

## Comparison of Selected Provisions of House and Senate Health Reform Legislation

National Association of Public Hospitals and Health Systems  
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(as of December 22, 2009)

	<b>Final House Legislation, H.R. 3962</b> Passed by House of Representatives on 11/7/09	<b>Senate Legislation, H.R. 3590</b> Combined Bill Released 11/18/2009, as amended by Manager's Amendment Released on 12/19/08
<b>Disproportionate Share Hospital (DSH) Programs</b>	<p><i>Medicaid DSH</i> Reduces total Medicaid DSH spending by \$10 billion over ten years: \$1.5 billion in FY 2017, \$2.5 billion in FY 2018, and \$6 billion in FY 2019, and contains provisions intended to ensure that these reductions result in decreased payments. More significant reductions will be targeted at states 1) that have the lowest percentage of uninsured residents (based on audited hospital cost reports) and 2) that do not target DSH payments to hospitals with high Medicaid volumes and high rates of uncompensated care. The Secretary is required to publish notice of DSH allotments as of January 1 of each year in which reductions are scheduled to occur (e.g., January 1, 2016 for the fiscal year 2017 reduction).</p> <p><i>Medicare DSH</i> According to the Congressional Budget Office, reduces Medicare DSH payments by an estimated \$10 billion over ten years. Reduces total Medicare DSH payments beginning in 2017 (by an amount recommended in the DSH report), if there is more than an 8% decrease in the national rate of uninsurance between 2012 and 2014. Simultaneously, provides an additional Medicare DSH payment, using a formula to be determined by the Secretary, targeted to hospitals based on uncompensated care criteria to be established by the Secretary. The aggregate amount of the additional payments may not exceed 50% of the total reduction in Medicare DSH payments.</p> <p>Additionally, the Secretary is required to submit Medicaid and Medicare DSH reports to Congress by January 1, 2016 (as opposed to July 1 in the draft bill)—nine months in advance of the first scheduled reduction in payments on October 1, 2016. The Medicaid DSH report will examine the extent to which there is a continued role for Medicaid DSH payments based on the impact of health reform on the number of uninsured, and provide recommendations on the appropriate targeting and distribution of funds, taking into account the ratio of allotted DSH funds to the number of uninsured individuals in each state. The Medicare DSH report will take into account the impact of health reform on reducing the number of uninsured individuals and provide recommendations on the appropriate amount, targeting and distribution of Medicare DSH payments to compensate for higher Medicaid costs associated with serving low-income beneficiaries and uncompensated care costs.</p>	<p><i>Medicaid DSH</i> According to CBO estimates, reduces total Medicaid DSH spending by \$19 billion over ten years (\$3.4 billion less than under the original Senate bill).</p> <p>Initial cuts are triggered once the state's uninsurance rate decreases 45% relative to fiscal year 2009, which the CBO estimates would not happen until 2015.</p> <ul style="list-style-type: none"> <li>• For most low DSH states, the initial cut will be 25%. If a low-DSH state spent greater than 99.9% of its DSH allotments on average for fiscal years 2004-2008, the reduction will be 17.5%.</li> <li>• For most non low DSH states, the initial reduction will be 50%. If a non low DSH state spent greater than 99.9% of its DSH allotments on average for fiscal years 2004-2008, the reduction will be 35%.</li> </ul> <p>Additional reductions occur in subsequent years based on the product of the percentage reduction in uncovered individuals from the prior year times a certain percentage.</p> <ul style="list-style-type: none"> <li>• For most low DSH states, that percentage will be 27.5% (as compared to 25% under the prior version). If a low DSH state spent greater than 99.9% of its DSH allotments on average for fiscal years 2004-2008, the percentage will be 20%.</li> <li>• For most non low DSH states, the percentage will be 55% (as compared to 50% under the prior version). If a non low DSH state spent greater than 99.9% of its DSH allotments on average for fiscal years 2004-2008, the percentage will be 40%.</li> </ul> <p>No state's allotment may be reduced to less than 50% of its 2012 allotment.</p> <p>Provides Hawaii with a permanent Medicaid DSH allotment.</p> <p><i>Medicare DSH</i> Reduces Medicare DSH payments by an estimated \$24 billion over ten years (up \$3.4 billion from the original Senate bill). Starting no later than 2015, and continuing on an annual basis, the Secretary would reduce current DSH payments by 75%. A portion of these cuts (although a smaller pool than in the original Senate version) would be restored through an additional payment made to reflect hospitals' continued uncompensated care costs. The funding available for these additional payments would be reduced proportional to each percentage point reduction in the uninsured based on projected national rates of uninsurance.</p>

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<p align="center"><b>Medicaid Expansion</b></p>	<p>Effective 2013, extends Medicaid to all individuals with family incomes at or below 150% of the FPL regardless of categorical eligibility.</p> <p>The federal government would pay 100% of the costs of the newly eligible before 2015, and 91% of the costs of the newly eligible from 2015 to 2019 (except for costs of children between current CHIP levels and 150% FPL, for which states will receive the CHIP enhanced match). Imposes a maintenance of eligibility requirement on states that now cover those above 150 percent FPL.</p> <p>Provides an initial 60 days of coverage while eligibility determination is completed to all newborns who are not otherwise covered, regardless of income. (At the end of this period, infants not otherwise covered will continue to be deemed Medicaid eligible.) In addition, states would be given the option of extending coverage to HIV-infected individuals through December 31, 2013, and to women in need of family planning services.</p>	<p>States would be permitted to expand coverage to all non-elderly individuals under 133% FPL on April 1, 2010, and would be required to expand coverage to such individuals beginning on January 1, 2014. Newly eligible adults would be guaranteed a benchmark benefit package.</p> <p>States would be required to maintain existing income eligibility levels at enactment until their state exchange becomes fully operational (although states can receive an exemption from the MOE for non-pregnant, non-disabled adults above 133% FPL between January 2011 and 2014 if they certify that they are experiencing a current or projected budget deficit). States would also be required to maintain income eligibility for currently-eligible children in Medicaid until Sep. 30, 2019.</p> <p>Would require states to determine eligibility based on modified gross income (meaning states would no longer be able to use any income disregards now used to make certain populations with earned and unearned income above 133 % of FPL eligible for services).