

## HEALTH CENTER RELATED PROVISIONS OF HOUSE AND SENATE HEALTH REFORM BILLS

Provision	House	Senate
	<i>Affordable Health Care For America Act (HR 3962)</i>	<i>Patient Protection &amp; Affordable Care Act (HR 3590)</i>
Health Centers Program Funding & Program Changes	<ul style="list-style-type: none"> <li>• Authorizes and appropriates the following annual amounts 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 2011;</li> <li>• \$1.5 billion for FY 2012;</li> <li>• \$2.5 billion for FY 2013;</li> <li>• \$3 billion for FY 2014;</li> <li>• \$4 billion for FY 2015.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Authorizes and appropriates the following annual amounts to the Community Health Centers program out of a new Public Health and Prevention Trust Fund:               <ul style="list-style-type: none"> <li>• \$0.7 billion for FY2011;</li> <li>• \$0.8 billion for FY2012;</li> <li>• \$1 billion for FY2013;</li> <li>• \$1.6 billion for FY2014;</li> <li>• \$2.9 billion for FY2015.</li> </ul> </li> <li>• Separately authorizes and appropriates \$1.5 billion over five years for health center construction and renovation.</li> </ul>
National Health Service Corps Program Funding & Program Changes	<ul style="list-style-type: none"> <li>• Authorizes and appropriates the following annual amounts for the NHSC:               <ul style="list-style-type: none"> <li>• \$317 million for FY 2011;</li> <li>• \$332 million for FY 2012;</li> <li>• \$348 million for FY 2013;</li> <li>• \$365 million for FY 2014;</li> <li>• \$383 million for FY 2015.</li> </ul> </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 teaching to count as clinical practice for up to 20% of obligated service.</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>• Authorizes and appropriates the following annual amounts for the NHSC:               <ul style="list-style-type: none"> <li>• \$290 million for FY 2011;</li> <li>• \$295 million for FY 2012;</li> <li>• \$300 million for FY 2013;</li> <li>• \$305 million for FY 2014;</li> <li>• \$310 million for FY 2016.</li> </ul> </li> <li>• Allows for teaching to count as clinical practice for up to 50% of obligated service.</li> </ul>
Medicaid Eligibility & Financing Changes	<ul style="list-style-type: none"> <li>• Beginning in 2013 expands Medicaid to 150% FPL (\$33,100 for a family of 4) for all those not eligible for Medicare.</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</li> </ul>	<ul style="list-style-type: none"> <li>• Beginning in 2014 Expands Medicaid to 133% FPL in 2014; starting in 2011 states have the option to cover childless adults.</li> <li>• Guarantees that all newly eligible adults receive a benchmark benefit package that at least provides the essential health benefits.</li> </ul>

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	<p>eliminates cost-sharing for preventive services.</p> <ul style="list-style-type: none"> <li>• Requires states to pay for medical services furnished in school-based clinics if covered if furnished in a physician’s office or other outpatient clinic.</li> <li>• Provides a 100% (FMAP) matching rate to states for 2013 and 2014 (reduced to 91% in 2015 and beyond) to cover the cost of newly enrolled individuals.</li> <li>• Extends the enhanced FMAP to states (contained in the ARRA) for an additional six months.</li> <li>• Once CHIP sunsets in 2013 children are entitled to Medicaid or credits in an exchange.</li> </ul>	<ul style="list-style-type: none"> <li>• Provides a 100% FMAP (federal match) for states from 2014-16 and increased FMAP beginning in 2017 to cover the cost of the newly enrolled.</li> <li>• Requires Medicaid coverage of preventive services and eliminates cost-sharing for preventive services.</li> <li>• Extends CHIP program and funding through 2015.</li> </ul>
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 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</li> </ul>	<ul style="list-style-type: none"> <li>• Establishes a Prevention and Public Health Fund with appropriated through 2015 for prevention, wellness and public health activities.</li> <li>• Provides for implementation of a public-private partnership for prevention and health promotion outreach and education.</li> <li>• Awards competitive grants to state, local, and community-based agencies for evidence-based community prevention activities.</li> <li>• Establishes a demonstration program for health centers to receive funding for drafting individualized patient wellness plans.</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, as proposed in the HELP Committee bill.</li> <li>• Establishes a Preventive Services Task Force and a Community Preventive Services Task Force to review effectiveness of clinical and community-based preventive services and make</li> </ul>

