

**Section-By-Section Overview:
HR 3590/HR 4872
Patient Protection and Affordable Care Act
Prepared by NASADAD Public Policy
April 2010**

Background: On March 23, the President signed H.R. 3590, the Patient Protection and Affordable Care Act (PPACA), legislation that seeks to overhaul the healthcare system in the nation. On March 30th, the President signed H.R. 4872, a reconciliation bill that made changes to PPACA. Congress first began considering health reform in 2008. Efforts now move to implementation of this important Act.

Title: Patient Protection and Affordable Care Act

Title I: Quality, Affordable Health Care for All Americans

Subtitle A: Immediate Improvements in Health Care Coverage for All Americans

Sec. 2711: No Lifetime or Annual Limits: Prohibits plans from establishing lifetime limits and annual limits beginning in 2014.

Sec. 2713: Coverage of Preventive Services: Requires group health plans and health insurance issuers to provide coverage, without cost sharing requirements, for: evidence-based services that have been given a grade of “A” or “B” by the United States Preventive Services Task Force; immunizations that are recommended by Center for Disease Control (CDC); and services to infants, children and adolescents that are recommended by Health Resources and Services Administration (HRSA); and women’s preventive care and screening recommended by HRSA.

Sec. 2714: Extension of Dependent Coverage: Requires all plans offering dependent coverage to allow individuals until age 26 to remain on their parent’s health insurance.

Sec. 2717: Ensuring Quality of Care: Not later than two years after enactment of the Act, the Secretary, in consultation with experts in health care quality and stakeholders, shall develop reporting requirements for use by a group health plan, and a health insurance issuer offering group or individual health insurance coverage, with respect to plan or coverage benefits and health care provider reimbursement structures that—(A) improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical homes model as defined for purposes of section 3602 of the Patient Protection and Affordable Care Act, for treatment or services under the plan or coverage; (B) implement activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional; (C) implement activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; and (D) implement wellness and health promotion.

Sec. 2718: Bringing Down the Cost of Health Care Coverage: Requires plans offering coverage in the group and individual markets to report to the Secretary the amount of premium revenues spent on clinical services, activities to improve quality and all other non-claims costs as defined by the National Association of Insurance Commissioners (NAIC) and certified by the Secretary of HHS. Beginning in 2011, large group plans that spend less than 85 percent of premium revenue and small group and individual market plans that spend less than 80 percent of premium revenue on clinical services and quality must provide a rebate to enrollees. In addition, each hospital operating within the United States shall publish a list of standard charges for items and services provided by the hospital.

Subtitle B: Immediate Action to Make Coverage More Affordable and More Available

Sec. 1101: Immediate Access to Insurance for People with a Preexisting Condition: Enacts a temporary insurance program with financial assistance for those who have been uninsured for several months and have a pre-existing condition. This program ends in 2014 when the Exchanges are established.

Subtitle C: Quality Health Insurance Coverage for All Americans

Sec. 2701: Fair Health Insurance Premiums: Establishes that premiums in the individual and small group markets may vary only by family structure, geography, the actuarial value of the benefit, age (limited to a ratio of 3 to 1), and tobacco use (limited to a ratio of 1.5 to 1). This provision applies to insured plans in the large group market, not self-insured plans.

Sec. 2702: Guaranteed Availability of Coverage: Each health insurance issuer must accept every employer and individual in the State that applies for coverage, permitting annual and special open enrollment periods for those with qualifying lifetime events.

Sec. 2703: Guaranteed Renewability of Coverage: Requires guaranteed renewability of coverage regardless of health status, utilization of health services or any other related factor.

Sec. 2704: Prohibition of Preexisting Condition Exclusions or Other Discrimination Based on Health Status: No group health plan or insurer offering group or individual coverage may impose any pre-existing condition exclusion or discriminate against those who have been sick in the past.

Sec. 2705: Prohibiting Discrimination Against Individual Participants and Beneficiaries Based on Health Status: No group health plan or insurer offering group or individual coverage may set eligibility rules based on health status, medical condition “(including both physical and mental illnesses),” claims experience, receipt of medical care, medical history, genetic information, and evidence of insurability.

Sec. 1251: Preservation of Right to Maintain Existing Coverage: Allows any individual enrolled in any form of health insurance to keep their coverage as it existed on the date of enactment of this Act.

