

Health Centers and Health Reform

HEALTH REFORM GLOSSARY

Accountable Care Organizations (ACOs): Networks of health providers joined together for the purpose of offering the full continuum of health care services for patients to improve quality and patient outcomes, and reduce costs.

Bonus Payments (under Medicare): Incentive payments under Medicare to primary care physicians who demonstrate quality achievements, participate in electronic health records, or practice in underserved areas.

CMS Innovation Center: The CMS Innovation Center is a new office within CMS that is authorized to test, evaluate and expand different payment structures and methodologies which aim to foster patient-centered care, improve quality, and slow the rate of Medicare cost growth.

Community Based Collaborative Care Network Program (CBCCN): Section 10333 of the newly enacted health reform law authorizes the creation of Community-Based Collaborative Care Networks (CBCCNs). CBCCNs are made up of safety net hospitals, community health centers and other safety net providers that will offer coordinated care for vulnerable patients in their areas – increasing health care access and quality.

Community Health Center Trust Fund: Established under the new health reform law with a total of \$11 billion in guaranteed funding from general revenues for the Health Center Program to be distributed over 5 years (FY 2011-FY2015). This funding is in addition to program funding appropriated annually by the Congress.

Consumer Oriented and Operated Plans (CO-OP): This option will give patients more opportunities for health care choice than a Medicare-like, price controlled plan. In addition, the Co-Op plans, which will be member-run, nonprofit insurance companies will be owned and run by the consumers who use them.

Doughnut Hole: The coverage gap under the Medicare Part D Prescription Drug Program during which individuals must assume the full costs of their medications. The coverage gap is reached when the retail cost of their medications reaches \$2,830 (the initial coverage limit under the standard plan) and continues until the individual has spent \$4,550 in out-of-pocket costs and when the covered costs of medications total \$6,440 in 2010.

Federal Medical Assistance Percentage (FMAP): Percentage of federal share or matching rate of state expenditures for state medical and medical insurance expenditures. Generally, the federal government covers 50-76 percent of state Medicaid expenditures, depending on a state's per capita income.

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Federal Poverty Level (FPL): The income threshold established by the federal government to measure poverty status or determine financial eligibility for certain public programs. FLP varies according to family size and measures pre-tax cash income: [FPL for 2009 is set at \$10,830 for a single adult and \$22,050 for a family of four]

Individual Mandate: The requirement under health reform that US citizens and legal residents have health insurance coverage or pay a tax penalty. The tax penalty is phased in: \$95 in 2014; \$325 in 2015; and \$695 in 2016 (or up to 2.5 percent of household income in 2016). Exemptions can be granted for financial hardship or for those persons with incomes below the tax filing threshold, which in 2009 was \$9,350 for singles and \$18,700 for couples.

Medicare (Graduate Medical Education (GME): The Medicare program makes payments for graduate medical education (GME) to support the training of medical residents in specialties at teaching hospitals. Medicare payments cover a portion of the salaries of physicians related to the time spent in teaching residents, as well as a portion of residents' salaries and reimbursement for providing services to Medicare beneficiaries.

Medicare Medical Homes: The Medicare Medical Home Demonstration project was authorized in Section 204 of the Tax Relief and Health Care Act of 2006 and attempts to redesign the health care delivery system to provide targeted, accessible, continuous and coordinated, family-centered care by a personal physician practicing in a medical home to Medicare beneficiaries with qualifying chronic conditions.

Medicare Physician Value-based Care Measures: Measures by which a differential payment to a physician or group of physicians will be established based upon the quality of care provided compared with its costs. Measures are to be published by HHS in 2012 with phase in of payment modifier from 2015-2017.

National Health Care Workforce Commission (NHCWC): The Patient Protection and Affordable Care Act established a National Health Care Workforce Commission that will serve as a national resource on the nation's health care workforce for Congress and the president.

National Health Service Corps Trust Fund: Established under the health reform law with a total of \$1.5 billion in guaranteed funding for the purpose of increasing number of National Health Service Corps providers in underserved areas. Funds will be distributed to the Corps over five years with first year-funding at \$290 million in FY 2011 and increasing to \$390 by FY 2015. This funding will be in addition to annual program funding appropriated by the Congress.

National High Risk Pool: Temporary program subsidized by the federal government to provide affordable health coverage to persons who have preexisting medical conditions and who have been uninsured for at least 6 months. Plans will be required to cover on average no less than 65% of medical costs and to limit out of pocket spending [capped at \$5,950 for individuals and \$11,000 for families].

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Patient Protection and Affordable Care Act (PPACA) [Public Law 111—148]: Commonly referred to as simply health reform, was signed into law by the President on March 23, 2010.

Premium Subsidies: Refundable or advanceable tax credits provided to individuals in meeting the premium costs of private health insurance policies offered through the Exchanges.

Small Business Health Options Program (SHOP Exchanges): Established by the states to assist small businesses in obtaining health insurance coverage for their employees. Prior to 2016, states can limit such exchanges to businesses with 50 or fewer employees, and beginning in 2017, states can allow businesses with more than 100 employees to purchase coverage from an exchange.

Small Business Health Care Affordability Tax Credit: Available to small businesses and nonprofit groups with fewer than 25 employees and average wages of under \$50,000 to offset the costs of providing employee health coverage. From 2010-13, the credit will cover up to 35 percent of an employer's premium contributions. In 2014, the credit will increase to 50 percent of that cost. The tax credit for tax exempt groups is set at a lower rate: 25 percent in 2010-13; 35 percent in 2014. The maximum credit will be available to employers with less than 10 employees with average wages of \$25,000, phasing out for larger firms. Only firms that contribute 50 percent of their employees' premiums will be eligible.

State Health Insurance Exchanges (also called American Health Benefit Exchanges): Established by states and administered by government or nonprofit entities to provide a competitive marketplace and assist individuals in the purchase of health insurance coverage. Exchanges are limited to US citizens, legal immigrants, who do not have access to employer-sponsored or public health insurance. Health plans offered in the exchange must be certified and required to meet rules related to affordability, benefits and marketing standards. In addition, health plans must include a sufficient choice of providers, including essential community providers such as health centers.

State Loan Repayment Programs under the National Health Service Corps: Assists health professionals repay educational loans in return for a service commitment to populations located in health professional shortage areas. Objective of these programs is to increase the supply of primary care physicians, nurse practitioners, physicians' assistants, dentists, behavioral and mental health professionals and others needed in medically underserved communities. Under health reform law, state loan repayments are no longer subject to federal income tax.

The CLASS Act: The Community Living Assistance Services and Supports Act also known as the CLASS ACT is a federal insurance plan for long-term care. The CLASS Act establishes a national voluntary insurance program that will allow for voluntary pre-financing of long-term care through payroll deductions and then provides a cash benefit to purchase services.