

MEMORANDUM

To: Brain Injury Association of America

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Date: April 16, 2010

Re: Highlights of the New Health Reform Law—H.R. 3590 as modified by H.R. 4872

Health Care Reform Becomes Law

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA—H.R. 3590, also known as Pub. L. No. 111-148). One week later, on March 30th, he signed a reconciliation bill, the Health Care and Education Reconciliation Act of 2010 (HCERA—H.R. 4972, also known as Pub. L. No. 111-152) that modifies the newly enacted health reform law. This capped off a year-long legislative process that had faltered at the beginning of the year and was only able to be passed through parliamentary procedures that avoided a Senate filibuster. This process led to the splitting of the health reform legislation into two different bills, causing a number of provisions to be eliminated from the final package.

In the end, the House and Senate passed these two bills on a partisan basis, with significant numbers of Democrats and no Republicans in both chambers supporting the measure. In addition to dramatically expanding private health insurance coverage, the new law rewrites the rules of insurance, expands Medicaid, and makes numerous Medicare payment and policy changes affecting hospitals, physicians, post-acute care providers, the Part D drug benefit, and the government's ability to fight health care fraud and abuse.

While it is not yet clear whether the push to enact comprehensive health care reform will erode or bolster Democratic House and Senate margins in the coming elections, there is no question that the passage of these bills constitute the most significant reforms to the U.S. health care system in history.

Health Reform Summary

This memorandum summarizes key provisions of the Senate bill (H.R. 3590) as modified by the House reconciliation bill (H.R. 4872). Section references are provided for ease in learning more

about particular provisions. In some instances, there are multiple section numbers reflecting the original Senate bill, changes made by the “Reid Manager’s Amendment” to the Senate bill (5 digit section numbers) as well as references to “RA” (Reconciliation Act) which cites edits made by the House through H.R. 4872.

The new law is nearly 1,000 single-spaced pages long and, therefore, not all issues are captured in the following summary, which is written primarily from the health care provider and consumer perspective. The following general topics are covered:

- Private insurance market reforms (pp. 2-8)
- Medicaid (pp. 8-10)
- Children’s Health Insurance Program (CHIP) (pp. 10-11)
- CLASS Act (p. 11)
- Medicare (pp. 11-17)
- Medical malpractice (p. 17)
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- Workforce and education (pp. 18-20)
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Private Insurance Market Reforms

Consumer Protections and Nondiscrimination Provisions

- **Application and Scope**: All private market reforms apply to individuals and group health plans, and many apply to ERISA group health plans (i.e., self-insured plans);
 - ERISA plans continue to be exempt from the jurisdiction of state insurance commissioners, and instead, continue to report to the U.S. Department of Labor.
- **Lifetime and Annual Limits**: Prohibits all plans from establishing lifetime limits on the dollar value of essential benefits within the exchange; *See* Sec. 1001 (adds: Sec. 2711)/ Sec. 10101/ Sec. 2301 (RA);
 - Provides restrictions on annual limits for all group and non-grandfathered individual plans until 2014 when limits are prohibited;
 - Effective for plan years beginning Sept. 23, 2010.
- **Rescission of Health Insurance**: Prohibits all plans from rescinding coverage except to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage; effective for plan years beginning Sept. 23, 2010. *See* Sec. 1001 (adds: Sec. 2712).
- **Preventive Services**: Requires all plans to cover certain preventive services and immunizations without any cost-sharing; effective Sept. 23, 2010. *See* Sec. 1001 (adds: Sec. 2713).

- **High Risk Pool**: Enacts a temporary high risk pool insurance program for those who have been uninsured for at least 6 months and have a pre-existing condition; *See* Sec. 1101;
 - Allows premium rating based on age subject to no more than a 4 to 1 ratio;
 - Maximum cost-sharing at HSA standard limit (see below);
 - Allows sanctions for plans that “dump” into the program;
 - Effective June 21, 2010 and ends upon creation of Exchange in 2014;
 - Provides \$5 billion in funding.
- **Premium Rating**: Allows premiums in the individual and small group markets to vary based only on five factors: family structure, geography, the actuarial value of the benefit, age (limited to a 3-1 ratio), and tobacco use (limited to a 1.5-1 ratio); effective 2014; *See* Sec. 1201 (adds: Sec. 2701);
 - Example: Application of premium rating ratios for age would prohibit a health plan from charging a 56 year old more than three times the premium a health plan would charge a 28 year old, all else being equal.
- **Guaranteed Issue**: Requires each health insurance issuer to accept every employer and individual that applies for coverage in the State, restricted to annual and special enrollment periods; effective 2014. *See* Sec. 1201 (adds: Sec. 2702).
- **Guaranteed Renewability**: Requires guaranteed renewability of coverage in the individual and group markets; effective 2014. *See* Sec. 1201 (adds: Sec. 2703).
- **Pre-Existing Conditions**: Prohibits insurers in individual and group markets from imposing pre-existing condition exclusions; effective 2014; *See* Sec. 1201 (adds: Sec. 2704);
 - Applicable to children under 19 in plan years beginning on or after Sept. 23, 2010.
- **Health Status Discrimination**: Expands to the individual insurance market HIPAA non-discrimination protections that prohibit discrimination against participants due to health status, medical condition or history, claims experience, genetic information, disability, evidence of insurability or any other factor determined by HHS; effective 2014; *See* Sec. 1201 (adds: Sec. 2705);
 - Codifies an exception for premium rating up to 30 percent generally, and 50 percent when HHS/Treasury/Labor permits, in the group market based on employer wellness program participants’ achievement of health outcomes;
 - 10-state demo to test wellness premium rating in the individual market.
- **Immediate Non-discrimination**: Protects individuals against discrimination through exclusion from participation in or benefits denial under any health program or activity by applying existing laws (Civil Rights Act, the Education Amendments, the Age Discrimination Act, and the Rehabilitation Act); effective Mar. 23, 2010. *See* Sec. 1557;
 - There are major disagreements over the meaning and intent of this section of the new law, with some arguing a very expansive interpretation and others arguing a narrow one.
- **Provider Discrimination**: Prohibits plans from discriminating against health care providers by denying them participation in a plan if the provider acts within the scope of their professional license and applicable State laws; effective 2014; *See* Sec. 1201 (adds: Sec. 2706);

- But this provision does *not* require a group health plan or health insurance issuer to contract with “any willing provider,” even if the provider agrees to abide by the terms and conditions for participation established by the plan or issuer.
- **Waiting Periods**: Prohibits waiting periods in excess of 90 days in the small group or individual market (includes grandfathered plans); effective 2014. *See* Sec. 1201 (adds: Sec. 2708).
- **Access to Therapy Limits**: Prevents the HHS Secretary from promulgating regulations limiting access to therapies and healthcare services based on a variety of factors. Effective March 23, 2010. *See* Sec. 1554.

