HEALTH CENTER RELATED PROVISIONS IN HEALTH REFORM LEGISLATION

Provision	Senate Bill *SIGNED INTO LAW 3/23/2010*	Reconciliation Bill *PASSED BY THE HOUSE 3/21/2010*
	Patient Protection & Affordable Care Act (HR 3590)	*Health Care & Education Affordability Reconciliation Act (HR 4872)*
Health Centers Program Funding & Program Changes	Authorizes and appropriates the following annual amounts to the Community Health Centers program out of a new Public Health and Prevention Trust Fund: • $0.7 billion for FY2011; • $0.8 billion for FY2012; • $1 billion for FY2013; • $1.6 billion for FY2014; • $2.9 billion for FY2015. • TOTAL = $8.5 billion over five years. • Separately authorizes and appropriates $1.5 billion over five years for health center construction and renovation	Authorizes and appropriates the following annual amounts to the Community Health Centers program out of a new Public Health and Prevention Trust Fund • $1 billion for FY2011; • $1.2 billion for FY2012; • $1.5 billion for FY2013; • $2.2 billion for FY2014; • $3.6 billion for FY2015. • TOTAL = $11 billion over five years. • Separately authorizes and appropriates $1.5 billion over five years for health center construction and renovation.
National Health Service Corps Program Funding & Program Changes	Authorizes and appropriates the following annual amounts for the NHSC: • $290 million for FY 2011; • $295 million for FY 2012; • $300 million for FY 2013; • $305 million for FY 2014; • $310 million for FY 2015. • Allows for teaching to count as clinical practice for up to 50% of obligated service.	NO CHANGE TO THE SENATE BILL
Medicaid Eligibility & Financing Changes	• Beginning in 2014 expands Medicaid to 133% FPL in 2014; starting in 2011, states have the option to cover childless adults. • Guarantees that all newly eligible adults receive a benchmark	

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<tr><td></td><td>benefit package that at least provides the essential health benefits.
• 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.
• Requires Medicaid coverage of preventive services and eliminates cost-sharing for preventive services.
• Extends CHIP program and funding through 2015.</td><td>Changes federal Medicaid matching payments (FMAP) for the costs of services to newly eligible individuals to the following rates in all states except expansion states:
• 100% in 2014, 2015, and 2016;
• 95% in 2017;
• 94% in 2018;
• 93% in 2019;
• 90% thereafter.

Improves upon Senate bill by offering States that have already expanded eligibility to adults with incomes up to 100% FPL a phased-in increase in the federal medical assistance percentage(FMAP) for non-pregnant childless adults so that by 2020 they receive the same federal financing (90%) as other states.

Sec. 1204 Increases the federal funding in the Senate bill for Puerto Rico, Virgin Islands, Guam, American Samoa, and the Northern Marianas Islands by **$2 billion (Appropriations).** Raises the caps on federal Medicaid funding for each of the territories. Allows each territory to elect to operate a Health Benefits Exchange.
The bill will provides **$6.3 billion** in new **Medicaid** funding for the territories in the form of an increase to their current federal funding caps.</td></tr>
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Prevention and Wellness Programs	• Establishes a Prevention and Public Health Fund with appropriated through 2015 for prevention, wellness and public health activities. • Provides for implementation of a public-private partnership for prevention and health promotion outreach and education. • Awards competitive grants to state, local, and community-based agencies for evidence-based community prevention activities. • Establishes a demonstration program for health centers to receive funding for drafting individualized patient wellness plans. • Directs the President to establish the *"National Prevention, Health Promotion and Public Health Council"* 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. • 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 recommendations.	NO CHANGE TO THE SENATE BILL
Health Insurance Exchange	• Requires all U.S. citizens and legal residents to purchase health insurance through the individual market, small group market, public program or employer; or through the large group market. Exemptions would include religious objectors and undocumented residents. • Provides premium and cost-sharing credits for individuals and families between 100-400% FPL starting in 2014. • Creates state-based American Health Benefit Exchanges and	• Improves the financing for premiums and cost sharing for individuals with incomes up to 400% of the federal poverty level. Subsection (a) improves tax credits to make premiums more affordable as a percent of income; and subsection (b) improves support for cost sharing, focusing on those with incomes below 250% of the federal poverty level. • Modifies the assessment that individuals who choose to remain uninsured will pay.

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	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. • 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. • 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. • 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. • Requires all plans operating in the Exchanges to pay FQHCs based on the Medicaid PPS rates.	
Network Adequacy Standards for Exchange Plans	• Basic exchange plans must contract with 'essential community providers,' such as eligible 340B entities. • 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.	NO CHANGE TO THE SENATE BILL
Required Benefits in Exchange Plans	• 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.	NO CHANGE TO THE SENATE BILL

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	• 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).
	• Creates 4 benefit categories to be offered through individual and small business exchange plans with out of pocket limits at current law HSA levels:
	  • *Bronze* plan includes essential benefits and covers 60% of the cost of the plan;
	  • *Silver* plan includes essential benefits and covers 70% of the cost of the plan;
	  • *Gold* plan includes essential benefits, and covers 80% of the cost of the plan;
	  • *Platinum* plan includes essential benefits and covers 90% of the cost of the plan; and
	  • *Catastrophic* plan to those under 30 or exempt from the mandate and provides catastrophic coverage at current law HSA levels.
	• 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.	

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Medicaid Interaction with the Exchange	• 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. • 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.	NO CHANGE TO THE SENATE BILL
Teaching Health Centers	• 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. • 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. • Strictly prohibits hospitals from receiving payments for Sec. 340H reimbursed time. • Appropriates directly $230 million in funding for Sec. 340H over 5 years.	NO CHANGE TO THE SENATE BILL
Reimbursement for Primary Care Physicians	• 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. • FQHCs' Medicare reimbursement would be updated to a new funding mechanism based on costs and the current, outdated cap	NO CHANGE SPECIFIC TO FQHC REIMBURSEMENT

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	would be eliminated. • FQHC preventive services are updated to include an expanded list of preventives services covered under Medicare (according to the provisions in the MATCH Act). • The Secretary would negotiate rates under the consumer health insurance (public) option with non-FQHC providers.	
Medical Home & Coordinated Care Demonstrations	• Authorizes a new Center for Medicare Innovation to carry out innovative projects, such as medical homes and ACOs (below). • 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 mental health center, clinic, physician's office or group practice. • 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. • Establishes a new office within CMS for the coordination of care for dual eligibles.	NO CHANGE TO THE SENATE BILL

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HPSA / MUA Shortage Designation Guidelines	• 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.	NO CHANGE TO THE SENATE BILL
340B Managed Care Organization	• Would extend Medicaid rebates to 340B drugs purchased by a Medicaid Managed Care Organization (exempts covered drugs from rebate if subject to 340B discount).	• Drugs Purchased by Covered Entities. Repeals the underlying 340B expansion to inpatient drugs and exemptions to GPO exclusion. Exempts orphan drugs from required discounts for new 340B entities.