</p> <p>Would increase the FMAP for expenditures for newly-eligible individuals from 2014 to 2019. For January 2014 to December 2016, the federal government would pay 100 percent of the costs for all states. For 2017 and 2018, states with coverage (including coverage of inpatient hospital services) of both parents and childless adults at or above 100% FPL as of the date of the enactment of health reform initially receive a smaller FMAP increase (30.3 percentage points in 2017, 31.3 in 2018) for their newly covered populations than states with no such current coverage (34.3 percentage points in 2017, 33.3 in 2018). From 2019 on, all states (except Nebraska, as described below) will receive a 32.3 percentage point increase.</p> <ul style="list-style-type: none"> <li>Nebraska will receive 100% FMAP assistance for newly eligible populations even after 2017.</li> </ul> <p>Provides additional assistance to certain states that have already implemented significant coverage expansions:</p> <ul style="list-style-type: none"> <li>An expansion state that would not otherwise benefit from the FMAP increase for newly eligible individuals and has not been permitted to divert a portion of DSH funds to coverage will receive a 2.2 percentage point FMAP increase from January 2014 through September 30, 2019 for expenditures for existing Medicaid populations. (This provision is for Vermont.)</li> <li>The expansion state determined to have had the highest percentage of its population insured during 2008 will receive a 0.5% FMAP increase for all Medicaid expenditures from January 1, 2014 through December 31, 2016. (This provision is for Massachusetts.)</li> </ul> <p>States will not be eligible for enhanced FMAP if they require that political subdivisions pay a greater percentage of the non-federal share for Medicaid or Medicaid DSH payments than on December 31, 2009. Clarifies that voluntary contributions by political subdivisions are not considered required contributions. It also applies this interpretation of required contributions to the ARRA enhanced FMAP local share provision.</p> <p>Provides a limited extension of the ARRA enhanced FMAP beginning January 2011 for disaster-recovery states, scored at \$100 million.</p> <p>Adds former foster children as a mandatory population as of 2014. Adds a new</p>

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<p><b>Medicaid Expansion</b></p>		<p>optional categorically-needy eligibility group for certain non-pregnant individuals who would be entitled to family planning services and supplies.</p>
<p><b>Other Medicaid/CHIP</b></p>	<p>Extends the enhanced FMAP provided under the American Reinvestment and Recovery Act, which is slated to expire on December 31, 2010, for an additional six months (through June 30, 2011).</p> <p>Eliminates cost-sharing for preventive services in Medicaid.</p> <p>Extends the transition period for states with a Medicaid managed care tax to October 1, 2010.</p> <p>Expands the mission of the Medicaid and CHIP Payment and Access Commission (MACPAC), which was authorized under the Children's Health Insurance Program Reauthorization Act (CHIPRA), to include assessment of all Medicaid and CHIP eligible individuals' access to Medicaid services.</p> <p>Requires states to amend their Medicaid State Plans to require Medicaid participating hospitals to report charge information for the most common inpatient and outpatient hospital services, the Medicare and Medicaid reimbursement amount for such services, and information about reduced charges for patients with financial need.</p> <p>Repeals the CHIP program beginning in 2014, and moves CHIP-eligible children to Medicaid or the Exchange. States must maintain current eligibility for children until that date. For children moved into the Medicaid program, states will receive the CHIP enhanced match rate for children above current CHIP eligibility levels and up to 150% FPL.</p>	<p>States that opt to provide Medicaid coverage for certain preventive services and remove cost-sharing for those services would receive a 1 percentage point FMAP bump for those services. Would require coverage of comprehensive tobacco cessation services for pregnant women.</p> <p>Requires MACPAC to assess Medicaid and CHIP policies related to eligibility, enrollment, coverage, and to review regulations affecting Medicaid. Requires MedPAC to report aggregate Medicaid trends in spending, utilization and financial performance for providers where, on an aggregate national basis, a significant portion of revenue and/or services is associated with Medicaid. MedPAC is directed to coordinate with MACPAC as necessary.</p> <p>Expands the mission of the Medicaid and CHIP Payment and Access Commission (MACPAC), which was authorized under the Children's Health Insurance Program Reauthorization Act (CHIPRA), to include assessment of adult access to Medicaid services, including for dual eligibles.</p> <p>Requires the Secretary to issue regulations within 180 days of enactment to increase the transparency of the Medicaid waiver development and approval processes. Application for or renewal of any 1115 demonstration that would result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing will be subject to new CMS review, including: public notice and comment and other public input; requirements related to goals, cost and coverage projections; submission of specific plans to ensure compliance; and, periodic submission of reports and evaluation.</p> <p>Extends current CHIP reauthorization through September 30, 2015. Maintains the current CHIP structure and requires states to maintain income eligibility levels for currently eligible children in CHIP until Sep. 30, 2019. Provides a 23 percentage point increase in the CHIP match rate for expenses related to all CHIP enrollees, subject to a cap of 100%, beginning in FY2016 through FY2019. Children who cannot enroll in CHIP due to capped allotments will be deemed ineligible for CHIP and eligible for tax credits in the Exchanges.</p>
<p><b>Delivery System Reforms</b></p>	<p>Establishes and authorizes funding for Community-Based Collaborative Care Networks, which are defined as consortia of providers with a joint governance structure that provide a comprehensive range of coordinated and integrated health care services for low-income patient populations or medically underserved communities. Each Network must include a safety net hospital that serves a high volume of low-income patients and all FQHCs within the Network's geographic area, unless such providers do not exist, refuse to participate, or place unreasonable demands on such participation. Each Network is required to provide a set of core services, including support services, which are approved by the Secretary and must assign each patient to a primary care provider. The bill authorizes such sums as may be necessary to carry out the program between 2011 and 2015.</p> <p>Creates medical home pilot programs in Medicare and Medicaid. The Medicare pilot program, replacing the existing medical home demonstration, would evaluate 1) an</p>	<p>Establishes and authorizes funding for Community-Based Collaborative Care Networks, which are defined as consortia of providers with a joint governance structure that provide a comprehensive range of coordinated and integrated health care services for low-income patient populations. Each Network must include a safety net hospital that serves a high volume of low-income patients and all FQHCs within the Network's geographic area, unless such providers do not exist, refuse to participate, or place unreasonable demands on such participation. The bill authorizes such sums as may be necessary to carry out the program between 2011 and 2015.</p> <p>Provides grants to establish community health teams to support a medical home model. States or state-designated entities will be eligible to receive grants to</p>