Essential Benefits Package

- **Adequate Benefits Coverage**: Requires insurers in small group and individual markets, selling insurance both in and outside of the new health insurance Exchanges (see below), to offer coverage that includes the essential health benefits package by 2014; effective for plan years on or after Sept. 23, 2010; *See* Sec. 1001 (adds Sec. 2707);
 - If a state permits large employers to enter an exchange, then plans must offer the benefits to those employers;
 - Plans covering dependents must continue coverage until children are age 26.
- **Essential Benefits Package**: Defines essential benefits package for exchanges. For the individual and small group markets, qualified health plans pay a specified percentage of costs (i.e. actuarial value is); *See* Sec. 1302:
 - Bronze: 60 percent;
 - Silver: 70 percent;
 - Gold: 80 percent;
 - Platinum: 90 percent.
 - Provides out-of-pocket limits in all markets at the level for Health Savings Accounts (\$5,950 for individuals and \$11,900 for families);
 - Prohibits deductibles that are greater than \$2,000 for individuals and \$4,000 for families; effective 2014;
 - Catastrophic coverage is available in the individual market for those under age 30;
 - Includes key categories of essential health services, including hospitalization, physician services, prescription drugs, rehabilitative and habilitative services and devices, vision and oral pediatric services, mental health services, and chronic disease management services, amongst others;
 - Requires the Secretary to develop standard definitions for these and other terms used in insurance coverage; *See* Sec. 1001 (adds: Sec. 2715(g)(3)).
 - Allows states to add on benefits at their own cost;
 - Requires the HHS Secretary to define package so benefits are not unduly weighted towards one category; benefits are not designed to discriminate against individuals because of age, disability or expected length of life; the health care needs of diverse segments of the population are accounted for and that essential benefits are not denied due to an individual’s health status; HHS works with Labor Secretary to ensure scope of essential benefits is equal to that provided by a typical employer plan;

- Essential benefits package requirements do not apply to self-insured plans organized under the ERISA statute.
- **Premium Assistance:** As of 2014, provides refundable and advanceable premium credits to eligible individuals and families with incomes between 133-400% FPL to purchase insurance through the Exchanges;
 - The premium credits are tied to silver plans and set on a sliding scale as follows:
 - Up to 133% FPL: caps individual of family contribution at 2% of income;
 - 133-150% FPL: 3 – 4% of income;
 - 150-200% FPL: 4 – 6.3% of income;
 - 200-250% FPL: 6.3 – 8.05% of income;
 - 250-300% FPL: 8.05 – 9.5% of income;
 - 300-400% FPL: 9.5% of income.
 - These premium credits would be adjusted annually as necessary to account for any greater premium growth in relation to income in future years.
- **Cost-sharing and Out-Of-Pocket Limits:** The standard out-of-pocket maximum limits in the essential benefits package for Exchange plans would be reduced for individuals enrolled in silver plans with an income between 100-400% of the federal poverty level (FPL). The plan covers all costs once the out-of-pocket limit is reached. Effective 2014. (*See Sec. 1402/ Sec. 1001 (RA)*):
 - Above 400% FPL – the maximum limit is \$5,950 for individuals and \$11,900 for families;
 - Between 300-400 % FPL - the limits are two-thirds of the maximum;
 - Between 200-300 % FPL - the limits are one-half of the maximum;
 - Between 100-200 % FPL – the limits are one-third of the maximum.

To coordinate this cost-sharing support with actuarial values, the plan's share of total allowed costs of benefits would be limited to a set percentage for those in certain federal poverty levels, as follows:

- Between 250-400% FPL: the plan's share is 70% (i.e., the individual's liability is limited to 30% of the plan's actuarial value on average);
- 200-250% FPL: plan's share is 73% (individual's liability is 27% on average);
- 150-200% FPL: plan's share is 85% (individual's liability is 15% on average);
- 100-150% FPL: plan's share is 94% (individual's liability is 6% on average);

Such cost-sharing assistance does not take into account benefits mandated by States.

State Exchanges

- **Exchange Structure:** Requires states to establish a new American Health Benefit Exchange by 2014 for the individual and small group markets. *See Sec. 1311/ Sec. 10104.* Exchanges must:
 - Offer private plans in the exchange with the essential benefits package (states must cover the cost of any additional benefits they require);
 - Require exchanges to certify and rate plans that meet established criteria (taking into account whether a network includes a sufficient number of providers and the amount of premium variation among plans);
 - Ensure plans establish the same cost sharing requirements for essential services inside and outside of plan networks;

- States must establish a Small Business Health Options Program (SHOP) to assist small employers obtain employee coverage; small employers with 100 or less employees may enroll in the exchange (state discretion to include employers with 100+ employees as of 2017);
- HHS will establish an exchange if a state fails to do so by 2014;
- Funded by HHS grant program; each exchange must be self-sustaining by 2015;
- This section also allows voluntary and HHS approved interstate and regional exchanges, as well as subsidiary exchanges; requires HHS to issue guidelines on developing plan payment structures that use payment incentives to reward improved health outcomes, decreased hospital readmissions, the reduction of medical errors and the implementation of health and wellness promotion activities; and requires HHS to report to exchanges on the payment incentive activities of qualified health plans.
- **Consumer Choice**: Nothing in the bill precludes an individual from obtaining coverage outside of the state exchange (but consumer protections and insurance market rules still apply to non-exchange plans). *See* Sec. 1312/ Sec. 10104.
- **State Flexibility**: States have flexibility to offer certain standard health plans to eligible individuals in lieu of offering those individuals insurance through an exchange; eligible individuals would have income between 133 and 200 percent of the federal poverty level and would be ineligible for Medicaid, Medicare or an affordable employer sponsored plan. *See* Sec. 1331/ Sec. 10104.
- **Multi-State Plans**: The final bill omitted a “national plan” option and replaced it with a multi-state plan option. The Office of Personnel Management (OPM) is required to contract with insurers to offer at least two multi-state qualified health plans (at least one a non-profit) through the exchanges in each state.
 - OPM is to negotiate a related contract in a similar manner as with FEHBP (the Federal Employee Health Benefits Plan).
 - Such plans must cover essential benefits and meet all requirements of qualified health plans provided in the new health reform laws (unless otherwise stated).
 - States can require extra benefits but must cover cost. *See* Sec.1334/Sec. 10104(q).

Antitrust

- **Rule of Construction**: Provides no change in antitrust laws for insurance companies, as was considered during the health reform debate. *See* Sec. 1650.

Public Option

- A “public option” was not included in the final bill.

Individual Mandate

- **Coverage Requirement (Individual Mandate)**: Requires individuals (and dependents) to keep minimum essential health care coverage as of 2014 or face a penalty (*See* Sec. 1501/ Sec. 10106/ Sec. 1002 (RA) (adds: Sec. 5000A)):
 - Penalty (indexed to inflation): \$95/ person in 2014, \$325 in 2015, \$695 thereafter;

- Exceptions include religious objectors, illegal immigrants and the incarcerated;
- An exemption from the penalty is available based on financial hardship;
- Note: Several states are expected to legally challenge the Constitutionality of the individual mandate to purchase private insurance.

Federal Subsidies and Tax Credits

- **Individual Tax Credits**: Offers a premium assistance credit calculated on a sliding scale starting at two percent of income for those up to 133 percent of poverty and phasing out to 9.5 percent of income for those at 400 percent of poverty; *See* Sec. 1401/ Sec. 1001 (RA) (adds: Sec. 36B);
 - Employees offered coverage where the employer's share of the total cost is less than 60 percent or where the premium exceeds 9.5 percent of the employee's income are eligible for the premium assistance credit.
- **Small Business Tax Credits**: Provides sliding scale tax credits to small employers with fewer than 25 full time equivalent (FTE) employees and average annual wages of less than \$50,000; *See* Sec. 1421/ Sec. 10105 (RA) (adds: Sec 45R);
 - The full credit is available to employers with 10 or fewer employees and average annual wages of less than \$25,000;
 - For 2010-2013, the amount of the tax credit is up to 35% of employer contributions (25% for nonprofit employers);
 - For 2014 and beyond, the amount of the tax credit is up to 50% of employer contributions (35% for nonprofit employers) for two consecutive years.