Subtitle D: Available Coverage for All Americans

Sec. 1301: Qualified Health Plan Defined: Requires qualified health plans to be certified by Exchanges, provide the essential benefits package and be offered by licensed insurers that offer at least one qualified

health plan at silver and gold levels. Allows for multi-State plans and allows qualified health plans to provide coverage through a qualified primary care medical home plan.

Sec. 1302: Essential Health Benefits Requirements: Includes “mental health and substance use disorder services, including behavioral health treatments” as minimum services to be covered within the essential benefit package that all qualified plans must provide.

Sec. 1311: Affordable Choices of Health Benefits Plans: Requires the Secretary to award grants, available until 2015, to States for planning and establishment of American Health Benefit Exchanges. By 2014, requires States to establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans and includes a SHOP Exchange for small businesses. This section also notes that all plans must adhere to the mental health and substance use disorder parity requirements. Specifically, the language states that, “APPLICABILITY OF MENTAL HEALTH PARITY.—Section 2726 of the Public Health Service Act shall apply to qualified health plans in the same manner and to the same extent as such section applies to health insurance issuers and group health plans.”

Sec. 1312: Consumer Choice: Allows qualified individuals or individuals who are not incarcerated and who are lawfully residing in the State, to enroll in a qualified health plan through the State’s Exchange.

Sec. 1321: State Flexibility in Operation and Enforcement of Exchanges and Related Requirements: Requires the Secretary, in consultation with National Association of Insurance Commissioner (NAIC), to set standards for Exchanges, qualified health plans, reinsurance, and risk adjustment. States are required to implement these standards by 2014. If the Secretary determines before 2013 that a State will not have an Exchange in operation by 2014, or will not implement the standards, requires the Secretary to establish and operate an Exchange in the State and to implement the standards. Presumes that a State operating an Exchange before 2010 meets the standards, and establishes a process for the State to come into compliance with the standards. Also requires at least two multi-State qualified health plans to be offered through each State Exchange.

Sec. 1331: State Flexibility to Establish Basic Health Programs for Low-Income Individuals not Eligible for Medicaid: Allows States to contract with standard health plans for individuals who are not eligible for Medicaid or other affordable coverage and have incomes below 200 percent of Federal Poverty Level (FPL).

Sec. 1332: Waiver for State Innovation: Beginning in 2017, allows the States to apply for a waiver for up to 5 years of requirements relating to qualified health plans, Exchanges, cost-sharing reductions, tax credits, the individual responsibility requirement and shared responsibility for employers. Requires States to enact a law and to comply with regulations that ensure transparency. Requires the Secretary to provide a State the aggregate amount of tax credits and cost-sharing reductions that would be been paid to residents of the State in the absence of the waiver. Requires the Secretary to determine that the State plan for a waiver will provide coverage that is at least as comprehensive and affordable to at least a comparable number of residents, as this title would provide and that it will not increase the federal deficit.

Sec. 1334: Multi-State Plans: Requires the Office of Personnel Management (OPM) to contract with health insurers to offer at least two multi-State qualified health plans through Exchanges in each State. Requires multi-State plans to cover essential health benefits and meet all of the requirements of a qualified health plan.

Subtitle F—Shared Responsibility for Health Care

Sec. 1501 and Sec. 1513: Individual and Employer Responsibility: Requires individuals to maintain minimum essential coverage beginning in 2014. Failure to maintain coverage will result in a penalty of the greater of \$95 or one percent of income in 2014, \$325 or two percent of income in 2015, \$69 or 2.5 percent of income in 2016, up to a cap of the national coverage bronze plan premium. Exceptions include religious objectors; health care sharing ministry; individuals not lawfully present; and incarcerated individuals. Exceptions are also made for individuals who cannot afford health coverage.

Requires employers with more than 200 employees to automatically enroll new full-time employees in coverage. Requires an employer with more than 50 full-time employees that does not offer coverage and has at least one full-time employee receiving the premium assistance tax credit to pay the lesser of \$3,000 for each of those employees receiving a tax credit of \$2,000 for each of their full time employees.