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	preventive services, and make recommendations.	recommendations.
Health Insurance Exchange	<ul style="list-style-type: none"> <li>• Requires all individuals to have health insurance starting in 2013.</li> <li>• Provides premium and cost-sharing credits for individuals/families with incomes up to 400% FPL.</li> <li>• All individuals not enrolled in a qualified or grandfathered employer or individual plan, Medicare, Medicaid, VA or TRICARE would be eligible to enroll in any Exchange-participating plan.</li> <li>• Establishes a Public Option to operate within the exchange and provide at least essential benefits.</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 “Consumer Operated and Oriented Plans” program by 2011 to provide subsidies and loans to nonprofits to develop CO-OPs, or cooperatives, to provide insurance statewide within the exchange.</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</li> </ul>	<ul style="list-style-type: none"> <li>• Requires all U.S. citizens and legal residents to purchase health insurance through the individual market, a small group market, a public program or employer; or through the large group market. Exemptions would include religious objectors and undocumented residents.</li> <li>• Provides premium and cost-sharing credits for individuals and families between 100-400% FPL starting in 2014.</li> <li>• Creates state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges administered by a government or non-profit entity with start-up funding available to states starting in 2010.</li> <li>• Creates a community health insurance (public) option to be offered through all state Exchanges that complies with all requirements for other Exchange plans, with provider reimbursement as negotiated by the HHS Secretary.</li> <li>• Authorizes a Consumer Operated and Oriented Plan (CO-OP) program of \$6B to promote the creation of non-profit, member-run health insurance companies in all 50 states and the District of Columbia.</li> <li>• Permits states option to create a Basic Health Plan for uninsured individuals between 133-200% FPL. States would leverage federal subsidies to negotiate with plans, providers, companies, etc to purchase health care at a better value for families.</li> <li>• Requires all plans operating in the Exchanges to pay FQHCs based on the Medicaid PPS rates.</li> </ul>

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	coverage requirements.	
Network Adequacy Standards for Exchange Plans	<ul style="list-style-type: none"> <li>• Basic exchange plans must contract with ‘essential community providers,’ such as eligible 340B entities. The Commissioner specifies the extent and manner of this interaction, especially with regard to HMOs.</li> <li>• For plans using a provider network, the Health Choices Commissioner could establish requirements to ensure network adequacy.</li> <li>• Medicare-participating providers would be considered as participating providers in the public plan unless they opt out.</li> </ul>	<ul style="list-style-type: none"> <li>• Basic exchange plans must contract with ‘essential community providers,’ such as eligible 340B entities.</li> <li>• Private insurers would be required to develop and implement reimbursement structures to provide incentives for high quality care to address: care coordination; hospital readmissions; use of best clinical practices, evidence-based medicine and HIT; wellness; and other measures.</li> </ul>
Required Benefits in Exchange Plans	<ul style="list-style-type: none"> <li>• Creates 4 benefit categories of plans to be offered through the exchange: <ul style="list-style-type: none"> <li>• <i>Basic</i> plan includes essential benefits package and covers 70% of the cost of the plan;</li> <li>• <i>Enhanced</i> plan includes essential benefits package, reduced cost-sharing compared to basic plan and covers 85% of benefit costs;</li> <li>• <i>Premium</i> plan includes essential benefits, further reduced cost sharing and covers 95% of benefit costs; and</li> <li>• <i>Premium Plus</i> plan is a premium plan with additional benefits including oral health and vision care.</li> </ul> </li> <li>• Insurers offering plans in the Exchange must offer at least the essential benefits package.</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;</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>• Creates 4 benefit categories to be offered through individual and small business exchange plans with out of pocket limits at current law HSA levels: <ul style="list-style-type: none"> <li>• <i>Bronze</i> plan includes essential benefits and covers 60% of the cost of the plan;</li> <li>• <i>Silver</i> plan includes essential benefits and covers 70% of the cost of the plan;</li> <li>• <i>Gold</i> plan includes essential benefits, and covers 80% of the cost of the plan;</li> </ul> </li> </ul>

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	<p>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.</p> <ul style="list-style-type: none"> <li>• Requires a report on including oral health benefits in the essential benefit package due one year after enactment.</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 essential benefits package. The Committee would be chaired by the Surgeon General and membership would include public officials and stakeholders.</li> <li>• The public option is considered a qualified health benefits plan with all requirements and privileges of other QHBPs.</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Platinum</i> plan includes essential benefits and covers 90% of the cost of the plan; and</li> <li>• <i>Catastrophic</i> plan to those under 30 or exempt from the mandate and provides catastrophic coverage at current law HSA levels.</li> <li>• The community health insurance (public) option is considered a qualified insurance plan and must offer coverage and benefits according to the standards of other qualified plans.</li> </ul>
Medicaid Interaction with the Exchange	<ul style="list-style-type: none"> <li>• CHIP covers low-income children who are not Medicaid-eligible and expires at the end of 2013, the year that the new Health Insurance Exchange would begin operation. The bill ensures that at the beginning of 2014 (once the exchange is in effect), children who were covered by CHIP could, depending on family income, enroll either in Medicaid or in a plan of their family’s choice in the Exchange with financial assistance to make their new coverage affordable.</li> <li>• Requires a report to Congress with recommendations to ensure exchange coverage is comparable to the average CHIP plan and procedures to transfer CHIP enrollees into the exchange without interrupting coverage or benefits.</li> </ul>	<ul style="list-style-type: none"> <li>• CHIP would be maintained at current eligibility and benefits levels with cost-sharing under current law until 2015; after 2014, CHIP-eligible children who are not able enroll in CHIP due to enrollment caps would be eligible for tax credits in state Exchanges.</li> <li>• States would be required to maintain eligibility levels for Medicaid until 2019. Beginning in 2014, individuals with incomes between 100-400% FPL would be eligible for subsidies to purchase insurance through the Exchanges although individuals with incomes less than 133% FPL are intended to get coverage through Medicaid.</li> </ul>