Employer Sponsored Plans

- **Employer Responsibility**: Requires an employer to pay a fee if the employer has more than 50 full-time equivalent employees, does not offer coverage (or affordable coverage) to employees, and has at least one full-time employee receiving the premium credit through an exchange; effective 2014; *See* Sec. 1513/ Sec. 10106/ Sec. 1003 (RA);
 - Penalty is at least \$2,000 per employee;
 - First 30 employees are not counted for purposes of calculating the fee;
 - Employers with 200+ employees must provide coverage.
- **Cafeteria Plans**: Plans provided through the exchange will not be an eligible benefit under an employer-sponsored cafeteria plan, except in the case of qualified employers (i.e., small employers, and, after 2017, large employers in electing states) offering a choice of plans to their employees through the exchange. *See* Sec. 1515.
- **No Discrimination Based on Wages**: Employers that provide health coverage will be prohibited from limiting eligibility for coverage based on the wages or salaries of full-time employees. Effective Sept. 23, 2010. *See* Sec. 10101(d) (adds: Sec. 2716).

Insurer Fees and Reporting Responsibilities

- **Insurer Reporting**: Requires the Secretary to promulgate regulations for health insurer reporting requirements on coverage, benefits, and reimbursement structures that improve health outcomes, prevent hospital readmissions, emphasize best practices and implement

wellness activities. Effective Sept. 23, 2010. *See* Sec. 1001 (adds: Sec. 2717)/ Sec. 10101.

- **Insurer Refunding Costs**: Requires insurers to refund each enrollee for non-claims costs that exceed 20 percent in the group market and 15 percent in the individual market. Health insurance companies will be required to report the percentage of premiums spent on clinical services (e.g., medical loss ratios), quality, and all other non-claims costs. Effective Sept. 23, 2010. *See* Sec. 1001 (adds: Sec. 2718).
- **Claims Appeals Process**: Requires insurers to implement an effective internal appeals process of coverage determinations and claims and comply with any applicable state external review process. For states without an external review process or for self-insured plans, plans must implement an external review process meeting minimum standards established by the Secretary. Effective Sept. 23, 2010. *See* Sec. 1001 (adds: Sec. 2719)/ Sec. 10101.

Medicaid

Eligibility and Services Updates

- **Increased Medicaid Coverage**: Establishes 133 percent of the federal poverty level as the new mandatory minimum Medicaid income eligibility level (for all non-elderly, non-pregnant individuals not eligible for Medicare) beginning in 2014 (however, the new law also applies a new 5% income disregard to all Medicaid beneficiaries, so the effective eligibility percentage is 138% of FPL); the federal government would provide significant financial assistance to states to help defray the costs of covering newly-eligible beneficiaries; prescription drugs and mental health services must be covered at actuarial equivalence. (The special treatment for Nebraska Medicaid was struck from the bill.) *See* Sec 2001/ Sec. 1201 (RA).
- **Income Eligibility Changes**: As with the calculation of premium subsidies within the Exchange, states are required to use “modified adjusted gross income” as the standard for determining Medicaid eligibility; effective 2014; *See* Sec. 2002;
 - A new mandatory eligibility category is created for low-income, non-pregnant, non-Medicare, under age 65 persons without health coverage;
 - Income disregards and asset tests would no longer apply to certain Medicaid beneficiary groups but people whose Medicaid eligibility depends upon their need for long-term services and supports would not have this protection.
- **Premium Assistance**: Requires states in 2013 to offer premium assistance and wrap-around benefits to Medicaid beneficiaries who are offered insurance through an employer. *See* Sec. 2003.
- **Enrollment Simplification**: Allows individuals to apply for and enroll in Medicaid, CHIP or the Exchange through a state-run website using coordinated procedures amongst all programs. *See* Sec. 2201.
- **Concurrent Hospice Care for Children**: Allows children enrolled in Medicaid or CHIP to receive hospice services without foregoing curative treatment related to a terminal illness. *See* Sec. 2302.
- **Community First Choice Option**: Establishes an optional Medicaid benefit for community-based attendant services and supports to Medicaid beneficiaries with

disabilities who would otherwise require the level of care offered in a facility such as a nursing home. Effective date delayed until October 1, 2011. *See* Sec. 2401/ Sec. 1205 (RA).

- **Removes Barriers to HCBS**: Allows states to provide more types of home and community based services (HCBS) to individuals with higher levels of need, rather than through a waiver, and to extend full Medicaid benefits to individuals receiving HCBS under a State plan amendment; effective Apr. 1, 2010. *See* Sec. 2402.
- **HCBS State Incentives**: Creates financial incentives for States to shift Medicaid beneficiaries out of nursing homes and into HCBS. Provides FMAP (Federal Matching Assistance Percentage) increases for States to rebalance their spending between nursing homes and HCBS. Effective Oct. 1, 2011 – Sept. 30, 2015. *See* Sec. 10202.
- **Improving Access to Medicaid Preventive Services**: Expands current Medicaid option to provide diagnostic, screening, preventive, and rehabilitation services to include clinical preventive services recommended with grade A or B by the U.S. Preventive Services Task Force, and immunizations for adults; states that cover these services would receive increased Federal funding for these services. Effective 2013. *See* Sec. 4106.
- **Lifestyles Program Participation**: Grant program for states to provide incentives to Medicaid beneficiaries to participate in healthy lifestyles programs (lower cholesterol, weight loss, smoking cessation, diabetes prevention, etc.). *See* Sec. 4108.

Payment Adjustments

- **Medicaid Primary Care Adjustment**: Requires that payments to primary care physicians be no less than 100% of the Medicare payment rate in 2013 and 2014. Effective 2013. *See* Sec. 1202 (RA).
- **Medicaid Prescription Drug Rebates**: Increases the flat rebate percentage for outpatient brand name prescription drugs from 15.1 percent to 23.1 percent, except for certain clotting factors and outpatient drugs, for which the basic rebate would increase to 17.1 percent; total rebate liability would be limited to 100 percent of the average manufacturer price. Effective 2010. *See* Sec. 2501/ Sec. 1206 (RA).
- **Eliminating Certain Drug Exclusions**: Removes smoking cessation drugs, barbiturates, and benzodiazepines from Medicaid's excludable drug list in 2014. *See* Sec. 2502.
- **DSH Payment Adjustment**: Lowers Medicaid DSH payments by \$14.1 billion beginning in FY 2014. Provides a new methodology for reducing federal DSH state allotments to meet the mandated reductions. Extends through FY 2013 the DSH state allotment with a \$0 allotment after FY 2011. *See* Sec. 2551/ Sec. 10201/ Sec. 1203 (RA).
- **Health Care Acquired Conditions Adjustment**: Expands upon current policy to prohibit federal payments to states for Medicaid services to treat preventable health care acquired conditions. Effective July 1, 2011. *See* Sec. 2702.

Delivery Reform and Demonstration Programs

- **Money Follows the Person Demo**: Extends the Money Follows the Person Rebalancing Demonstration through 2016 and changes the eligibility rules by requiring that participating individuals reside in an inpatient facility for at least 90 consecutive days. *See* Sec. 2403.