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<p align="center"><b>Delivery System Reforms</b></p>	<p>independent patient-centered medical home model targeting the top half of high-need Medicare beneficiaries (using a risk score specified by the Secretary) with multiple chronic illnesses; and 2) a community-based medical home model targeting a broader range of Medicare beneficiaries. The bill authorizes payments for such programs. The Medicaid medical home pilot program would provide certain incentives including a higher matching rate for administrative expenditures during the pilot period.</p> <p>Establishes Medicare and Medicaid accountable care organization ("ACO") pilot programs to test different ACO payment incentive models designed to constrain expenditure growth and improve quality. To participate, an ACO would have to include a physician group and could include hospitals and other providers. Aggregate expenditures for an ACO under the pilot program could not result in higher spending for participating beneficiaries than would otherwise occur without the program. To establish a Medicaid ACO, states would be required to apply to the Secretary for approval. States would receive an enhanced administrative match of 90 percent for the first two years of the pilot program and 75% for the next three years of the pilot program.</p> <p>Requires the Secretary of HHS to develop a plan to establish Medicare bundled payments for post acute services. To further promote bundled payments, requires the Secretary to convert the Medicare acute care episode demonstration program into a voluntary pilot program and to expand the program to include post acute care services. Specifically permits the Secretary to apply bundled payments to 1) hospitals and physicians; 2) hospitals and post-acute care providers; 3) hospitals, physicians, and post-acute care providers; or 4) combinations of post-acute care providers. Defines "Collaborative Care Networks" and requires the Secretary to apply bundled payments to CCNs. The bill authorizes such sums as may be necessary to fund the program. Funds would need to be appropriated through the regular appropriations process.</p> <p>Reduces hospital payments, for hospital discharges on or after October 1, 2011, to account for "excess readmissions" for a limited number of conditions. Hospitals with higher risk-adjusted readmission rates for these conditions would receive lower average per case payments. Hospitals that have a disproportionate patient percentage of at least 30% would be eligible for a payment adjustment (subject to an aggregate cap of 5% of estimated savings from the readmissions policy and a hospital-specific cap equal to the estimated savings attributable to the hospital) to pay for transitional care activities to address patient noncompliance resulting in readmissions, including care coordination services. Priority for the payment adjustment would be given to hospitals serving Medicare beneficiaries at the highest risk for readmission or for a poor transition from the hospital to a post-hospital site of care.</p>	<p>establish community-based multi-disciplinary, interprofessional teams that will establish contractual relationships with primary care providers to provide support services, support medical homes, and improve quality and coordination of care. Health teams may include specialists, nurses, nutritionists, dieticians, social workers, behavioral and mental health providers, and licensed complementary and alternative medicine practitioners. The grants may also be used to provide capitated payments to primary care providers.</p> <p>Creates a new Medicaid state plan option under which Medicaid enrollees with chronic conditions could designate a provider as their health home, including providers based at a hospital. The CMS Innovation Center (described below) may fund patient-centered medical home models for high need individuals.</p> <p>By January 1, 2012, requires the Secretary to establish a shared savings program, under which qualifying groups of providers, including hospitals, would be recognized as Medicare ACOs and would share in Medicare cost savings above a certain threshold. The Secretary may pay ACOs using a partial capitation model or other payment models that improve quality and efficiency and may give preference to ACOs participating in similar payment arrangements with other payers. Prior to implementation of the program, ACOs could participate in the physician group practice demonstration. Also creates a Medicaid ACO demonstration beginning January 1, 2012 for certain pediatric medical providers.</p> <p>Establishes a Medicare pilot program to evaluate alternative payment methodologies that promote care coordination, including bundled payments, for 10 conditions to be selected by the Secretary (up from 8 in the base bill). Authorizes the Secretary to expand the pilot if it reduces spending without decreasing quality, and directs the Secretary to include continuing care hospitals in the pilot. Creates a Medicaid bundled payment demonstration, to begin on January 1, 2012 in up to 8 states, under which hospitals would receive bundled payments for a hospitalization and physician services provided during the hospitalization.</p> <p>Establishes a Medicaid Global Payments demonstration available in up to 5 states from 2010 to 2012 under which a large, safety net hospital system could alter its provider payment system from FFS to a capitated, global payment structure. Would be evaluated by the CMS Innovation Center (discussed below).</p> <p>Adopts readmissions provisions that largely mirror language in H.R. 3962, but does not provide for financial assistance to disproportionate share hospitals. Beginning October 1, 2012 (one year later than the House bill), reduces hospital payments to account for preventable readmissions for a limited number of high-volume or high-expenditure conditions to be selected by the Secretary of HHS. Payment reductions would apply to all admissions, whereas the Senate Finance bill previously limited reductions to discharges relating to excess readmissions. Reductions would be capped at 3% (compared to 5% in the House bill). Planned readmissions would be exempt. Hospitals' readmission rates would be publicly available on the CMS Hospital Compare website. Requires HHS to develop a program for hospitals with high risk-adjusted readmission rates (as determined by the Secretary) to improve readmission rates through the use of patient safety organizations. Establishes a five-year pilot program, the Community Care Transitions Program, for hospitals with high readmission rates to encourage the provision of patient-centered, evidence-based care</p>

