

## HEALTH CENTER RELATED PROVISIONS OF CONGRESSIONAL HEALTH REFORM PROPOSALS

Provision	House	Senate	
	<i>Tri-Committee Proposal</i>	<i>HELP Committee Proposal</i>	<i>Finance Committee Proposal</i>
Health Centers Program Funding & Program Changes	<ul style="list-style-type: none"> <li>• Authorizes to be appropriated for [increases to] the Community Health Centers program out of a new Public Health Investment Fund (PHIF) the following amounts:               <ul style="list-style-type: none"> <li>• \$1 billion for FY 2010;</li> <li>• \$1.5 billion for FY 2011;</li> <li>• \$2.5 billion for FY 2012;</li> <li>• \$3 billion for FY 2013, and;</li> <li>• \$4 billion for FY 2014.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Authorizes to be appropriated for the Health Centers program approx. \$3 billion in 2010, increasing incrementally to \$8.3 billion by 2015, then increasing in line with inflation and patients served for 2016 and the following years.</li> <li>• Makes clarifications to Section 330 to align statute with practice as it relates to several areas including: location of service delivery sites and affiliation agreements. Also includes new joint purchasing technical assistance section in 330(l).</li> </ul>	
National Health Service Corps Program Funding & Program Changes	<ul style="list-style-type: none"> <li>• \$75 million each year for [increases to the] NHSC field line for 2010-2014, out of the PHIF; and</li> <li>• \$300 million each year for [increases to the] recruitment line (scholarship and loans) for 2010-2014, out of PHIF.</li> <li>• Allows for part-time service to satisfy loan or scholarship obligations, provided commitment time is increased, or award is reduced.</li> <li>• Allows for reappointment to the National Advisory Council.</li> <li>• Loan repayment amount increased to \$50,000 and after 2011, Secretary may increase to reflect inflation.</li> </ul>	<ul style="list-style-type: none"> <li>• The bill authorizes to be appropriated for the National Health Service Corps.: approximately \$300 million in 2010, with allocations increasing to \$1.2 billion in 2016.</li> </ul>	
Medicaid Eligibility Changes	<ul style="list-style-type: none"> <li>• Expands Medicaid to 133<sup>1/3</sup>% FPL.</li> <li>• Deems children born in the U.S. who are not otherwise covered to be Medicaid eligible.</li> <li>• Requires Medicaid coverage of preventive services and eliminates cost-sharing for preventive services.</li> <li>• Requires states to pay for medical services</li> </ul>	<ul style="list-style-type: none"> <li>• Assumes an expansion of Medicaid to 150% of poverty, improvements to facilitate enrollment, a maintenance of effort by the States, and increased FMAP levels.</li> </ul> <p><i>Note: Medicaid is not in the HELP Committee's jurisdiction.</i></p>	

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	furnished in school-based clinics if covered if furnished in a physician’s office or other outpatient clinic.		
Prevention and Wellness Programs	<ul style="list-style-type: none"> <li>• Requires HHS to promote use of a preventive care visit card to encourage use of services.</li> <li>• Establishes a Prevention and Wellness Trust to fund prevention and wellness activities, appropriated through 2014.</li> <li>• Provides for community-based prevention and wellness research grants that would be available to state or local health departments or a public or private nonprofit entities.</li> <li>• Provides for community-based prevention and wellness services grants to assist state or local health departments or public/private nonprofit entities providing evidence-based community based prevention and wellness services.</li> <li>• Provides formula grants to each state and for competitive grants for state, local, and tribal health departments to support core public health infrastructure and activities.</li> <li>• Provides for coordination of prevention and wellness research across agencies.</li> <li>• Establishes a National Prevention and Wellness Strategy, a Task Force on Clinical Preventive Services and a Task Force on Community Preventive Services to evaluate national priorities in prevention and wellness, identify gaps in preventive services, and make recommendations.</li> </ul>	<ul style="list-style-type: none"> <li>• Establishes a temporary program (“Right Choices Program”) giving uninsured adults access to preventive services by providing chronic disease health risk assessment, a care plan, and referrals to community-based resources for low-income, uninsured adults until universal insurance coverage is made available.</li> <li>• Directs the President to establish the “<i>National Prevention, Health Promotion and Public Health Council</i>” composed of the heads of virtually all the Federal departments and agencies (e.g., HHS; DHS; Agriculture; Transportation; FTC; FCC; etc.), dedicated to promoting “healthy policies” at the Federal level.</li> <li>• The Council would: coordinate prevention, wellness, and health promotion practices; develop a national prevention and integrative health care strategy; provide recommendation on achieving public health goals; propose models and approaches for producing health and wellness; establish processes for public input; submit reports; and other activities required by the President. The Council will report annually to Congress on the activities of the Council.</li> <li>• Establishes a “<i>Prevention and Public Health Investment Fund</i>” to provide for investment in prevention and public health programs (authorized</li> </ul>	