- **Dual Eligible Demos**: Waivers for coordinating care for dual eligible beneficiaries can be for up to five years. *See* Sec. 2601.
- **Increased Dual Eligible Benefit Coordination**: Establishes a new CMS office, the Federal Coordinated Health Care Office. Effective Mar.1, 2010. *See* Sec. 2602.
- **Medicaid Health Homes**: Gives states the option of enrolling Medicaid beneficiaries with chronic conditions into a health home, which would be composed of a team of health professionals to provide a comprehensive set of medical services, including care coordination; during the first eight years of implementation, Federal assistance would equal 90 percent of the cost of the program; effective 2011. *See* Sec. 2703;
 - HHS would partner with an independent entity to evaluate and assess reductions in hospital admissions, emergency room visits and admissions to skilled nursing facilities (SNFs).
- **Medicaid Hospital Bundle Demo**: Establishes a Medicaid demonstration in up to eight states, from 2012 through 2016, that would give hospitals a single payment from Medicaid for hospitals and physician services. Effective 2011-2016. *See* Sec. 2704.
- **Medicaid Global Payment Demo**: Allows participating States to change their payment structure for safety net hospitals from a fee-for-service model to a global capitated payment structure. Effective 2010-2012. *See* Sec. 2705.
- **Pediatric Accountable Care Organization Demo**: Establishes a demonstration allowing pediatric providers to be recognized and receive payments as Accountable Care Organizations under Medicaid if they follow guidelines and provide services at lower cost. Effective 2012. *See* Sec. 2706.
- **Psychiatric Demo**: Requires participating states to reimburse “institutions for mental disease” when stabilizing an emergency psychiatric condition. *See* Sec. 2707.

Nursing Home Transparency

- **SNF Ownership Disclosure**: Requires nursing facilities to make ownership information available. Effective Mar. 23, 2010. *See* Sec. 6101.
- **Penalty Adjustment**: Allows Secretary to reduce civil monetary penalties by 50% for facilities that self-report and promptly correct deficiencies. *See* Sec. 6111.
- **Independent Monitor Demo**: Directs the Secretary to establish a demonstration project to test a national independent monitor program of interstate and intrastate chains of nursing facilities. Effective Mar. 23, 2011. *See* Sec. 6112.
- **Best Practices Demo**: Requires the Secretary to conduct two facility-based demonstration projects to test best practice models in facilities that are involved in the “culture change” movement and best practices in IT that facilities are using to improve resident care. Effective Mar. 23, 2011. *See* Sec. 6114.
- **Dementia and Abuse Prevention Training**: The Secretary may require facilities to include dementia management and abuse prevention training as part of pre-employment initial training. Effective Mar. 23, 2011. *See* Sec. 6121.

CHIP

- **Program Eligibility**: Requires states to maintain income eligibility levels for CHIP through September 30, 2019; between FY 2014 and 2019, states would receive a 23

percentage point increase in the CHIP match rate, subject to a cap of 100 percent. *See* Sec. 2101.

CLASS Act

- **Long Term Services and Supports Insurance Program**: Establishes a new, voluntary, self-funded public long-term care insurance program (known as the “CLASS Act”) for the purchase of community living assistance services and supports by individuals with functional limitations. Effective 2011. *See* Sec. 8002.
 - The program has a five-year minimum vesting period and distributes a cash benefit to individuals to be used to purchase services and supports necessary to stay in the home and community rather than institution-based settings.

Medicare

Payment Adjustments and Benefits Updates

Physicians

- **Physician Update**: Repeals Sec. 3101 which would have provided another one-year physician payment update (on the premise that the physician fee schedule fix would be addressed in separate legislation). *See* Sec. 10310.
- **Primary Care Bonus**: Provides primary care practitioners (family practice, internal medicine, geriatrics, and pediatrics) with a 10 percent payment bonus for five years if 60% of allowed charges are for designated evaluation and management services. Effective 2011. *See* Sec. 5501/ Sec. 10501(h).
- **Geographic PE Adjustment**: Extends phase-in of the floor for the Medicare geographic practice expense adjustment for areas with below average practice expense payment rates. The change benefits physicians in certain rural areas. Accelerates phase-in by changing the value used in calculations from $\frac{3}{4}$ to $\frac{1}{2}$; retroactive to Jan. 1, 2010. Effective 2012. *See* Sec. 3102/ Sec. 1108 (RA).
- **Mental Health Add-On**: Increases the payment rate for psychiatric services by 5 percent for one year through 2010. Effective Mar. 23, 2010. *See* Sec. 3107.
- **Mis-Valued Physician Codes**: Directs the Secretary to review fee schedule rates regularly for physician services; strengthens the Secretary’s authority to adjust fees schedule rates that are found to be “mis-valued” or inaccurate. Effective Mar. 23, 2010. *See* Sec. 3134.
- **Equipment Utilization Modifier for Advanced Imaging**: Increases the presumed utilization rate for MRIs, CAT Scans and other “advanced imaging services” to 75% (excludes low-tech imaging such as ultrasound, x-rays and EKGs from this adjustment) which results in reduced payment for these services. Effective 2010. *See* Sec. 3135/ Sec. 1107 (RA).
- **Power Wheelchair Payment**: Eliminates the option for Medicare beneficiaries to purchase power-driven wheelchairs with a lump-sum payment at the time the chair is supplied; complex rehabilitative power wheelchairs are exempt from this mandatory rental policy. Effective 2011. *See* Sec. 3136.

- **Biosimilar Add-On**: Sets the add-on payment rate for biosimilar products reimbursement under Medicare Part B at 6 percent of the average sales price of the brand biological product. *See* Sec. 3139.

Hospitals

- **Adjustment for Hospital Acquired Conditions**: Starting in FY 2015, requires Medicare to adjust hospital payments so that hospitals in the top 25th percentile of rates for certain hospital acquired conditions will be subject to a payment penalty in order to discourage avoidable medical errors; requires HHS to submit a report to Congress in 2012 on establishing a similar policy for other Medicare providers. *See* Sec. 3008.
- **Rewarding Efficient Care**: For FY 2011 and 2012, rewards high efficiency hospitals by providing an additional IPPS payment to hospitals located in counties in the bottom quartile of counties in risk-adjusted spending per Medicare enrollee. *See* Sec. 1109 (RA).
- **Readmissions Reduction Program**: Effective on or after FY 2012, requires a hospital payment adjustment based on the dollar value of each hospital's percentage of potentially preventable Medicare readmissions for three specified conditions; as of FY 2015, the Secretary may expand the number of affected conditions. This provision is designed to reduce the rate of hospital readmissions that are deemed to be unnecessary and preventable. *See* Sec. 3025.
- **Medicare DSH**: Effective in 2015, reduces base Disproportionate Share Hospital payments to reflect lower uncompensated care costs relative to increases in the number of insured. *See* Sec. 3133/ Sec. 10316/ Sec. 1104 (RA).
- **Wage Index Improvement**: Extends section 508 reclassifications to September 30, 2010; requires the Secretary to provide recommendations to Congress on comprehensive ways to reform the Medicare wage index system; directs the Secretary to restore the reclassification thresholds used to determine hospital reclassifications to the percentages used in FY2009; starting in FY 2011. *See* Sec. 3137/ Sec. 10317.
- **National Wage Index Floor**: Requires application of budget neutrality associated with the effect of the imputed rural and rural floor to be applied on a national basis, rather than state-wide, to the area hospital wage index, starting in October 2010. *See* Sec. 3141.
- **Rural Hospitals**: Includes several provisions expanding, extending and/or reinstating programs and demonstration projects protecting hospitals continued provision of vital services in rural areas.

Post-Acute Care

- **Therapy Caps Exceptions Process**: Extends by one year the exceptions process to caps on medically necessary rehabilitation therapy services (i.e., the therapy caps); expires Dec. 31, 2010. *See* Sec. 3103.
- **Home Health Adjustment**: By 2014, directs the Secretary to rebase home health payments based on an analysis of the current mix of services and intensity of care provided to home health patients; establishes a 10 percent cap on the amount of reimbursement a home health provider can receive from "outlier" payments. *See* Sec. 3131/ Sec. 10315.

