

HEALTH CENTER RELATED PROVISIONS OF CONGRESSIONAL HEALTH REFORM PROPOSALS

Provision	House	Senate	
	<i>Affordable Health Care For America Act (HR 3962)</i>	<i>HELP Committee Bill</i>	<i>Finance Committee Bill</i>
Health Centers Program Funding & Program Changes	<ul style="list-style-type: none"> • 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"> • \$1 billion for FY 2011; • \$1.5 billion for FY 2012; • \$2.5 billion for FY 2013; • \$3 billion for FY 2014; • \$4 billion for FY 2015; 	<ul style="list-style-type: none"> • 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. • 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). 	
National Health Service Corps Program Funding & Program Changes	<ul style="list-style-type: none"> • Authorizes \$349 million from 2011 through 2015 for increases to the NHSC field line, out of the PHIF; and • Authorizes \$1.4 billion from 2011 through 2015 for increases to the NHSC recruitment line (scholarships and loan repayment), out of the PHIF. • Allows for part-time service to satisfy loan or scholarship obligations, provided commitment time is increased, or award is reduced. • Allows for teaching to count as clinical practice for up to 20% of obligated service. • Loan repayment amount increased to \$50,000 and after 2011, Secretary may increase to reflect inflation. 	<ul style="list-style-type: none"> • 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. 	
Medicaid Eligibility & Financing Changes	<ul style="list-style-type: none"> • Expands Medicaid to 150% FPL (\$33,100 for a family of 4) in 2013 for all those not eligible for Medicare. • Deems children born in the U.S. who are not otherwise covered to be Medicaid eligible. • Requires Medicaid coverage of preventive services and eliminates cost-sharing for preventive services. 	<ul style="list-style-type: none"> • Assumes an expansion of Medicaid to 150% of poverty, improvements to facilitate enrollment, a maintenance of effort by the States, and increased FMAP levels. <p><i>Note: Medicaid is not in the HELP Committee's jurisdiction.</i></p>	<ul style="list-style-type: none"> • Expands Medicaid to 133% FPL in 2014; starting in 2011 states have the option to cover childless adults. • States will receive an increased FMAP through 2019 to cover costs of the newly eligible.

HEALTH CENTER RELATED PROVISIONS OF CONGRESSIONAL HEALTH REFORM PROPOSALS

Provision	House	Senate	
	<i>Affordable Health Care For America Act (HR 3962)</i>	<i>HELP Committee Bill</i>	<i>Finance Committee Bill</i>
	<ul style="list-style-type: none"> 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. Provides a 100% matching rate to states for 2013 and 2014 (reduced to 91% in 2015 and beyond) to cover the cost of newly enrolled individuals; and Continues the FMAP increase to states from the ARRA for an additional six months. 		
Prevention and Wellness Programs	<ul style="list-style-type: none"> Requires HHS to promote use of a preventive care visit card to encourage use of services. Establishes a Prevention and Wellness Trust to fund prevention and wellness activities, appropriated through 2014. 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. 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. Provides for coordination of prevention and wellness research across agencies. 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 	<ul style="list-style-type: none"> 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. 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. 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; 	<ul style="list-style-type: none"> Improves coverage and access for recommended preventive services and immunizations. Requires HHS to develop criteria for healthy lifestyle programs using relevant, evidence-based resources that address the needs of Medicaid eligible beneficiaries. States may collaborate with community-based programs, non-profit organizations, providers, and faith-based groups, among others. Authorizes \$100 million in funding for these grants during a 5-year period starting 01/11. Appropriate \$25 million for the Secretary to carry out the Childhood Obesity Demonstration Project.

HEALTH CENTER RELATED PROVISIONS OF CONGRESSIONAL HEALTH REFORM PROPOSALS

Provision	House	Senate	
	<i>Affordable Health Care For America Act (HR 3962)</i>	<i>HELP Committee Bill</i>	<i>Finance Committee Bill</i>
	and wellness, identify gaps in preventive services, and make recommendations.	<p>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.</p> <ul style="list-style-type: none"> Establishes a “<i>Prevention and Public Health Investment Fund</i>” to provide for investment in prevention and public health programs (authorized 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"> Requires all individuals to have health insurance starting in 2013. Provides premium and cost-sharing credits for individuals/families with incomes up to 400% FPL. 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. Establishes a Public Option to operate within the exchange and provide at least essential benefits. Establishes the “Health Choices Administration,” led by a Health Choices Commissioner, to establish and run a Health Insurance Exchange (HIE). 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. State-based HIEs could be offered by single states or groups of states as an alternative to the HIE in those areas. 	<ul style="list-style-type: none"> Only U.S. citizens or lawful aliens would be considered eligible individuals. “American Health Benefit Gateways” would be established in each State by States or HHS. 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. 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. 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. 	<ul style="list-style-type: none"> 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. Provides a refundable tax credit for those under 300% FPL. By 2010, establishes state exchanges to facilitate the sale and regulation of insurance plans for individuals and small groups (SHOP Exchange, defined as 1-50, or up to 100 at state option). Establishes federal rating, issue, renewability and pre-existing condition rules and creates a high risk pool upon enactment-2013 for those who have been denied coverage due to a pre-existing condition. Authorizes a Consumer Operated and Oriented Plan (CO-OP) program of \$6B to promote the creation of non-profit, member-run health insurance