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<p align="center"><b>Delivery System Reforms</b></p>	<p>Notably, H.R. 3200 does not contain a value-based purchasing program proposal; however, the bill requires the IOM to consider the adoption of a value index based on a composite of quality and cost measures that would adjust provider payments on a regional or provider-level basis. Recommendations regarding the adoption of such a program would be included as part of the IOM's recommended Medicare payment system change proposals to the HHS Secretary (see Provider Payment Adequacy below).</p> <p>Establishes a Center for Medicare and Medicaid Innovation at CMS. The Center would test, evaluate and expand different payment models and methodologies under Medicare, Medicaid, and CHIP that aim to foster patient-centered care, improve quality, and reduce the cost of care. The Center would be funded through the Medicare Trust Fund and would receive \$350 million in FY 2010, \$440 million in FY 2011, and \$550 million in FY 2012 and an inflation-adjusted amount for each succeeding fiscal year.</p>	<p>transition services. Priority would be given to eligible hospitals that serve a disproportionate share of medically underserved populations.</p> <p>Implements a budget neutral value-based purchasing program for hospitals, under which Medicare IPPS payments would be reduced by 1% in fiscal year FY 2013, 1.25% in FY 2014, 1.5% in FY 2015, 1.75% in FY 2016, and 2% in FY 2017 and thereafter to fund incentive payments to hospitals achieving certain quality-based performance scores. Performance standards would measure both the attainment of performance thresholds and the degree of quality improvement and would not include readmissions measures.</p> <p>Establishes a CMS Innovation Center by January 2011 and appropriates \$15 billion over ten years to the Center to design, implement, test, evaluate and expand different payment models and methodologies under Medicare, Medicaid, and CHIP that aim to foster patient-centered care, improve quality, and reduce the cost of care. Suggests various models for the Center to consider testing, which could include, but would not be limited to, coordination of care for dual eligibles, establishment of Healthcare Innovation Zones centered around teaching hospitals, and utilization of telehealth services, particularly in medically underserved areas, among other models.</p> <p>Creates a Federal Coordinated Health Care Office within CMS to improve program coordination and integration of care for Medicare and Medicaid dual eligibles.</p> <p>Establishes a three-year, \$75 million Medicaid demonstration project to expand the number of emergency inpatient psychiatric care beds available in communities.</p>
<p align="center"><b>Provider Payment Adequacy</b></p>	<p><i>Medicare</i> Provides a Medicare payment bonus of bonus of 5% for primary care services furnished by primary care providers (10% for providers in Health Professional Shortage Areas) after January 1, 2011.</p> <p>Requires the IOM to study the geographic variation of health care expenditures and, by April 2011, to recommend payment system changes to address Medicare spending variations by promoting high value care with an emphasis on high-volume, high-cost conditions. Requires the Secretary to submit an implementation plan, taking into consideration the IOM's proposals, to the House and Senate. If the House and Senate fail to adopt a resolution of disapproval within 145 days, the Secretary will issue a rule adopting the implementation plan. Also directs the IOM to study and make recommendations regarding the Medicare wage adjustment factors and requires the Secretary to revise the geographic adjustment factors for physician and inpatient hospital services based on the IOM's recommendations. No reductions in the geographic adjustment factors could be made until 2014, and any payment changes after 2014 would have to be budget neutral.</p> <p>Adjusts downward (but not below zero) the annual market basket increase for hospitals for both inpatient and outpatient services to account for productivity gains, but does not otherwise impose hospital market basket reductions.</p>	<p><i>Medicare</i> Establishes a five-year, 10% Medicare bonus for select E&amp;M codes furnished by physicians and other primary care providers (e.g., nurse practitioners, clinical nurse specialists, or physician assistants) and major surgical procedures furnished by general surgeons in a health professional shortage area, beginning January 1, 2011. The Manager's Amendment removed a budget-neutrality adjustment that would have offset half of the cost of these bonuses.</p> <p>Temporarily restores geographic hospital wage index reclassification ratios to pre-October 1, 2008 levels until the first fiscal year one year after the Secretary issues a proposal to revise the hospital wage index taking into account issues specified in MedPAC's June 2007 report.</p> <p>Establishes the Independent Medicare Advisory Board, outside of MedPAC, that would submit proposals aimed at reducing excess cost growth in the Medicare program by targeted amounts to Congress and the President annually beginning January 1, 2014. For certain providers, including Medicare Advantage and Part D Plans, the Advisory Board's proposal automatically would be enacted if Congress fails to pass an alternative package that cuts costs by the same amount. For hospitals and other providers scheduled to receive a reduction to inflationary payment updates greater than their productivity adjustment through 2019, the Advisory Board's recommendations would be non-binding until 2020.</p> <p>Adjusts downward the annual market basket increase for inpatient and outpatient hospital services to account for economy-wide productivity gains, beginning in 2012.</p>

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<p align="center"><b>Provider Payment Adequacy</b></p>	<p><i>Public Plan</i> For new public plan: The Secretary is required to negotiate public plan rates with health care providers. Negotiated rates may not exceed the average rates paid by Exchange plans and may not be less than Medicare rates. Medicare providers will be deemed to participate in the public plan, unless they opt out.</p> <p><i>Medicaid</i> Increases fee-for-service and managed care payments for primary care services provided by physicians and other health professionals (e.g., nurse practitioners or physician assistants) to 80% of the adjusted payment Medicare Part B rates in 2010, 90% in 2011, and 100% in 2012 (which are increased by five percent, or by ten percent for physicians practicing in HPSAs). The federal government would pay 100% of the costs of the amount of the increased payments before FY 2015, and 91% of the costs from FYs 2015 to 2019.</p> <p>Requires states to submit annual reports to CMS on provider payments rates under Medicaid, including the final rates, the methodologies used to determine those rates, and justifications for the rates.</p> <p>Requires states to submit annual Medicaid State Plan amendments specifying provider payment rates and providing any additional data necessary to assist the Secretary in evaluating the adequacy of the rates.</p> <p>Requires the Government Accountability Office (GAO) to submit by February 15, 2011 two reports: 1) a report on the effect of changing FMAP (removing the 50% floor and the 83% ceiling and revising the current formula), and 2) a report on the use of administrative payments under Medicaid.