- **Hospice Reform**: Requires the Secretary to update Medicare hospice claims forms and cost reports by 2011 and implement changes to the hospice payment system in 2013. *See* Sec. 3132.
- **DME Competitive Bidding**: Expands the number of areas to be included in round two of the durable medical equipment competitive bidding program from 79 to 100 of the largest metropolitan statistical areas, and to use competitively bid prices in all areas by 2016. (The list of DME products to be subject to competitive bidding is not expanded in statute.) *See* Sec. 6410.

Market Basket Payment Adjustments

- **Provider Adjustments**: Implements market basket reductions for various providers as follows (*See* Sec. 3401/ Sec. 10319/ Sec. 1105 (RA)):
 - Hospitals (in/out patient, IPF, IRF, LTCH): 2010 & 2011 – 0.25% off the annual market basket update (LTCH 2011 – 0.5%); 2012 – 2013 – 0.1%; 2014 - 0.3%; 2015-2016 – 0.2%; 2017-2019 – 0.75%;*
 - Home Health: 1% off market basket in 2011 -2013;
 - Laboratory Services: 1.75% from 2011-2015;
 - Hospice: 0.3% in 2013 – 2019;*
 - NOTE: The effective date is April 1, 2010 for all 2010 market basket updates;
 - Out-year gains in “productivity” would lead to further market-basket adjustments and apply to multiple types of providers.

Part D Prescription Drugs

- **“Donut Hole” Discount**: Provides an additional \$250 rebate for “donut hole” coverage gap costs in 2010. Requires 50% “donut hole” discount on brand and generic drugs starting in 2010. To close “donut hole,” phases-in discounts from 97.5% in 2013 down to 75% on brand and generic drugs by 2020. *See* Sec. 3301/ Sec. 1101 (RA).
 - Combination of this and other provisions entirely close the donut hole by 2020.

Medicare Workforce – DGME / IME

- **Redistribution of Residency Positions**: Redistributes 65% of unused DGME and IME residency slots in non-rural hospitals. 75% of the slots will be redistributed to primary care and general surgery programs; gives preference for the redistributed slots to hospitals located in states with a low resident-to-population ratio, states with a high percent of the population living in health professional shortage areas, and rural states. A hospital may receive a maximum of 75 redistributed FTEs. Effective July 1, 2011. *See* Sec. 5503.
- **Counting Non-Provider Resident Time**: Allows time spent by the resident in non-provider settings to be counted toward DGME and IME if the hospital incurs the costs of the stipends and fringe benefits; if more than one hospital incurs these costs, such hospitals shall count a proportional share of the time, as determined by a written agreement between the hospitals, that a resident spends training in that setting. All time

will be counted toward DGME; only patient-care time will be counted toward IME. Effective for cost reporting periods as of 7/1/10. *See* Sec. 5504.

- **Counting Didactic Resident Time**: Allows hospitals to count resident time spent in certain non-patient care activities, such as didactic conferences, in provider settings in calculating the IME adjustment (effective for cost periods on or after 1/1/83) and in non-provider settings in calculating the DGME and IME payments (except for research unassociated with the treatment or diagnosis of a particular patient - effective for cost periods on or after 7/1/09); clarifies that sick leave and vacation can be counted for IME and DGME. Time spent in research not involving the care of patients is not included in the IME FTE count (effective for cost reporting periods as of 10/1/01). *See* Sec. 5505/ Sec. 10501(j).
- **Preserves Resident Cap Positions**: Allows for the redistribution of resident slots from closed hospitals, with preference for the redistribution given to hospitals in proximity to the closed hospital. Effective Mar. 23, 2010. *See* Sec. 5506.
- **Grants for Treating Underserved Populations**: Allows states to create grant programs to support health care providers who treat a high percentage of medically underserved populations. *See* Sec. 10501(k) (adds Sec. 5606).
- **Rural Physician Training Grants**: Authorizes grants for medical schools to establish programs that recruit students from underserved rural areas who have a desire to practice in their hometowns. Effective FY 2010-2013. *See* Sec. 10501(l).
- **Preventive Medicine Training Grants**: Reauthorizes the preventive medicine and public health residency program. Effective FY 2011-2015. *See* Sec. 10501(m)(1).

Advisory Boards/ Delivery Reform/ Quality Reporting and Demonstrations

- **National Payment Bundling Pilot**: Directs the Secretary to develop a national, voluntary bundled payment pilot for hospitals, doctors, and post-acute care providers by 1/1/13; requires the Secretary to submit a plan by 2016 on expansion of the program; allows pilot to be expanded if found to improve quality and reduce costs; requires testing of the continuing care hospital (CCH) model. *See* Sec. 3023/ Sec. 10308.
- **Community-Based Care Transitions Program**: Provides funding to selected hospitals and/or community-based entities that furnish evidence-based care transition services to Medicare beneficiaries at high risk for readmission; program to begin by 1/1/11 and last for five years; program may be expanded if found to reduce spending without reducing quality. *See* Sec. 3026.
- **Independent Payment Advisory Board (IPAB)**: Creates a “Super MedPAC” to recommend cost cutting proposals to Congress; in years when Medicare costs are projected to be unsustainable, the Board’s proposals would take effect unless Congress passed an alternative measure that achieves the same level of savings. Effective Jan. 15, 2014. *See* Sec. 3403/ Sec. 10320.

Quality

- **Hospital Value-based Purchasing Program**: Starting in 2013, a percentage of hospital payments would be tied to performance on quality measures (developed with stakeholders) related to common high-cost conditions such as cardiac, surgical and

pneumonia care; program funding derived from reductions in base DRG payments. *See* Sec. 3001/Sec. 10335.

- **Physician PQRI Improvements**: Extends Physician Quality Reporting Initiative (PQRI) quality reporting payments through 2014; creates appeals and feedback processes; requires integration of PQRI and electronic health record (EHR) reporting by 2012; penalties for non-participation starting in 2014. *See* Sec. 3002/ Sec. 10327.
- **Physician Value-based Payment Modifier**: Directs the Secretary to develop and implement a budget-neutral physician payment adjustment related to the quality and cost of care delivered; measures are risk-adjusted and geographically standardized; phase-in payments over 2 years beginning in 2015. *See* Sec. 3007.
- **Post-Acute Quality Reporting Program**: Starting in 2014, the Secretary will implement a quality measure reporting program for Long Term Care Hospitals (LTCHs), Inpatient Rehabilitation Hospitals (IRFs), and hospice providers; penalties for non-participation. *See* Sec. 3004.
- **Post Acute Value-Based Purchasing Program**: By 2012, Secretary will submit a plan for a SNF and home health value-based purchasing payment system. *See* Sec. 3006.
- **National Quality Strategy**: Establishes a national strategy to improve health care service quality, patient health outcomes, and population health. Effective no later than 2011. *See* Sec. 3011/ Sec. 10302.
- **Interagency Working Group on Health Care Quality**: Establishes this working group to improve quality measures and increase collaboration amongst agencies. *See* Sec. 3012.
- **Quality Measure Development**: Authorizes \$75 million over 5 years for development of quality measures at AHRQ and CMS; requires Secretary to develop and report on patient outcomes measures. Effective FY 2010-2014. *See* Sec. 3013/ Sec. 10303.
- **Data Collection & Reporting**: HHS to award grants for the collection of quality and resource use data to implement the public reporting of performance information. Effective FY 2010-2014. *See* Sec. 3015.