HEALTH CENTER RELATED PROVISIONS OF CONGRESSIONAL HEALTH REFORM PROPOSALS

Provision	House	Senate	
	<i>Affordable Health Care For America Act (HR 3962)</i>	<i>HELP Committee Bill</i>	<i>Finance Committee Bill</i>
	<ul style="list-style-type: none"> 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. 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. 	<ul style="list-style-type: none"> The bill also includes a sense of the Senate that all Americans should have access to care in a manner similar to the FEHBP. 	<p>companies in all 50 states and the District of Columbia.</p> <ul style="list-style-type: none"> Requires all state-licensed insurers in the individual and small group markets to participate in state exchanges. Establishes national plans to operate across state lines. Exchanges must develop a standardized format for presenting insurance options. Exchanges are also required to create a web portal to help consumers find insurance, maintain a call center for customer service, and establish procedures for enrolling individuals and businesses and for determining eligibility for tax credits. AMENDED: In 2015 gives states an opt-out if they provide a coverage plan that at least as comprehensive as that under the bronze plan in this bill. AMENDED: Creates non-Medicaid Basic Health Plans, a federally funded state option for those with incomes above Medicaid eligibility but below 200% FPL. States leverage federal subsidies to negotiate with plans, providers, companies, etc to purchase health care at a better value for families. Benefits, cost sharing would be set at the levels established for this population elsewhere in the bill.
Network Adequacy Standards for Exchange Plans	<ul style="list-style-type: none"> For plans using a provider network, the Health Choices Commissioner could establish requirements to ensure network adequacy. Basic exchange plans must contract with ‘essential community providers,’ defined as eligible 340B 	<ul style="list-style-type: none"> 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; 	

HEALTH CENTER RELATED PROVISIONS OF CONGRESSIONAL HEALTH REFORM PROPOSALS

Provision	House	Senate	
	<i>Affordable Health Care For America Act (HR 3962)</i>	<i>HELP Committee Bill</i>	<i>Finance Committee Bill</i>
	<p>entities. The Commissioner specifies the extent and manner of this interaction, especially with regard to HMOs.</p> <ul style="list-style-type: none"> Medicare-participating providers would be considered as participating providers in the public plan unless they opt out. 	<p>wellness; and other measures.</p> <ul style="list-style-type: none"> AMENDED: 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. 	
Required Benefits in Exchange Plans	<ul style="list-style-type: none"> Creates 4 benefit categories of plans to be offered through the exchange: <ul style="list-style-type: none"> <i>Basic</i> plan includes essential benefits package and covers 70% of the cost of the plan; <i>Enhanced</i> plan includes essential benefits package, reduced cost-sharing compared to basic plan and covers 85% of benefit costs; <i>Premium</i> plan includes essential benefits, further reduced cost sharing and covers 95% of benefit costs; and <i>Premium Plus</i> plan is a premium plan with additional benefits including oral health and vision care. Insurers offering plans in the Exchange must offer at least the essential benefits package. 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 	<ul style="list-style-type: none"> 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. 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). Insurers would be required to cover preventative health services with minimal cost sharing. Creates the “Medical Advisory Council” to evaluate items and services that constitute the “essential health benefits.” 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. 	<ul style="list-style-type: none"> Creates 4 benefit categories to be offered through individual and small business exchange plans: bronze (65% actuarial value); silver (70% AV); gold (80% AV) and platinum (90% AV). OOP maximum for each plans would depend on income (between 100-400% FPL). All plans would include preventive services (with no cost sharing), primary care, ER services, hospitalization, physician services, outpatient, day surgery/anesthesia, medical/surgical care, imaging/xrays, maternity and newborn care, pediatric services including dental and vision, prescription drugs, radiation/chemo, and mental health and substance abuse services (per the Wellstone Act of 2008). HHS Secretary would define and modify these benefits. Also creates a “young invincible plan” available to those 25 years and younger (provides catastrophic coverage only with the coverage level set at the HSA current law w/ prevention benefits exempt from deductibles. The National Association of Insurance Commissioners (NAIC) will develop standards as to how benefit categories should be implemented by