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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.</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> <li>• Creates a new grant program in Title VII of the PHSa for the establishment and operation of community-based residency training program.</li> <li>• Eligible entities for Title VII program include FQHCs, RHCs, and participants in Teaching Health Centers Demo.</li> <li>• Allows for up to \$220 million over 5 years in dedicated PHIF dollars to be appropriated for the program.</li> </ul>	<ul style="list-style-type: none"> <li>• Authorizes Title VII grant program for development of Teaching Health Centers, defined as community-based ambulatory patient care centers operating a primary care residency program.</li> <li>• Creates new Sec. 340H in the PHSa which would provide per-resident payments to teaching health centers for operation of residency programs, covering both direct and indirect costs. Establishes a baseline year and allows payment for residency slots created above the baseline.</li> <li>• Strictly prohibits hospitals from receiving payments for Sec. 340H reimbursed time.</li> <li>• Appropriates directly \$230 million in funding for Sec. 340H over 5 years.</li> </ul>
Reimbursement for Primary Care Physicians	<ul style="list-style-type: none"> <li>• The Secretary would negotiate rates under the public option with providers to be no less than Medicare rates and no more than comparable qualified health benefits plans.</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> <li>• FQHC preventive services are updated to include an expanded list of preventives services covered under Medicare (according to the provisions in the MATCH Act).</li> </ul>	<ul style="list-style-type: none"> <li>• FQHCs would be reimbursed through a Prospective Payment System (similar to that for FQHCs under Medicaid) by private insurance plans participating in the new exchanges.</li> <li>• FQHCs’ Medicare reimbursement would be updated to a new funding mechanism based on costs and the current, outdated cap would be eliminated.</li> <li>• FQHC preventive services are updated to include an expanded list of preventives services covered under Medicare (according to the provisions in the MATCH Act).</li> <li>• The Secretary would negotiate rates under the consumer health insurance (public) option with non-FQHC providers.</li> </ul>
Medical Home & Coordinated Care Demonstrations	<ul style="list-style-type: none"> <li>• Establishes two 5-year Medicare pilots for (1) independent medical homes (single provider) and (2) community-based medical homes (non-profit entities); provides funding to support implementation costs.</li> </ul>	<ul style="list-style-type: none"> <li>• Authorizes a new Center for Medicare Innovation to carry out innovative projects, such as medical homes and ACOs (below).</li> <li>• Creates a new Medicaid state plan option in 2011 under which enrollees with two or more chronic conditions including</li> </ul>

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	<ul style="list-style-type: none"> <li>• Creates a Medicaid Medical Home Pilot program to which a State may apply for approval to test either or both of the Medicare medical home models (above).</li> <li>• Creates a grant program establishing Collaborative Care Networks for safety net hospitals to help decrease ER use and improve care coordination for low-income, underserved individuals; requires each network include at least 1 FQHC, among other safety net provider entities.</li> <li>• Creates a grant program to assist in the development of integrated healthcare delivery systems to serve defined communities; Grants will go to groups representing a balanced consortium and are required to include at least 1 FQHC, among other safety net provider entities.</li> <li>• Requires the Secretary to improve coordination of care for dual eligibles through a new office or program within CMS.</li> </ul>	<p>behavioral health conditions (especially those with at least 1 seriously and persistent mental health condition) qualify for care under a team of health providers offering a comprehensive list of services; teams can be free-standing, virtual, at a CHC, hospital, community mental health center, clinic, physician’s office or group practice.</p> <ul style="list-style-type: none"> <li>• Establishes Medicaid and Medicare demonstration projects where states apply to the CMS Secretary to allow providers who meet certain criteria to be recognized as an Accountable Care Organization (ACO) and be eligible to share in the federal and state cost savings achieved by Medicaid, CHIP and Medicare.</li> <li>• Establishes a new office within CMS for the coordination of care for dual eligibles.</li> </ul>
FTCA For Volunteers	<ul style="list-style-type: none"> <li>• Guarantees Federal Tort Claims Act protections to physicians and other health professionals who volunteer services at health centers.</li> </ul>	
HPSA / MUA Shortage Designation Guidelines		<ul style="list-style-type: none"> <li>• Would establish a process of “negotiated rulemaking” between HHS and stakeholders to determine new criteria and methodology for defining Health Professional Shortage Area (HPSA) and Medically Underserved Area (MUA) measurements.</li> </ul>