Delivery Reform and Demos

- **CMS Innovation Center**: Establishes the Center for Medicare & Medicaid Innovation to develop payment and delivery arrangements to improve the quality and reduce the cost of care. Effective 2011. *See* Sec. 3021/ Sec. 10306.
- **ACO Shared Savings Program**: Rewards Accountable Care Organizations that meet quality-of-care targets and reduce costs with a share of the savings they achieve for the Medicare program. Effective 2012. *See* Sec. 3022/ Sec. 10307.
- **Independence at Home Demo**: Creates a new demonstration program for beneficiaries with multiple chronic conditions to test a payment and delivery system that rewards “independence at home medical practices” for improving health outcomes and meeting spending targets; requires minimum savings of 5% annually and provides for sharing of savings with providers beyond 5%. Effective 2012. *See* Sec. 3024.
- **Gain-Sharing Demo**: Extends the Deficit Reduction Act’s authorized gain-sharing demonstration through mid-2011. *See* Sec. 3027.
- **Complex Diagnostic Lab Test Demo**: Creates a demonstration program to test the impact of direct payments for certain complex laboratory tests on Medicare quality and costs. *See* Sec. 3113.

- **Concurrent Care Hospice Demo**: Directs the Secretary to establish a demonstration program allowing patients eligible for hospice care to receive all other Medicare covered services simultaneously. *See* Sec. 3140.

Medicare Advantage (MA)

- **MA Payments**: Freezes payments to Medicare managed care plans in 2011. Restructures and phases-in payments; caps total payments at current levels. *See* Sec. 3201, Sec. 3203/ Sec. 1102 (RA).
- **MA Administrative Cost Limits**: Ensures MA plans are committed to medical-loss ratios of at least 85% or suffer payment remissions, suspension and termination from the MA program. This provision is designed to ensure that the vast majority of premiums are directed to paying for beneficiary treatment. Effective 2011. *See* Sec. 1103 (RA).
- **MA Cost-Sharing Protections**: Prohibits Medicare Advantage plans from charging beneficiaries more than what is charged under the traditional fee-for-service program. Effective 2011. *See* Sec. 3202.
- **MA Plan Denial Authority**: Authorizes HHS Secretary to deny bids submitted by Medicare Advantage and prescription drug plans, beginning in 2011, that propose to increase beneficiary cost sharing significantly or decrease benefits offered under the plan. *See* Sec. 3209.

Wellness and Prevention under Medicare

- **Annual Wellness Visit**: Provides coverage with no co-payment or deductible for an annual wellness visit providing personalized prevention plan services. Effective 2011. *See* Sec. 4103.
- **Preventive Service Coinsurance**: Waives beneficiary coinsurance requirements for most preventive services, including preventive services recommended with a grade of A or B by the U.S. Preventive Services Task Force. Effective 2011. *See* Sec. 4104/ Sec. 10406.
- **Preventive Service Improvement**: Authorizes the Secretary to modify Medicare coverage of any currently covered preventive service if the modification is consistent with the U.S. Preventive Services Task Force recommendations and the services are not used for diagnosis or treatment. Effective 2010. *See* Sec. 4105.

Transparency under Medicare

- **Physician-Owned Hospital Prohibition**: Prohibits physician-owned hospitals that do not have a provider agreement prior to December 31, 2010 from participating in Medicare; provides a limited exception to the growth restrictions for grandfathered hospitals that treat the highest percentage of Medicaid patients in their county; strikes the physician enrollment fee. *See* Sec. 6001/ Sec. 10601 & 10603/ Sec. 1106 (RA).
- **Imaging In-Office Ancillary Exception**: Requires physicians relying on the in-office ancillary exception to inform the patient in writing that the individual may obtain the specified imaging service outside the practice. Effective 2010. *See* Sec. 6003.

- **Mandatory Compliance Program**: Secretary will require providers of medical or other items or services or suppliers within a certain industry to enact mandatory compliance program as a condition of enrollment. Secretary to establish timeline. Sec. 6401.
- **Beneficiary Inducement**: Clarifies that charitable programs for beneficiaries are not prohibited remuneration under the Civil Monetary Penalty (CMP) statute so long as they meet the specified criteria. Effective March 23, 2010 Sec. 6402.
- **Maximum Claim Period**: Cuts the period for Medicare claims submission to no more than 12 months. Secretary may specify exceptions. Claims for services furnished before Jan. 1, 2010 must be submitted by Dec. 31, 2010. Effective 2010. *See* Sec. 6404.
- **DME/Home Health – Ordering**: Requires durable medical equipment or home health services to be ordered by a Medicare-eligible physician enrolled in the Medicare program. *See* Sec. 6405/ Sec. 10604.
- **DME/Home Health – Referral Documentation**: Grants the Secretary authority to revoke enrollment for up to one year for a physician or supplier who fails to maintain and is unable to provide the Secretary access to documentation relating to written orders, requests for payment for durable medical equipment, certifications for home health services or referrals for other items or services; effective 2010. *See* Sec. 6406.
- **DME/Home Health – Face-to-Face Requirement**: Requires providers to certify that they have had a face-to-face encounter with the patient during the six months preceding issuance of home health certification (for those made after January 1, 2010) or the written order for durable medical equipment; effective Mar. 23, 2010. *See* Sec. 6407/ Sec 10605.
- **Physician Self Referral Disclosure Protocol**: Creates a new process for disclosing violations and potential violations of the Medicare Physician Self-Referral Law (Stark law). Authorizes the Secretary to reduce civil monetary penalties for the violation of the Stark law by taking into consideration the timeliness of the disclosure, the physician's and/or DHS entity's cooperation, the nature and extent of the illegality or impropriety of the act and other factors deemed necessary by the Secretary. Protocol to be developed within six months of enactment. *See* Sec. 6409.
- **RAC Program Expansion**: Expands jurisdiction of Recovery Audit Contractors to the Medicaid program; requires states to establish contracts by Dec. 31, 2010 with one or more RACs to identify Medicaid overpayments and underpayments. *See* Sec. 6411.

Medical Malpractice

- **State Grants to Evaluate Alternatives**: Authorizes \$50 million over 5 years in grants to states to evaluate alternatives to medical malpractice litigation designed to expedite resolution of disputes, reduce medical errors, and improve patient safety. Effective Oct. 1, 2010. *See* Sec. 10607.
- **Med-Mal for Free Clinics**: Extends protections from liability contained in the Federal Tort Claims Act to free clinics. Effective Mar. 23, 2010. *See* Sec. 10608.

Public Health and Prevention

- **Key National Indicators System**: Establishes a Commission to conduct comprehensive oversight of a newly established key national indicators system, with a required annual report to Congress. Effective Apr. 22, 2010. *See* Sec. 5605.