</p>	<p>Unlike H.R. 3962, productivity adjustments may result in negative market basket changes and a reduction in payment rates from the preceding fiscal year. For inpatient and outpatient hospitals, also implements market basket reductions of 0.25% in 2010 and 2011, 0.1% in 2012 and 2013 (reduced from 0.2% in the base bill), and 0.2% in 2014 through 2019.</p> <p>Establishes a prospective payment system beginning October 1, 2014 for Medicare-covered services furnished by FQHCs. Payment rates under the PPS would be based on 100% of the estimated reasonable costs (as opposed to 103% of estimated program expenditures under the base bill) that would have been incurred in the first year had the PPS not been implemented.</p> <p><i>Exchange</i> Requires Exchange plans to pay FQHC rates that are at least as high as payments to FQHCs under Medicaid.</p> <p>Provides grants to states to establish medical reimbursement data centers that, among other things, will develop fee schedules and other database tools that fairly and accurately reflect market rates for medical services and the geographic differences in those rates, and provide this information to insurers, providers and the public.</p> <p><i>Medicaid</i> Extends the Recovery Audit Contractors program to Medicaid.</p>
<p align="center"><b>GME/IME</b></p>	<p><i>Medicare</i> Redistributes unused residency positions to be used for primary care training, providing preference to hospitals with programs that place greater emphasis on training in FQHCs, provider-based outpatient departments, and hospitals with positions in excess of the applicable resident limit.</p> <p>Requires Secretary to issue regulations defining process for redistribution of resident allotments from closed or acquired hospitals.</p> <p>Would count time spent on certain training activities toward DGME and IME payments, effective retroactively for unsettled cost reports or those under appeal.</p> <p>Amends Medicare direct GME and IME payment rules to encourage training in "non-provider" settings, and requires an OIG report on the impact of these changes.</p> <p>Creates a Medicare demonstration program for the operation of primary care</p>	<p><i>Medicare</i> Would redistribute 65% of unused residency slots to increase primary care and general surgery residencies. 70% of the pool of redistributed slots would be reserved for hospitals in states with resident to population ratios in the lowest quartile. Among other factors, would consider the likelihood of a hospital participating in an innovative delivery model that promotes quality and care coordination when redistributing the slots to particular hospitals.</p> <p>Requires the Secretary to issue regulations defining the process for redistribution of resident allotments from closed or acquired hospitals, and outlines priorities for redistribution.</p> <p>Would count time spent on certain training activities toward DGME and IME payments, effective for cost reporting periods beginning on or after July 1, 2009 for DGME and October 1, 2001 for IME, although settled cost reports would not be reopened unless under appeal.</p> <p>Would provide flexibility in counting time spent by residents in nonhospital settings toward Medicare direct and indirect GME payments effective July 1, 2010.</p>

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<p align="center"><b>GME/IME</b></p>	<p>residency programs by approved "teaching health centers" (including FQHCs or rural health centers) in cooperation with a teaching hospital, in which the health center would be eligible for payment for its own DGME costs and those of its contracting hospital.</p> <p><i>Medicaid</i> Provides explicit authority for payment of the costs of graduate medical education "whether provided in or outside of a hospital" as part of medical assistance under the Medicaid statute, undermining CMS' reasoning for elimination of Medicaid GME payments in its 2007 proposed rule. Requires states to submit to CMS on an annual basis information on how payments are being used to fund GME. Requires CMS to publish a rule by December 31, 2011, outlining program goals for the use of Medicaid GME funds.</p>	<p>Would make qualified teaching health centers (including FQHCs among other designated clinics) eligible for DGME and IME payments for operating primary care residency programs. Appropriates \$230 million for FY2011 through 2015 for these payments. Also would create new Teaching Health Centers Development Grants to establish or expand such residency programs and authorizes \$125 million in funding from FY2010 through 2012, and additional funding as necessary in later years, for these grants.</p> <p>Creates a graduate nurse education demonstration program in Medicare for advance practice nurses. Eligible hospitals would receive Medicare reimbursement for the clinical training costs attributable to the training of advance practice nurses. Appropriates \$50 million in annual grant funding in FY 2012 through FY 2015. Also creates a demonstration through which grants would be available to FQHCs and nurse-managed health clinics training family nurse practitioners. Authorizes such sums as may be necessary to fund the demonstration from FY 2011 through FY 2014.</p>
<p align="center"><b>Workforce</b></p>	<p>Creates an Advisory Committee on Health Workforce Evaluation and Assessment to make recommendations on workforce policy.</p> <p>Provides grants for primary care training institutions, including grants to public and non-profit hospitals and schools of medicine, to support training programs, with preference given to entities that target vulnerable populations.</p> <p>Provides grants or contracts to eligible entities, including schools of medicine and public or private hospitals, for residency programs in preventative medicine.</p> <p>Permits the Secretary to allow up to 20 percent of teaching time to count toward National Health Service Corps program requirements.</p> <p>Establishes a grant program to assist community-based settings, such as community health centers, to establish new primary care residency programs or operate or participate in established primary care residency programs.</p> <p>Establishes a mental and behavioral health training program, including grants to health professions schools and public or nonprofit private hospitals.</p> <p>Establishes a Frontline Health Providers Loan Repayment Program, for which providers in Health Professionals Needs Areas are eligible. These are areas, populations, or facilities with high needs for services to address health disparities, those with an insufficient capacity of health professionals, and those with high needs for health services. An area, population, or facility that currently is in a HPSA is eligible only if there is a shortage of primary care health services.</p>	<p>Adopts the provisions from the HELP Committee bill. Establishes a National Health Care Workforce Commission that would include providers and educational institutions in its membership and, among other initial priorities, would examine Medicare and Medicaid graduate medical education policies.</p> <p>Appropriates \$1.5 billion from 2011 to 2015 for the National Health Service Corp (as part of a new Community Health Center Fund, described in the CHC section below).