 1, 2011.
- §6502. An individual or entity is automatically excluded from Medicaid by the state if it (1) owns, manages or controls an entity that has unpaid overpayments; (2) is suspended or excluded from participation in a federally funded program; or (3) is affiliated with an individual or entity that has been suspended or excluded from participation in a federally funded program. This provision is effective on January 1, 2011.
- §6503. Any billing agent, clearinghouse or other alternative payee that submits claims on behalf of a health care provider must register with the state and the Secretary of HHS, effective January 1, 2011.
- §6504. States and managed care entities will be required to report on an expanded set of data elements from the Medicaid Management Information System to help detect fraud and abuse. This provision is effective on January 1, 2011.
- §6505. Medicaid payments to any entity located outside the United States are prohibited, beginning on January 1, 2011.
- §6506. The timeframe for states to be able to recover overpayments due to fraud without penalty in federal funding is extended from 60 days to 1 year. This provision is effective as of the date of enactment of the Act.

- §6507. Medicaid state programs are required to adopt compatible federal Correct Coding Initiatives, effective for claims filed on or after October 1, 2010.
- §6508. Provisions in this subtitle generally become effective January 1, 2011.
- §1204(a) of the Reconciliation Act. Funding is provided for territories that elect to establish a Health Benefit Exchange for the years 2014 to 2019.

#### SUBTITLE G – ADDITIONAL PROGRAM INTEGRITY PROVISIONS

- §6601. In regard to multiple employer welfare arrangements, no person may make any false statement relating to the financial condition of the plan, the benefits provided by the plan or the regulatory status of the plan as it relates to federal or state compliance. There are criminal penalties of fines or up to 10 years in prison or both for a violation of this section.
- §6602. Several crimes have been added to the definition of “federal health care offense.”
- §6603. The National Association of Insurance Commissioners must develop a uniform report for purposes of allowing private health insurance issuers to report suspected fraud.
- §6604. The Secretary of HHS may adopt regulations providing that insurers offering health insurance through multiple employer welfare arrangements are subject to state laws regardless of any preemption argument.
- §6605. The Secretary of HHS may issue cease and desist orders if it appears that a multiple employer welfare arrangement is fraudulent.
- §6606. Multiple employer welfare arrangements must register with the Department of Labor (“DOL”) prior to operating in a state and enrolling participants.
- §6607. The DOL is authorized to provide for the confidentiality of communications between the DOL and federal agencies and state governments with respect to the enforcement of ERISA.

#### SUBTITLE H – ELDER JUSTICE ACT

- §6703. This section establishes the Elder Care Justice Act with the following provisions:
  - §2011. Definitions.
  - §2021. A permanent Elder Justice Coordinating Council is established to advise the Secretary of HHS on the coordination of activities of the Department of Health and Human Services, the Department of Justice, and other relevant federal, state and local, public and private entities, relating to elder abuse, neglect and exploitation.
  - §2022. A permanent Advisory Board on Elder Abuse, Neglect and Exploitation is established. The Advisory Board will be made up of members of the public to advise the Elder Justice Coordinating Council.
  - §2031. A grant program is established for eligible entities for the formation and support of Elder Abuse, Neglect and Exploitation Forensic Centers.
  - §2041. A grant program is established for eligible entities to attract, train and retain qualified health care workers in long-term care settings. A grant program is established for eligible entities involved in long-term care to purchase electronic health records. The sum of \$4 million per year through 2014 is allocated to fund state and local agencies investigating elder abuse. A grant program is created for states to develop or enhance adult protective services programs. The sum of \$100 million per year through 2014 is to be appropriated for this program. A grant program is established for states to develop demonstration programs that test methods to detect or prevent elder abuse. The sum of \$25 million per year through 2014 is to be appropriated for this program.

- §2043. A grant program is established for eligible entities to improve the capacity of state long-term care ombudsman programs to respond to elder abuse. The sum of \$10 million per year through 2014 is to be appropriated for this program.