- **Interagency Council; National Prevention Strategy**: Creates an interagency council to establish a national prevention and health promotion strategy and develop interagency relationships to implement the strategy. Effective Mar. 23, 2010. *See* Sec. 4001.
- **Prevention Funding**: Establishes a Prevention and Public Health Investment Fund to improve health and reduce long term costs. \$15 billion is appropriated to this fund over ten years. Effective FY 2010. *See* Sec. 4002.
- **Community Preventive Services Task Force**: This Task Force is established to review the effectiveness of population-based services. *See* Sec. 4003.
- **Education and Outreach Campaign**: Directs the Secretary to convene a national public/private partnership to conduct a national prevention and health promotion outreach and education campaign. *See* Sec. 4004.
- **School-Based Health Center Program**: Invests (Approx. \$50 million/year from FY 2010-2013) in school-based health clinics. *See* Sec. 4101.
- **Community Transformation Grants**: Authorizes a community grant program (for FY 2010-2014) to promote community health and prevent chronic diseases associated with obesity, tobacco use, mental illness, etc. *See* Sec. 4201.
- **Pre-Medicare Wellness**: Creates a pilot program focused on wellness programs for the pre-Medicare population to prevent chronic disease. *See* Sec. 4202.
- **Standards of Accessibility for Diagnostic Equipment**: Requires the Access Board to establish standards for accessibility of medical diagnostic equipment (e.g., exam tables, weight scales) for individuals with disabilities; effective Mar. 23, 2012. *See* Sec. 4203.
- **Health Disparity Data Collection**: Ensures that any ongoing or new Federal health program collect data on health disparities, including by race, ethnicity, sex, primary language, and disability status. Effective Mar. 23, 2012. *See* Sec. 4302.
- **Employer-Based Wellness Program**: Requires the CDC to study employer-based wellness practices and provide an educational campaign and technical assistance to worksite health promotion to employers. *See* Sec. 4303.
- **Pain Care Research and Treatment**: Authorizes an Institute of Medicine (IOM) Conference on Pain Care to evaluate the adequacy of pain assessment, treatment, and management; authorizes the Pain Consortium at NIH to enhance and coordinate clinical research on pain causes and treatments; establishes a grant program to improve the assessment and treatment of pain. Effective Mar. 23, 2010. *See* Sec. 4305.

Workforce and Education

*Primary Care Workforce and Education**

- **National Commission**: Establishes a national commission to review health care workforce and projected needs. Effective Sept. 30, 2010. *See* Sec. 5101/ Sec. 10501(a).
- **Workforce Assessment**: Codifies the National Center for Health Care Workforce Analysis and establishes several regional centers to report data on the primary care workforce. *See* Sec. 5103.
- **Primary Care Loan Program**: Eases current criteria to make the primary care student loan program more attractive to medical students. Effective Mar. 23, 2010. *See* Sec. 5201.

- **Pediatric/ Mental Health Care Loan Program**: Establishes a loan repayment program for certain pediatric subspecialists (effective FY 2010-2014) and providers of mental and behavioral health services to children and adolescents (effective FY 2010-2013). *See* Sec. 5203.
- **Public Health Service Loan Program**: Loan repayment program for public health students that agree to work at least three years at a public health agency. Effective FY 2010-2015. *See* Sec. 5204.
- **Allied Health Loan Program**: Offers loan repayment program to allied health professionals employed at certain public health agencies. Effective March 23, 2010. *See* Sec. 5205.
- **Primary Care Training Grants**: Provides grants to develop and operate training programs relating to family medicine, general internal medicine, general pediatrics, and physician assistantships. Effective FY 2010-2014. *See* Sec. 5301.
- **Primary Care Extension Program**: Creates program to educate primary care providers about evidence-based therapies, preventive medicine, health promotion, chronic disease management, and mental health. Effective FY 2011-2014. *See* Sec. 5405.
- **Primary Care Residency Grants**: Directs the Secretary to establish a grant program, and provides additional funding under the PHSA, to support new or expanded primary care residency programs. *See* Sec. 5508.
- **National Health Service Corps Improvements**: Improves National Health Service Corps program by increasing loan repayment amount, allowing for half-time service, and allowing teaching to count for up to 20% of commitment. *See* Sec. 10501(n)(1).
- **NHSC Funding**: Increases and extends authorization for the National Health Service Corps (\$1.5 billion from FY 2010-2015). *See* Sec. 10503/ Sec. 2303 (RA).

* *Also see IME and GME provisions under Medicare payment adjustments.*

Nurse Education

- **Nursing Loan Program**: Increases loan amounts and updates the years for nursing schools to establish and maintain student loan funds. Effective FY 2010. *See* Sec. 5202.
- **Nurse-Managed Clinics**: Creates a \$50 million grant program administered by HRSA to support nurse-managed health clinics. Effective FY 2010-2014. *See* Sec. 5208.
- **Education and Training Grants**: Awards grants to nursing schools for education and training programs. Effective FY 2010-2012. *See* Sec. 5309.
- **Faculty Loan Repayment Program**: Allows faculty at nursing schools to be eligible for loan repayment and scholarship programs. Effective FY 2010-2016. *See* Sec. 5310.
- **Graduate Nursing Demo**: Establishes a Medicare demonstration program to increase graduate nurse education training. Effective FY 2012-2015. *See* Sec. 5509.

Direct Care and Geriatric Workforce and Education

- **Direct Care Worker Training**: Authorizes funding to establish new training opportunities for direct care workers rendering care in the field of geriatrics, disability services, long term services and supports, or chronic care management. Effective FY 2011-2013. *See* Sec. 5302.

- **Geriatric Education and Training**: Authorizes funding to geriatric education centers for training in geriatrics, chronic care management, and long-term care for faculty in health professions schools and family caregivers; develop curricula and best practices in geriatrics; establishes traineeships for individuals preparing for advanced education degrees in geriatric nursing. *See* Sec. 5305.

Mental Health

- **Mental/Behavioral Health Education and Training**: Awards grants to schools for the development of training programs in social work, graduate psychology, professional training in child and adolescent mental health, and pre-service or in-service training to paraprofessionals in child and adolescent mental health. Effective FY 2010-2013. *See* Sec. 5306.

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

- **Cultural Competency Training for Individuals with Disabilities**: Awards grants to schools for the development of disability sensitivity training programs that teach cultural competency, prevention, public health proficiency, reduction of disparities, and aptitude for working with individuals with disabilities. Effective FY 2010-2015. *See* Sec. 5307.

Centers of Excellence

- **Centers of Excellence Funding**: Reauthorizes this program which develops a minority applicant pool interested in health careers. Authorized at 150% of 2005 appropriations \$50 million. *See* Sec. 5401.

Community Health Center Fund & FQHCs

- **CHC Funding**: Establishes a new Community Health Center (CHC) Fund and designates \$11 billion for CHCs; allows HHS to conduct a grant program for healthy lifestyles and decreasing chronic disease incidence; promotes CHCs in medically underserved areas. Effective FY 2011-2015. *See* Sec. 10503/ Sec. 2303 (RA).
- **PPS for FQHCs**: Establishes a new prospective payment system (PPS) for federally qualified health centers (FQHCs). *See* Sec. 5502/ Sec. 10501(i).
- **FQHC Funding**: Authorizes nearly \$34 billion for FQHCs from FY 2010-2015, a huge increase in funding from the current level of \$2 billion. *See* Sec. 5601.

Fraud and Abuse

- **Reporting of Physician Ownership**: Requires drug, device, biological and medical supply manufacturers to report transfers of value made to a physician, physician medical practice, a physician group practice, and/or a teaching hospital. Effective Mar. 31, 2013. *See* Sec. 6002.
- **Long-term Care Background Checking System**: Requires the Secretary to establish a nationwide program for national and state background checks on direct patient access

employees of certain long-term supports and services facilities or providers. Effective Mar. 23, 2010. *See* Sec. 6002.