HEALTH CENTER RELATED PROVISIONS OF CONGRESSIONAL HEALTH REFORM PROPOSALS

Provision	House	Senate	
	<i>Affordable Health Care For America Act (HR 3962)</i>	<i>HELP Committee Bill</i>	<i>Finance Committee Bill</i>
	<p>services.</p> <ul style="list-style-type: none"> • Requires a report on including oral health benefits in the essential benefit package due one year after enactment. • 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. • 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. • The public option is considered a qualified health benefits plan with all requirements and privileges of other QHBPs. 		<p>2010 (or the federal government will preempt). After NAIC publishes these standards, the state insurance commissioners will ensure that insurance companies offering national plans are providing plans that are compliant.</p>
Medicaid Interaction with the Exchange	<ul style="list-style-type: none"> • 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. • 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 		<ul style="list-style-type: none"> • Starting in 2014, those under 100% FPL would be eligible for Medicaid; 100-133% FPL would be able to choose between Medicaid and state exchange plans. States must ensure that all children of parents choosing the exchange continue to receive benefits (including EPSDT) that children get under Medicaid. • AMENDED: Once beneficiaries can choose state exchange plans (starting in 2014): Medicaid cost-sharing and out of pocket limits (5%) still apply to children; states can choose to extend full Medicaid benefits to those over 133% FPL through traditional Medicaid or a supplemental wrap.AMENDED: “High need states” would get additional FMAP assistance

HEALTH CENTER RELATED PROVISIONS OF CONGRESSIONAL HEALTH REFORM PROPOSALS

Provision	House	Senate	
	<i>Affordable Health Care For America Act (HR 3962)</i>	<i>HELP Committee Bill</i>	<i>Finance Committee Bill</i>
	exchange without interrupting coverage or benefits.		<p>to fund costs incurred from new enrollees who added between 2014-2018.</p> <ul style="list-style-type: none"> • AMENDED: the CHIP program would remain unchanged. On enactment through 2019, states would be required to maintain income eligibility levels for current Medicaid and CHIP children and would receive the current law enhanced CHIP match rate. • AMENDED: requires that enrollees can enroll in Medicaid, CHIP and tax credits (all subsidy programs) through a single, streamlined application form which they can complete online, in person, by mail or telephone. HHS Secretary is required to issue guidance to states on enrolling vulnerable populations in Medicaid and CHIP.
Teaching Health Centers	<ul style="list-style-type: none"> • 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. • 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. • Includes a new grant program in Title VII of the PHSA for the establishment and operation of community-based residency training programs. 		<ul style="list-style-type: none"> • AMENDED: Extends eligibility for Direct Graduate Medical Education (DGME) and indirect expenses associated with residency programs to Teaching Health Centers with primary care residency programs. THCs could be FQHCs, community mental health centers, or health centers operated by Indian Health Services. HHS Secretary would determine payments, programs would be in addition to existing Medicare-supporting residency slots. \$20 million would be transferred from the Medicare Part A trust fund for FY2011 – FY2015. • AMENDED: Includes a new grant program in Title VII of the PHSA for the establishment and operation of community-based residency training program.

HEALTH CENTER RELATED PROVISIONS OF CONGRESSIONAL HEALTH REFORM PROPOSALS

Provision	House	Senate	
	<i>Affordable Health Care For America Act (HR 3962)</i>	<i>HELP Committee Bill</i>	<i>Finance Committee Bill</i>
Reimbursement for Primary Care Physicians	<ul style="list-style-type: none"> 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. 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. FQHC preventive services are updated to include an expanded list of preventives services covered under Medicare (according to the provisions in the MATCH Act). 		<ul style="list-style-type: none"> AMENDED: HHS Secretary will establish a PPS for Medicare-covered services furnished by FQHCs, which will set an initial payment based on the 2-year average of a CHC's 'reasonable costs' for providing care and include an annual update. AMENDED: Insurers in state exchanges would be required to pay FQHC providers at levels no less than would be paid under Section 1902(bb) of the SSA for such services. States that "the PPS payment rate [established for FQHCs under Medicare] would be extended to health plans and health insurers participating in the state exchanges. Insurers participating in the state exchanges would be required to provide payment for services furnished to enrollees by FQHCs must pay these providers at the PPS rate described above." FQHC preventive services are updated to include an expanded list of preventives services covered under Medicare (according to the provisions in the MATCH Act).
Medical Home & Coordinated Care Demonstrations	<ul style="list-style-type: none"> Creates a Medicaid Medical Home Pilot program to which a State may apply for approval and which must reduce health disparities. 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 	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> Creates a new Medicaid state plan option in 2011 under which enrollees with two or more chronic conditions including 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

HEALTH CENTER RELATED PROVISIONS OF CONGRESSIONAL HEALTH REFORM PROPOSALS

Provision	House	Senate	
	<i>Affordable Health Care For America Act (HR 3962)</i>	<i>HELP Committee Bill</i>	<i>Finance Committee Bill</i>
	<p>safety net provider entities.</p> <ul style="list-style-type: none"> 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. Requires the Secretary to improve coordination of care for dual eligibles through a new office or program within CMS. 		<p>mental health center, clinic, physician’s office or group practice.</p> <ul style="list-style-type: none"> AMENDED: Establishes a Medicaid demonstration project where states apply to the CMS Secretary to allow pediatric 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 and CHIP.
FTCA For Volunteers	<ul style="list-style-type: none"> Guarantees Federal Tort Claims Act protections to physicians and other health professionals who volunteer services at health centers. 		