Section 6703 further establishes a National Training Institute for federal and state surveyors to teach skills necessary for identifying elder abuse and program fraud. The sum of \$12 million per year through 2014 is to be appropriated for this program. A grant program is established for state agencies that survey long-term care facilities to use in designing and implementing complaint investigation systems. The sum of \$5 million per year through 2014 is to be appropriated for this program. A mandatory reporting obligation is created for owners, managers and employees of long-term care facilities to report suspected crimes against residents of the facility. If the incident creates a serious risk to the patient, the report must be made within 2 hours of the incident. If the incident does not create a serious threat, the report must be made within 24 hours. Reports must be made to the Secretary of HHS and at least 1 law enforcement branch. A study on the formation of a national nurse aide registry is to be conducted.

#### SUBTITLE I – SENSE OF THE SENATE REGARDING MEDICAL MALPRACTICE

- §6801. This section discusses the need for national tort reform, with states to look at alternatives to current civil litigation for resolving medical malpractice issues. A grant program is established for states to create demonstration programs to look at alternatives to the current civil litigation for resolving medical malpractice issues. The sum of \$50 million per year through 2014 is to be appropriated for this program.
- §10608. Free clinics providing medical services paid by Medicare or Medicaid will be provided medical malpractice coverage.

### TITLE VII – IMPROVING ACCESS TO INNOVATIVE MEDICAL THERAPIES

#### SUBTITLE A – BIOLOGICS PRICE COMPETITION AND INNOVATION

- §§7001 to 7003. The Biologics Price Competition and Innovation Act of 2009 (“BPCIA”) is created. BPCIA amends the following: (1) the Public Health Service Act, (2) all references to patents under Section 271(e) of the Code, and (3) the Federal Food, Drug and Cosmetic Act. One purpose of BPCIA is to provide a process for the licensing of biosimilar biological products. These products are basically defined as a virus, serum, toxin or vaccine, applicable to the prevention, treatment, or cure of a disease or condition of human beings. BPCIA provides for the content of the application for licensure, who reviews and approves it, what happens to the confidential information, etc. There is a rigorous administrative process for the licensing of these products. Much of the process identified in BPCIA relates to how these products impact new and existing patents. The savings generated as a result of the price competition and innovation will go toward deficit reduction.
- §10609. Generic drug approvals when labeling is different than listed drug labeling are addressed. It is necessary to submit a revised label within 60 days of notification by the Secretary of HHS.

#### SUBTITLE B – MORE AFFORDABLE MEDICINES FOR CHILDREN AND UNDERSERVED COMMUNITIES

- §§7101 to 7103. This section outlines a process for more affordable medicines for children and underserved communities. Specifically, (1) the definition of “covered entity” under the Public Health Service Act, for those receiving discounted drug prices, is expanded to include (a) a children’s hospital (if they are excluded from the Medicare prospective payment system under the Social Security Act and meet disproportionate share requirements), (b) a free-standing cancer hospital (if they are excluded from the Medicare prospective payment system under the Social Security Act and meet disproportionate share requirements), (c) a critical access hospital, (d) a rural referral center and (e) a sole community hospital; (2) the discount provided by the Public Health Service Act is expanded to inpatient drugs (not just outpatient drugs); and (3)

program integrity is improved by detailing drug manufacturer compliance with ceiling prices on the drugs and covered entity compliance with discounting of the drugs.