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		in the Public Health Service Act) to improve health and help restrain the rate of growth in private and public sector health care costs.	
Health Insurance Exchange	<ul style="list-style-type: none"> <li>• Requires all individuals to have health insurance.</li> <li>• Provides premium and cost-sharing credits for individuals/families with incomes up to 400% FPL.</li> <li>• All individuals not enrolled in another qualified health benefits plan or other coverage would be eligible to enroll in any Exchange-participating plan.</li> <li>• Establishes the “Health Choices Administration,” led by a Health Choices Commissioner, to establish and run a Health Insurance Exchange (HIE).</li> <li>• Health Choices Commissioner would contract with entities offering qualified health benefit plans to offer plans through the Exchange, and carry out other duties related to the Exchange.</li> <li>• State-based HIEs could be offered by single states or groups of states as an alternative to the HIE in those areas.</li> <li>• Establishes a HIE Trust Fund to make payments to operate the Exchange. Funds would be derived from taxes on individuals who do not obtain acceptable coverage, employment taxes on those not providing acceptable coverage, and excise taxes on failures to meet certain health coverage requirements.</li> </ul>	<ul style="list-style-type: none"> <li>• Only U.S. citizens or lawful aliens would be considered eligible individuals.</li> <li>• “American Health Benefit Gateways” would be established in each State by States or HHS.</li> <li>• Gateways would facilitate enrollment in health insurance by individuals and employer groups, and perform other functions including: certifying plans; developing tools to inform consumers; entering agreements with “navigators”; facilitating purchase of long term-services; and collecting complaints from enrollees.</li> <li>• Gateways would be supported by planning and establishment grants from HHS, and a surcharge on insurers to fund administrative and operating expenses. Grants would be available to support community-based enrollment initiatives.</li> <li>• States could either establish a Gateway or participate by requesting that HHS establish a Gateway. If a State has done neither after 4 years, HHS will establish a Gateway in the State.</li> <li>• The bill also includes a sense of the Senate that all Americans should have access to care in a manner similar to the FEHBP.</li> </ul>	
Network Adequacy Standards for Exchange Plans	<ul style="list-style-type: none"> <li>• For plans using a provider network, the Health Choices Commissioner could establish requirements to ensure network adequacy.</li> </ul>	<ul style="list-style-type: none"> <li>• Private Insurers would be required to develop and implement reimbursement structures to provide incentives for high quality care to address: care</li> </ul>	

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	<ul style="list-style-type: none"> <li>Basic exchange plans must contract with ‘essential community providers’ as specified by the Commissioner. The Commissioner specifies the extent and manner of this interaction, especially with regard to HMOs.</li> </ul>	<p>coordination; hospital readmissions; use of best clinical practices, evidence-based medicine and HIT; wellness; and other measures.</p> <ul style="list-style-type: none"> <li><b>NB:</b> Mikulski amendment requiring exchange plans to include ‘essential community providers’ (defined as all 340B entities including FQHCs) to be “in network” was accepted in markup.</li> </ul>	
Required Benefits in Exchange Plans	<ul style="list-style-type: none"> <li>Insurers offering plans in the Exchange would be required to offer at least one “basic plan” (which offers the essential benefits package) and could offer one “enhanced plan” (lower cost-sharing), one premium plan (even lower cost-sharing), and one premium plus plan (with additional benefits including adult dental and vision).</li> <li>The Essential Benefits Package requires coverage of: hospitalization, outpatient hospitals and outpatient clinic services; professional services of physicians and other health professionals and services incident to such services; prescription drugs, rehabilitative and habilitative services; mental health and substance use disorder services; preventive services; maternity benefits; well baby and well child care including oral, vision, and hearing services.</li> <li>No cost-sharing for preventive services; limits cost-sharing for other services; would not permit annual or lifetime limit on coverage; actuarial equivalence requirements for cost-sharing.</li> <li>Establishes the “Health Benefits Advisory Committee” to recommend benefits for the</li> </ul>	<ul style="list-style-type: none"> <li>Qualified health insurance plans would be required to offer at least “essential benefits” and would need to meet additional criteria to receive required certification by a Gateway.</li> <li>Essential Health Benefits must include: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; medical and surgical care; mental health and substance abuse; prescription drugs; rehabilitative, habilitative, and laboratory services; preventative and wellness services; pediatric services (including oral and vision).</li> <li>Insurers would be required to cover preventative health services with minimal cost sharing.</li> <li>Creates the “Medical Advisory Council” to evaluate items and services that constitute the “essential health benefits.”</li> <li>The Council would determine criteria that coverage must meet to be considered minimum qualifying coverage, and conditions under which coverage would be considered affordable for individuals and families at different income levels.</li> </ul>	