- **Provider and Supplier Screening**: Requires the Secretary and the Office of Inspector General (OIG) to establish procedures for screening providers and suppliers participating in Medicare, Medicaid, and CHIP; effective Mar. 23, 2010; *See* Sec. 6401;
 - New providers and suppliers would be required to disclose current or previous affiliations with any provider or supplier that has uncollected debt, has had its payments suspended, has been excluded from participating in a Federal health care program, or has had its billing privileges revoked;
 - Certain providers and suppliers would be required to establish compliance programs.
- **Medicare/Medicaid Program Integrity Improvements**: Requires CMS to include in the integrated data repository claims and payment data from Medicare, Medicaid, CHIP, health-related programs administered by the Departments of Veterans Affairs and Defense, and the Social Security Administration; effective Mar. 23, 2010; *See* Sec. 6402;
 - Requires that overpayments be reported and returned within 60 days from the date the overpayment was identified; noncompliance is subject to false claims and civil monetary penalties liability;
 - Requires the Secretary to issue a regulation mandating that all Medicare, Medicaid, and CHIP providers include their National Provider Identifier on enrollment applications;
 - Expands the use of Civil Monetary Penalties to certain excluded individuals;
 - Authorizes the Secretary to suspend payments to a provider or supplier pending a fraud investigation.
- **Long-Term Care Protections (Elder Justice Act)**: Requires HHS to award grants for the provision of greater protection to those individuals seeking care in facilities that provide long-term services and supports. Effective Oct. 1, 2010. *See* Sec. 6703.
- **Fraud Enforcement Improvements**: Increases federal sentences for persons convicted of federal health care offenses; lessens proof of intent required under the Anti-Kickback statute; expands the definition of a federal health care offense; expands federal subpoena authority relating to health care investigations. Effective Mar. 23, 2010. *See* Sec. 10606.
- **Mental Health Centers**: Establishes new requirements for community mental health centers. Effective Apr. 1, 2011. *See* Sec. 1301 (RA).
- **Prepayment Review Limitations**: Repeals statute allowing Medicare contractors to conduct prepayment review. Effective Mar. 23, 2010. *See* Sec. 1302 (RA).
- **Fraud & Abuse Funding**: Increases funding for Health Care Fraud and Abuse Control Fund by \$250 million from FY 2011 to FY 2016. Indexes funds to fight Medicaid fraud based on the increase in the Consumer Price Index. *See* Sec. 1303 (RA).
- **Enhanced DME Oversight**: Requires a 90-day period of enhanced oversight for initial claims of DME suppliers in high-fraud areas; effective 2011. *See* Sec. 1304 (RA).

Health Information Technology

- **Administrative Simplification**: Accelerates HHS adoption of uniform standards and operating rules for electronic transactions that occur between providers and health plans,

such as benefit eligibility verification, prior authorization and electronic funds transfer payments, with most new operating rules effective in 2013 and 2014. *See* Sec. 1104.

- **Enrollment Standards**: Requires the development of standards and protocols on interoperability of systems for enrollment of individuals in health and human services programs; allows for electronic data matching, and electronic documentation; Secretary may require states to incorporate standards in order to receive Federal HIT funds. Effective Sept. 19, 2010. *See* Sec. 1561.
- **LTC Facility Grants**: Provides grants to long-term care facilities for the adoption of certified electronic health records technology. Effective Oct. 1, 2010. *See* Sec. 6703.
- **Financial and Administrative Transactions**: Requires the Secretary to consult stakeholders and others about opportunities to develop uniform standards for financial and administrative health care transactions, not already developed under HIPAA. Effective 2012. *See* Sec. 10109.

Comparative Effectiveness and Research

- **Patient-Centered Outcomes Research**: Establishes a private, nonprofit entity to identify priorities and provide for the conduct of comparative outcomes research; effective FY 2010; *See* Sec. 6301/ Sec. 10602;
 - Requires the entity to ensure that subpopulations are appropriately accounted for in research designs;
 - Prohibits any findings to be construed as mandates on practice guidelines or coverage decisions and contains patient safeguards to protect against discriminatory coverage decisions by HHS based on age, disability, terminal illness, or an individual's quality of life preference;
 - Clarifies publication rights of researchers;
 - Funding from appropriations and annual fee on health policies.
- **Improving Health Care Delivery Research**: Adds to the Center for Quality Improvement and Patient Safety's grant capacity to identify, develop, disseminate, and provide training in innovative methodologies and strategies for quality improvement practices in the delivery of health care services. Effective Mar. 23, 2010. *See* Sec. 3501.

Drug Provisions

- **Expanded 340B Participation**: Extends 340B drug discount program to outpatient departments of children's hospitals, cancer hospitals, critical access and sole community hospitals, and rural referral centers; effective 2010; *See* Sec. 7101/ Sec. 2302 (RA);
 - No expansion to inpatient drugs;
 - Excludes orphan drugs for rare diseases for these new entities.
- **340B Program Improvements**: Adopts certain 340B program integrity and compliance requirements for manufacturers to prevent overcharges and other violations. Effective Sept. 23, 2010. *See* Sec. 7102/ Sec. 2302 (RA).
- **Biosimilar Drug Approval Pathway**: Establishes pathway for licensure of a biological product due to similarity to a reference product (previously licensed biological); prohibits biosimilar or interchangeable application approvals for 12 years; allows a Part B

biosimilar to be assigned a separate billing code under “ASP+6” methodology. Effective Oct. 1, 2010. *See* Sec. 7002.

Revenue Raisers to Offset the Cost of Expanded Coverage

- **Excise Tax on High Cost Plans**: Levies an excise tax of 40 percent on the “excess amount” of high cost insurance plans above the threshold of \$10,200 for single coverage and \$27,500 for family coverage; provides for adjustments for high-risk groups and higher costs due to age/ gender; effective 2018 (indexed to CPI-U). *See* Sec. 9001/ Sec. 10901/ Sec. 1401 (RA).
- **FSA Limitation**: Contributions to flexible spending accounts (FSAs) are capped at \$2,500 annually (indexed to CPI-U); effective 2013. *See* Sec. 9005/ Sec. 10902/ Sec. 1403 (RA).
- **PhRMA Fee**: Imposes an annual fee varying from \$2.5 to 4.1 billion per year on the pharmaceutical manufacturing sector for a total of \$30.8 billion for the first 10 years beginning in 2011. *See* Sec. 9008/ Sec. 1404 (RA).
- **Medical Device Fee**: Imposes a 2.3% tax on Class I, II, and III medical devices with exemptions for eyeglasses, contact lenses, hearing aids, retail items, and other devices as designated by the Secretary. Effective 2013. *See* Sec. 9009/ Sec. 10904/ Sec. 1405 (RA).
- **Insurer Fee**: Imposes an annual fee on health insurers varying from \$8 - \$14.3 billion per annum, for a total of \$130.3 billion for the first 10 years beginning in 2014. Provides exemptions for voluntary employee benefit associations and nonprofit entities with over 80% in revenue from SSA low-income/elderly/disabled programs. *See* Sec. 9010/ Sec. 10905/ Sec. 1406 (RA).
- **Medical Expense Itemized Deduction Modified**: The adjusted gross income threshold for claiming the itemized deduction for medical expenses increases from 7.5 percent to 10 percent. The change becomes effective for tax years 2013 and beyond, except for individuals age 65 and older, who would be subject to the increase beginning in tax year 2017. *See* Sec. 9013.
- **Medicare Tax Increase**: Increases the hospital insurance (Medicare) tax rate by 0.9 percentage points on an individual earning over \$200,000 (\$250,000 for married couples). Effective 2013. For individuals, trust and estates, there would be an additional 3.8% tax on the lesser of investment income or modified gross income in excess of a threshold. The threshold is \$200,000 for individuals, \$250,000 for married couples, and the highest tax bracket for trusts and estates. Taxes are applicable to married couples filing jointly or separately. *See* Sec. 9015/ Sec. 10906/ Sec. 1402 (RA).
- **New Therapy Tax Credit**: Creates a two-year temporary tax credit to encourage investments in new therapies to prevent, diagnose, and treat acute and chronic diseases. Effective Mar. 23, 2010. *See* Sec. 9023.