## **TITLE VIII – CLASS ACT**

- **§§8001 to 8002.** The Community Living Assistance Services and Supports Act (“CLASS Act”) is established. The CLASS Act creates a national voluntary insurance program for purchasing community living assistance services (i.e., long-term care insurance). The basics of the national long-term care insurance exchange program are to be established by October 1, 2012. The basic are to include the following: (1) premium payments based upon the 75-year cost of the program to ensure solvency; (2) nominal premium amounts for full-time students and those below the poverty line (amount is \$5.00 per month, indexed for inflation); (3) a 5 year vesting period; (4) benefits triggered based upon any functional limitations (as defined under the Internal Revenue Code – eating, toileting, transferring, bathing, dressing and continence) which last for more than 90 continuous days; (5) a cash benefit amount not less than \$50.00 per day, with the amount to be varied based upon the functionality level, benefits paid daily or weekly and no lifetime or aggregate limit; and (6) premium amounts to remain the same for as long as a program beneficiary is an active enrollee, except that
  - premiums can be adjusted if required for program solvency with the exception of enrollees who have attained age 65, have paid premiums for at least 20 years, and are not actively employed;
  - premiums can be recalculated if re-enroll after more than a 3 month lapse;
  - if the enrollee is no longer a full-time student, then premiums are re-calculated; and
  - there is a penalty for re-enrollment after 5 years.

Certain individuals will be automatically enrolled, including those who are (1) 18 years or older; (2) who receive wages under the Railroad Retirement Tax Act or who are self employed; or (3) who are actively employed and not in a hospital/healthcare facility or in jail/prison. There are options for employers to automatically deduct the premium costs from the program beneficiary’s paycheck and to remit the same to the CLASS Independence Fund set up by the Secretary of HHS. No later than January 1, 2012, the Secretary of HHS must establish a process for applying for benefits. Benefit payments may be made to a “life independence account” where the eligible beneficiary must use the money to purchase non-medical services and support to maintain his/her independence at home.

Provisions are provided for coordination with the Medicaid rules. Each enrollee who is institutionalized is entitled to 5% of the benefit under the CLASS program in addition to the Medicaid personal needs allowance. The remainder of the benefit goes to the facility’s cost. Each enrollee who is receiving home or community-based services is entitled to retain 50% of the benefit and the remainder is to go to the cost incurred by the state in providing such assistance (Medicaid will provide secondary coverage for the remainder of any costs incurred in providing such assistance). Enrollees receiving care under the Medicaid for PACE program may retain 50% of the benefit with the remainder going to the state for providing such assistance. Benefits received under the CLASS program are to be disregarded for purposes of determining or continuing the beneficiary’s eligibility under any other federal or state program. The Secretary of the Treasury is the CLASS Fund manager and is responsible for investment of the funds. No taxpayer funds (i.e., any Federal funds from a source other than premiums deposited by CLASS program participants) are to be used to pay benefits.

## **TITLE IX - REVENUE PROVISIONS**

### **SUBTITLE A – REVENUE OFFSET PROVISIONS**

- **§9001.** This is the tax on so-called “Cadillac” health plans. Beginning in 2018, an excise tax is imposed if (1) the employee is covered under any “applicable employer-sponsored coverage” of an employer during the taxable period; and (2) there is any “excess benefit” with respect to the

coverage. "Applicable employer-sponsored coverage" means coverage under any group health plan made available to an employee by an employer that is excludable from the employee's gross income. There are certain exclusions from the definition of "applicable employer-sponsored coverage," including long-term care coverage and dental and vision coverage. Coverage includes government plans and the employee paid portion of more traditional health coverage. Self-employed individuals may also have applicable employer-sponsored coverage. The tax is equal to 40% of the "excess benefit amount." The "excess benefit amount" is the cost of employer sponsored coverage for the employee divided by one-half (1/2) of \$10,200 (for self-only coverage) or \$27,500 (for other coverage). The dollar amounts of \$10,200 and \$27,500 are the dollar amounts for 2018 (COLA for all future years). The tax is paid by the "coverage provider" which means the health insurance issuer if it is health insurance coverage provider or the employer if the coverage is an HSA or MSA. However, the employer must calculate the amount of the excess benefit for the coverage provider for each taxable period and notify the coverage provider in a timely manner as provided by the Secretary of the Treasury. There is a penalty for the failure to correctly calculate the excess benefit (except if for reasonable cause and if corrected within 30 days).