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	<p>essential benefits package. The Committee would be chaired by the Surgeon General and membership would include public officials and representatives of stakeholders.</p> <ul style="list-style-type: none"> <li>• Qualified health benefits plan requirements would apply to plans offered outside of Exchanges to the extent determined by the Health Choices Commissioner.</li> </ul>		
Medicaid Interaction with the Exchange	<ul style="list-style-type: none"> <li>• Would allow Medicaid-eligible individuals to enroll in a health plan through the health insurance exchange after the exchange has been in operation for four years. Beginning in Year 5, all individuals eligible for Medicaid and enrolled in a qualifying exchange plan would also be eligible for wrap-around coverage for Medicaid-covered benefits</li> </ul>		
Teaching Health Centers	<ul style="list-style-type: none"> <li>• Authorizes a demonstration where “teaching health centers” (THC) can receive payments under for their own direct costs, as well as the costs of the contracting hospital. THC must pay the hospital for direct costs such as salary and fringe hospital incurs. The hospital’s FTE amount does not affect the contracting hospital’s resident limit. The contracting hospital cannot diminish its number of primary care residents.</li> <li>• Teaching health center is defined as non-provider entity, including FQHC or rural health center that develops and operates an accredited primary care residency program for which funding would be available.</li> </ul>		

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Reimbursement for Primary Care Physicians	<ul style="list-style-type: none"> <li>• Primary care services (furnished on or after January 1, 2011), by a primary care practitioner, are to be reimbursed through an additional payment to the practitioner (or to an employer or facility in the cases) on a monthly or quarterly basis from the Federal Supplementary Medical Insurance Trust Fund</li> <li>• The amount should be equal 5% (or 10% if the practitioner predominately furnishes such services in an area that is designated as a health professional shortage area) above Medicare.</li> <li>• Increases Medicaid payments for primary care services to 80% of Medicare rates in 2010, 90% in 2011, and 100% by 2012. Requires the Federal government to pay for this increase in payments.</li> </ul>		
Medical Home & Coordinated Care Demonstrations	<ul style="list-style-type: none"> <li>• Creates a Medicaid Medical Home Pilot program to which a State may apply for approval.</li> <li>• Directs the Secretary to establish a medical home pilot program to evaluate the feasibility and advisability of reimbursing qualified patient-centered medical homes for furnishing medical home services to “high-need” beneficiaries in urban, rural and underserved areas. To administer and carry out the pilot program, directs the transfer of \$6 million for each FY, 2010- 2014 from the Federal Supplementary Medical Insurance Trust Fund to the Secretary for CMS.</li> <li>• Directs the Secretary to conduct a pilot program to test different payment incentive models (including</li> </ul>	<ul style="list-style-type: none"> <li>• Creates grant program for eligible entities to establish health teams to support primary care physicians and to provide capitated payments to primary care providers as determined by the HHS Secretary.</li> <li>• Requires the Secretary of HHS to establish a program that will provide grants to eligible entities for the implementation of medication management services ("MTM") provided by licensed pharmacists as a means of treating chronic diseases. MTM services under the grant program will be targeted to individuals who take 4 or more prescribed medications, take any ‘high risk’ medications, have 2 or more chronic diseases, or have undergone a</li> </ul>	

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	<p>the “Performance Target Model”, the “Partial Capitation Model”, and “Other Models”) designed to reduce the growth of expenditures and improve health outcomes in the provision of items and services to “applicable” beneficiaries by “qualifying” accountable care organizations (“ACOs”). The payment scheme should promote accountability for patient coordination, encourage investment in infrastructure and processes for efficient service delivery, and reward physician practices for providing high quality, cost-effective and coordinated care.</p> <ul style="list-style-type: none"> <li>• A “qualifying” ACO is defined as a group of physicians that is organized at least in part for the purpose of providing physicians’ services; they must also meet criteria the Secretary deems appropriate to participate in the pilot program. The pilot program shall begin no later than January 1, 2012.</li> </ul>	<p>transition of care that is likely to create a high-risk of medication-related problems.</p>	