</p> <p>Includes significant health and public health workforce investments through grant and loan programs for which NAPH members may be eligible, such as primary care training and enhancement grants, dental training grants and demonstrations, grants for nurse-managed clinics (including clinics associated with schools of medicine and federally qualified health centers), grants for public health and preventive medicine training, and grants to state partnerships (including public institutions of higher learning) and regional efforts for workforce planning and development.</p> <p>Permits states to award grants to health care providers who provide services to a high percentage of medically underserved populations or other special populations.</p> <p>Excludes from gross income payments made under any State loan repayment or loan forgiveness program that is intended to provide for the increased availability of health care services in underserved or health professional shortage areas. Effective in taxable years beginning after December 31, 2008.</p>
<p align="center"><b>340B</b></p>	<p>Expands 340B program eligibility to additional entities, including children's hospitals, critical access hospitals, maternal and child health programs, comprehensive mental health services programs, substance abuse treatment programs, Medicare-dependent small rural hospitals, sole community hospitals and rural referral centers.</p> <p>Adds new program integrity requirements for manufacturers and covered entities. Includes application of civil monetary penalties and possible program exclusion for</p>	<p>Expands 340B program eligibility to children's hospitals, critical access hospitals, and rural referral centers with DSH adjustments greater than 8%.</p> <p>Extends the 340B program to inpatient drugs. Provides for sharing a portion of the 340B savings on inpatient drugs for Medicaid patients with State Medicaid programs, with the amount of the share savings to be determined by the Secretary.</p> <p>Adds new program integrity requirements for manufacturers and covered entities. Includes application of civil monetary penalties and possible program exclusion for</p>

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<p align="center"><b>340B</b></p>	<p>knowing violation of program requirements.</p> <p>Provides that drugs purchased through the 340B program would not be subject to the rebates collected on behalf of Medicaid Managed Care Organizations.</p>	<p>knowing violation of program requirements.</p> <p>Drugs purchased through the 340B program would not be subject to the rebates collected on behalf of Medicaid Managed Care Organizations.</p> <p>Requires a GAO study on the 340B program given reform and the use of 340B discounts to fulfill program objectives. The report is due within 18 months of enactment.</p>
<p align="center"><b>Exchange Participation</b></p>	<p>Establishes a national health insurance exchange. A Health Choices Commissioner would certify qualifying health plans, which would be required to meet state licensure requirements among other requirements.</p> <p>All basic Health Exchange plans, including the public option plan, must include essential community providers, which are defined as 340B eligible providers, in their networks.</p> <p>Establishes a publicly-administered health insurance option to be offered through the Exchange and to be overseen by the Secretary of HHS.</p> <p>Authorizes \$5 billion in funding (in the form of start up loans and grants) for a Consumer Operated and Oriented Plan (CO-OP) program to support the creation of non-profit, member-run health insurance companies that, in addition to private health plans and the public plan, will be offered through the Exchange. Funds may be used to meet state solvency requirements.</p> <p>To serve as a CO-OP, a plan must be organized as a non-profit, member corporation under state law, may not be an existing organization that provides insurance as of July 16, 2009, must not be sponsored by a state, county, or local government or any government instrumentality, and must be governed by its members. CO-OPs must meet state solvency standards and comply with state laws impacting health insurers.</p>	<p>Establishes state-based and regional exchanges. All plans participating in an exchange must meet state licensure requirements, including solvency requirements among other requirements.</p> <p>All Exchange plans must ensure a wide choice of providers, including essential community providers that serve predominately low-income, medically-underserved individuals. "Essential community provider" means an entity that qualifies to participate in the 340B program.</p> <p>Requires the Office of Personnel Management to enter into contracts with insurers to offer at least two national multi-state qualified health plans that will be available through each state's Exchange. At least one contract must be entered into with a non-profit entity. OPM will implement the multi-state plan requirements according to the same rules that apply to the Federal Employees Health Benefits Program, including by negotiating a medical loss ratio, profit margin, premiums to be charged, and other terms and conditions. At least one multi-state plan must not cover abortion. Multi-state plans must meet state licensure requirements and all requirements for FEHBP plans and Exchange plans. States may require multi-state health plans to meet more stringent state age rating requirements. Multi-state plans also must meet all state coverage mandates. A multi-state plan must be offered in at least 60% of states in the plan's first year of operation and in all states by the plan's fourth year of operation. Clarifies that enrollees in Multi-state plans will be placed in a separate risk pool from FEHBP enrollees. Appropriates such sums as may be necessary.</p> <p>Authorizes \$6 billion in funding (in the form of start up loans and grants) for a Consumer Operated and Oriented Plan (CO-OP) program to support the creation of non-profit, member-run health insurance companies that, in addition to other private health plans, will be offered through state-based or regional exchanges. Funds may be used to meet state solvency requirements.</p> <p>To serve as a CO-OP, a plan must be organized as a non-profit, member corporation under state law, may not be an existing organization that provides insurance as of July 16, 2009, must not be sponsored by a state, county, or local government or any government instrumentality, and must be governed by its members. CO-OPs must meet state solvency standards and comply with state laws impacting health insurers.</p> <p>Permits states to create a federally-funded, non-Medicaid state plan for people under 65 with incomes between 133% and 200% FP, as well as lawfully present immigrants with incomes below 133% FPL who are ineligible for Medicaid due to the 5 year bar. Eligible individuals would enroll in such a state plan instead of obtaining coverage through the Exchange. States providing such an option would receive 95% (compared with 85% under the original bill) of the value of individual tax credits and cost-sharing</p>