- §9002. The cost of employer-sponsored health coverage must be included on the employee's W-2 for taxable years after December 31, 2010.
- §9003. The definition of "qualified medical expenses" is modified under both HSA Plans and Archer MSA Plans to limit the distribution for medicine to only those drugs that are prescribed or that are insulin. Reimbursements pursuant to Health Flexible Spending Arrangements will only be made for medicine that is prescribed or is insulin. The effective date of these changes is December 31, 2010.
- §9004. A 20% penalty (instead of a 10% penalty) is imposed on distributions from HSAs or Archer MSAs that are not used for qualified medical expenses. This provision applies to distributions made after December 31, 2010.
- §9005. Employees may not elect to have a salary reduction contribution under a Section 125 cafeteria plan health FSA in excess of \$2,500 annually, beginning after December 31, 2012. The \$2,500 maximum salary reduction contribution is adjusted for inflation beginning after December 31, 2013.
- §9006. With respect to Section 6041 of the Internal Revenue Code (which addresses information at source), information returns must be made if total payments are in excess of \$600 to a corporation in a taxable year. Total payments include "amounts in consideration for property." This provision is effective after December 31, 2011.
- §9007. Additional requirements are created for charitable hospitals to qualify under Section 501(c)(3) of the Internal Revenue Code. Specifically, to qualify as a charitable hospital, the hospital must (1) perform a community health needs assessment and develop a strategy to implement it and (2) establish a written financial assistance policy which includes eligibility criteria for free/discounted care, amounts to be charged to patients, methods for applying for financial assistance, etc. If a charitable hospital fails to meet these requirements, an excise tax is imposed equal to \$50,000 (applies for failures after enactment of the Act). The Secretary of the Treasury must review charitable hospital community benefit activities once every 3 years. Charitable hospitals must also now report on their Form 990, audited financial statements and a description of how the organization is addressing the needs identified by the community health needs assessment. Charitable hospitals cannot bill patients that qualify for financial assistance more than the amount generally billed to insured patients, and charitable hospitals cannot undertake certain extraordinary collection actions against a patient without first making reasonable efforts to inform the patient about the financial assistance policy and to determine whether the patient is eligible under the policy. These requirements generally apply to tax years beginning after March 23, 2010 (except that the community health needs assessment is not required until the tax year beginning after the date which is 2 years after March 23, 2010).