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<p align="center"><b>Exchange Participation</b></p>		<p>subsidies that would otherwise have been made to assist such individuals to purchase coverage through the Exchange.</p> <p>Allows states to apply for a waiver to opt out of certain aspects of the bill (e.g., Exchange creation, individual and employer mandate, and affordability credits) through a waiver process if the state can demonstrate that it has adopted a plan to provide coverage that is at least as comprehensive as that provided under the Mark to all its residents.</p>
<p align="center"><b>Transitions to Coverage Expansion</b></p>	<p>Creates a temporary high-risk pool for individuals who have been denied health care coverage due to a pre-existing condition and who have been uninsured for six months. Premiums could not exceed 125% of the prevailing standard rate for comparable coverage in the individual market. Provides \$5 billion to subsidize premiums for individuals in the high-risk pool, which expires in 2013.</p> <p>Codifies and builds upon the State Health Access Program, which was established by the FY 2009 Omnibus Appropriations Act, to assist states to establish programs to expand access to affordable health coverage, including the development of state-based exchanges, community coverage programs, reinsurance plan programs, transparency marketplace programs, and automated enrollment programs. States receiving grants must provide a match of at least 20%. Authorizes such sums as may be necessary to fund the program.</p> <p>Requires employers to extend the availability of COBRA to individuals who are eligible for COBRA on or after the date of enactment until coverage is available through the Exchange.</p> <p>Extends the Transitional Medicaid Assistance (TMA) program through December 31, 2012.</p>	<p>Creates a temporary high-risk pool for individuals who have been denied health care coverage due to a pre-existing condition and who have been uninsured for six months. Premiums would be 100% of the standard premium rate for a "Bronze plan." Appropriates \$5 billion to offset the cost of claims in excess of the collected premium amounts.</p> <p>The Secretary must establish not later than 6 months after enactment a three year demonstration project in up to 10 states to provide access to comprehensive health care services to the uninsured at reduced fees. To be eligible, an entity must be a State-based, nonprofit, public-private partnership that provides access to comprehensive health care services to the uninsured at reduced fees. Each state may receive no more than \$2 million. Authorizes such funds as are necessary.</p>
<p align="center"><b>Disparities</b></p>	<p>Extends the enhanced FMAP rate (75%) for translation services to children under CHIPRA to all Medicaid beneficiaries for whom English is not the primary language.</p> <p>Creates a Medicare demonstration program awarding 24, 3-year grants to Medicare providers to provide language services to Medicare beneficiaries. The bill would appropriate \$16 million for each year of the demonstration program.</p> <p>Requires the Secretary to conduct a study on ways that Medicare should develop payment systems for language services and submit a report 12 months after enactment. Requires an IOM report on the impact of language services.</p> <p>Creates grant programs to encourage workforce diversity and cultural competence in providing care, and mentions addressing health disparities in setting preferences for grants related to capacity building in primary care and training of medical residents in community-based settings, among others.</p> <p>Provides for preferences in the reauthorized telehealth grant program to telehealth networks in underserved areas that address health disparities</p> <p>Requires the Secretary to develop quality measures related to health disparities, including those associated with individual race, ethnicity, age, gender, place of residence or language.</p>	<p>Incorporates the comprehensive data collection and sharing provision from the HELP bill, which requires the collection of data on race, ethnicity, gender, geographic location, socioeconomic status, language, and disability status in all federally supported health care and public health programs by no later than 2 years after enactment.</p> <p>Standardizes the collection of race and ethnicity data utilizing the approach adopted by the Office of Management and Budget for race and ethnicity, and requiring creation of standards for the measurement of sex, primary language, and disability status.</p> <p>Requires State Medicaid and CHIP plans to include compliance with these data collection requirements. Requires HHS to report to Congress within 18 months of enactment on evaluation of approaches for collecting health disparities data through Medicaid and CHIP, taking into account the burden on providers and plans, and to implement approaches within 2 years of enactment.</p> <p>MIPAA quality reporting requirements would be extended to Medicaid and CHIP.</p> <p>Requires the Secretary to develop guidelines to adopt Exchange plan payment structures that provide increased reimbursement for a variety of activities, including activities to reduce health disparities, including through language services, community outreach, and cultural competency trainings.</p>

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<p align="center"><b>Disparities</b></p>	<p>Establishes an Assistant Secretary for Health Information, who will be tasked with the collection, collation, reporting, and publishing of statistics on national health indicators, including race and ethnicity data (based on OMB standards), and primary language data. The Assistant Secretary must submit Congress an annual report that, among other things, recommends strategies to address gaps in data and describes the status of analyses of health disparities.</p> <p>Permits the Secretary to collect data through the public health insurance plan option "to reduce racial, ethnic, and other disparities in health and health care."</p> <p>Requires entities contracting with the Exchange to provide for culturally and linguistically appropriate communication and health services.</p> <p>Medicaid DSH provision adds a new requirement that DSH hospitals must not discriminate in providing services based on race, color, national origin, creed, source of payment, status as a beneficiary under this title, or any other ground unrelated need for the services or the availability of the needed services in the hospital.</p>	<p>Codifies the Office of Minority Health and moves it from the Public Health Service to the Office of the Secretary. Authorizes funds for grants and contracts to public and non-profit private entities to improve health status of racial and ethnic minorities.</p> <p>Various workforce provisions and grant programs incorporate measures to address populations facing health disparities and to encourage workforce diversity and cultural competence.</p>
<p align="center"><b>Trauma Funding</b></p>	<p>Provides grants for trauma care and establishes a regionalized communications system demonstration program. Establishes a trauma care grant program that will provide \$100 million for FY 2010 and such sums as necessary through 2015. In addition to providing funds to existing trauma centers, these grants may be used by local governments and public and private non-profit entities to establish new trauma centers in urban areas with a substantial degree of trauma resulting from violent crimes. Prioritizes grants to trauma centers that among other things have at least one graduate medical education fellowship in trauma or trauma-related specialties, demonstrate a substantial commitment to serving vulnerable populations, or demonstrate financial support of the state or political subdivision (including through Medicaid funding for trauma services).</p> <p>Establishes an Emergency Care Coordination Center at HHS to promote and fund research in emergency medicine and trauma health care and to promote regional emergency medical systems partnerships.</p> <p>Establishes a demonstration program for regionalized systems for emergency care response. States or a partnership of one or more states and one or more local governments are eligible to compete for funding. Grantees must provide a 25 percent match. Eligible entities that serve a population in a medically underserved are given priority for grants. Appropriates \$12 million for each of FYs 2011 through 2015.</p>	<p>Establishes three grant programs for trauma centers, including public trauma centers. These programs will provide grants that will fund between 50 and 100 percent of trauma service-related uncompensated care (UCC) to trauma centers with the highest level of uncompensated/Medicaid care (at least 20% uncompensated care and 30% Medicaid); core mission support grants to Level I, II, III, and IV trauma centers that meet certain GME and UCC criteria (entities receiving UCC grants are not eligible for core mission support grants); and emergency awards to support trauma centers in geographic areas in which the availability of trauma care has significantly decreased or will significantly decrease if the trauma center is required to close. Grants are capped at \$2 million a year. Authorizes \$100 million for FY 2009 and such sums as may be necessary for each of FYs 2010 through 2015.</p> <p>Also establishes state-based trauma center grant programs (\$100 million appropriated for each of fiscal years 2010 through 2015). States are required to provide at least 40% of grant amounts to safety net public or non-profit trauma centers. The state-based grants may be used for a variety of operational and capital expenditure, including capital expenses and physician compensation.</p> <p>Establishes a pilot program for regionalized systems for emergency care response. States, or a partnership of one or more states and one or more local governments, are eligible to compete for funding. Grantees must contribute \$1 in matching funds for every \$3 in federal funding received. Eligible entities that serve a population in a medically underserved are given priority for grants. Authorizes \$24 million in appropriations for each of FYs 2010 through 2014.</p>
<p align="center"><b>Community Health Center Funding</b></p>	<p>Authorizes an additional \$12 billion in funding from FY 2011-2015 for community health centers (these funds would be available only to FQHCs and not to FQHC look-alikes). These funds would be provided out of funds that are appropriated to the Public Health Investment Fund that is created under the Act.</p>	<p>Authorizes the establishment of a New Community Health Center Fund and appropriates to the fund:</p> <ul style="list-style-type: none"> <li>• \$7 billion from 2011 to 2015 for the Community Health Center Program.</li> <li>• \$1.5 billion available from 2011 to 2015 for construction and renovation of CHCs.</li> <li>• \$1.5 billion from 2011 to 2015 for the National Health Service Corp.</li> </ul> <p>Authorizes an additional \$34 billion in funding from FY 2010 to FY 2015 for Section 330 grants to community health centers (these funds would be available only to FQHCs and not to FQHC look-alikes). CHC funding for FY 2016 and beyond would be</p>

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<p align="center"><b>Community Health Center Funding</b></p>		<p>based on the prior year's appropriated funds, which would be increased to account for increases in costs per-patient and increases in the number of patients served.</p>
<p align="center"><b>Health Plan Taxes</b></p>	<p>Imposes a per enrollee tax on insurance plans, including self-funded insurance plans, to fund the bill's comparative effectiveness fund. Governmental plans, including Medicaid managed care plans, are exempt from the tax. The tax, called a "fair share per capita amount," will be determined by the Secretary.</p>	<p>Imposes a 40% excise tax on the value of any employer-sponsored plan that exceeds \$8,500 in the case of individual coverage and \$23,000 in the case of family coverage.</p> <p>Imposes an annual fee on health insurance plans for calendar years beginning after 2010. As compared to the original Senate bill which imposed an annual fee of \$2 billion, the amount of the fee will increase from \$2 billion in 2011 up to \$10 billion in 2017 forward. The fee would be apportioned based on an insurer's net premiums. Governmental entities, non-profit entities for which premium increases are regulated by states and the medical loss ratio is 100%, non-profit entities for which the medical loss ratio is 90% in the individual and small and large group markets and 92% in all other markets, self-insured employer plans, and certain mutual insurance plans are exempt. Also exempts all long-term care plans, Medicare supplemental plans, and other insurance, such as accident and disability coverage.</p> <p>Imposes a \$2 per enrollee tax on insurance plans, including self-funded insurance plans, to fund the bill's comparative effectiveness fund. Governmental plans, including Medicaid managed care plans, are exempt from the tax.</p>
<p align="center"><b>Disclosure of Hospital Charges</b></p>	<p>Requires states to adopt laws requiring hospitals to disclose information on hospital charges to the public and the Secretary, including information on charges for the most common inpatient and outpatient hospital services.</p>	<p>All hospitals operating within the United States must annually establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital, including for Medicare DRGs.</p> <p>Limits the amount that can be charged by a charitable hospital for emergency or medically necessary care to "the amount generally billed" to individuals who have insurance. (The base bill indicated the "lowest amount charged.")</p> <p>Each tax-exempt hospital must conduct a community health needs assessment at least once every three years and adopt an implementation strategy that must be disclosed on the hospital's 990. Failure to do so will result in a penalty of \$50,000. Each hospital must adopt and widely publicize a written financial assistance policy and would be required to bill patients who qualify for financial assistance no more than the amounts generally billed. HHS would be required to report annually to Congress on the levels of charity care, bad debt expenses, unreimbursed costs of means tested government programs incurred by private tax-exempt, taxable, and governmental hospitals as well as the cost of community benefit activities incurred by private tax-exempt hospitals. These provisions take effect in the first taxable year after enactment.</p>