- §9008. An annual fee is imposed on branded prescription pharmaceutical manufacturers and importers. To have sales of branded prescription drugs, the sales must be to certain government programs (Medicare Part D, Medicare Part B, Medicaid, etc.). The fees are collected based upon the manufacturers' sales of branded prescription drugs to such programs. The fees are to be put into the Medicare Part D Trust Fund and are treated as excise taxes. The sale of branded prescription drugs is to be reported by the various federal agencies with such reporting information to the Secretary of the Treasury annually so the fee can be determined. The annual fees for branded prescription drugs apply for calendar years after December 31, 2010. A 2.3% excise tax is also imposed on sales of medical devices per Section 1405 of the Reconciliation Act. The excise taxes on medical devices apply to sales after December 31, 2012.
- §9010. An annual fee is imposed on health insurance providers, which are those "covered entities" engaged in the business of providing health insurance, for calendar years beginning in 2013. The fee is based upon a ratio involving the covered entity's net premiums written as well as third party administration fees. The fee does not apply to employers that self insure their employees' health risks, any governmental entity and certain nonprofit entities. Each covered entity must report annually to the Secretary of the Treasury its net premiums written. There is a penalty for the failure to report.
- §9011. This section outlines a veterans' health care study and creates an accuracy-related penalty.
- §9012. The deduction for expenses allocable to Medicare Part D subsidies is eliminated. This applies to taxable years beginning after December 31, 2012.
- §9013. Allowable itemized deductions for medical and dental expenses under Section 213 of the Internal Revenue Code are modified beginning for tax years after December 31, 2012. Specifically, the extent to which medical and dental expenses may be deducted is changed so that such expenses must exceed the threshold of 10% of adjusted gross income in order to be deducted. Previously, the applicable threshold percentage was 7.5%. There is a temporary waiver of such increase in threshold percentage for persons over the age of 65 for the 2013 through 2016 tax years.
- §9014. Section 162(m) of the Internal Revenue Code is modified with respect to excessive employee remuneration. Specifically, a special rule is added for application to certain health insurance providers. The rule provides that no deduction for remuneration is allowed if remuneration exceeds \$500,000 for "applicable individuals" or an individual with respect to a health insurance provider who is an officer, director or employee or provides services on behalf of a covered health insurance provider. There are also special rules for deferred deduction remuneration. These changes apply to tax years beginning after December 31, 2012.
- §9015. An additional hospital insurance tax is imposed on certain taxpayers beginning after December 31, 2012. The FICA provisions of the Internal Revenue Code are amended to include an additional tax of 0.9% on wages received with respect to employment, which are in excess of \$250,000 on a joint return or \$200,000 in any other case. The amount of additional tax in this section is to be withheld by the employer, but if it is not, the employee is responsible. The additional tax pursuant to this section also applies to those self-employed and receiving self-employment income based upon the same limits as provided above.
- §9016. Qualifying health organizations are only entitled to the special deduction under Internal Revenue Code Section 833 if 85% or more of premiums are spent on clinical services.

#### SUBTITLE B – OTHER PROVISIONS

- §9021. Qualified health care benefits provided to the member of an Indian tribe, the member's spouse or the member's dependents are excluded from the recipient's gross income.

- §9022. Simple cafeteria plans for small businesses (those with an average of 100 employees or less for the 2 years prior to implementation) are to be established. Simple cafeteria plans may be established for tax years beginning after December 31, 2010.
- §9023. A qualified therapeutic discovery project program is to be established. A credit is created in the amount of 50% of the qualified project's cost. The Secretary of the Treasury is required to set up the program within 60 days of enactment and to provide for the criteria for receiving the qualified investment credit. This change applies to tax years 2009 and 2010.
- §10907. The additional 5% tax on elective cosmetic medical procedures of Section 9017 is repealed and a 10% tax on indoor tanning services is imposed. The indoor tanning services tax is paid by the individual on whom the service is performed. The tax is collected by the tanning service and remitted to the Secretary of the Treasury quarterly. If the tax is not collected from the individual, the tanning service company is secondarily liable. This tax is effective July 1, 2010.
- §10909. The adoption credit and adoption assistance programs for 2010 and 2011 are expanded. The adoption credit is increased to \$13,170 per child. The same increases apply to credits for adoption of children with special needs. The credit has been made refundable.
- §1402 of the Reconciliation Act. A 3.8% tax is imposed on individuals and trusts and estates on certain investment income. The tax will be imposed on the lesser of (1) the total net investment income, or (2) the excess of modified adjusted gross income over the threshold amount. "Net investment income" means income from interest, dividends, annuities, royalties, rents and capital gains. The "threshold amount" is \$250,000 for married filing jointly, \$125,000 for married filing separately, and \$200,000 in all other cases.
- §1409 of the Reconciliation Act. The common law doctrine known as the Economic Substance Doctrine is codified. In the case in which such doctrine is relevant, the transaction will be treated as having economic substance only if the transaction changes in a meaningful way the taxpayer's economic position and the taxpayer has a substantial purpose (other than for Federal income tax purposes) for entering into such transaction. Profit shall only be considered if the pre-tax profit from the transaction is substantial in relation to the present value of the expected net tax benefits that would be allowed if the transaction were respected. Penalties shall be imposed for underpayments attributable to transactions lacking economic substance. Further, the penalty is increased for failure to disclose.