Title II—Role of Public Programs

Subtitle A: Improved Access to Medicaid

Sec. 2001: Medicaid Coverage for the Lowest Income Populations: (a) Creates a new State option to provide Medicaid coverage through a State plan amendment beginning on April 1, 2010. Eligible people include all non-elderly, non-pregnant individuals who are not entitled to Medicare (for example, childless adults and certain parents); (b) requires State Medicaid programs to cover newly-eligible individuals with incomes at or below 133% of the Federal Poverty Level (FPL) beginning January 1, 2014; (c) Increases the mandatory Medicaid income eligible level for children ages six to 19 from 100% to 133% of FPL; and (d) Newly-eligible individuals would receive benchmark or benchmark equivalent coverage consistent with the requirements of section 1937 of the Social Security Act. Benchmark and benchmark-equivalent coverage would be required to provide at least essential benefits (which would include mental health and substance use disorder services). In addition, this section makes reference to the mental health and substance use disorder parity requirements by noting that, “(6) MENTAL HEALTH SERVICES PARITY.—(A) IN GENERAL.—In the case of any benchmark benefit package under paragraph (1) or benchmark equivalent coverage under paragraph (2) that is offered by an entity that is not a Medicaid managed care organization and that provides both medical and surgical benefits and mental health or substance use disorder benefits, the entity shall ensure that the financial requirements and treatment limitations applicable to such mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.”

The federal government will pay 100 percent of the cost of covering newly-eligible Medicaid individuals from 2014 to 2016. In 2017, the federal government would provide Medicaid matching payments for the cost of services to the newly-eligible individuals at 95 percent; 94 percent in 2018; 93 percent in 2019; and 90 percent thereafter. In the case of expansion States, additional federal support for covering non-pregnant childless adults is phased-in so that in 2019 and after, expansion States would receive the same FMAP as other States for newly-eligible and previously-eligible non-pregnant childless adults.

Subtitle I: Improving the Quality of Medicaid for Patients and Providers

Sec. 2703: State Option to Provide Health Homes for Enrollees with Chronic Conditions: allows States the option of enrolling Medicaid beneficiaries with chronic conditions into a health home which would be comprised of a team of health professionals and would provide a comprehensive set of medical services including care coordination. States should consult and coordinate with Substance Abuse and Mental Health Services Administration (SAMHSA) regarding the prevention and treatment of mental illness and substance use disorders among eligible individuals with chronic conditions.

This section specifically states the following:

“ELIGIBLE INDIVIDUAL WITH CHRONIC CONDITIONS.—

(A) IN GENERAL.—Subject to subparagraph (B), the term ‘eligible individual with chronic conditions’ means an individual who—(i) is eligible for medical assistance under the State plan or under a waiver of such plan; and (ii) has at least—(I) 2 chronic conditions; (II) 1 chronic condition and is at risk of having a second chronic condition; or (III) 1 serious and persistent mental health condition. “

“(B) RULE OF CONSTRUCTION.—Nothing in this paragraph shall prevent the Secretary from establishing higher levels as to the number or severity of chronic or mental health conditions for purposes of determining eligibility for receipt of health home services under this section.”

This section defines a chronic condition in the following way:

“(2) CHRONIC CONDITION.—The term ‘chronic condition’ has the meaning given that term by the Secretary and shall include, but is not limited to, the following:

(A) A mental health condition.

(B) Substance use disorder.

(C) Asthma.

(D) Diabetes.

(E) Heart disease.

(F) Being overweight, as evidenced by having a Body Mass Index (BMI) over 25.”

Sec. 2707: Medicaid Emergency Psychiatric Demonstration Project: Requires the Secretary of HHS to establish a three year Medicaid demonstration project in up to eight States. Participating States would be required to reimburse certain institutions for mental diseases (IMDs) for services provided to Medicaid beneficiaries between the ages of 21 and 65 who are in need of medical assistance to stabilize an emergency psychiatric condition.

Subtitle L: Maternal and Child Health Services

Sec. 2952: Support, Education and Research for Postpartum Depression: Provides support services to women suffering from postpartum depression and psychosis and also helps educate mothers and their families about these conditions. Provides support for research into the causes of these conditions. A report is due to Congress on this research no later than five years after enactment of the Act. \$3,000,000 is authorized for fiscal year 2010 with such sums for fiscal years 2011 and 2012.

Title III—Improving the Quality and Efficiency of Health Care

Subtitle A: Transforming the Health Care Delivery System

Sec. 3011: National Strategy to Improve Health Care Quality: By January 1, 2011, requires the Secretary to establish, submit and update annually a national strategy to improve the delivery of health care services, patient outcomes and population health. Also establishes, no later than January 1, 2011, a federal health care quality website.

Sec. 3012: Interagency Working Group on Health Care Quality: Requires the President to convene an Interagency Working Group on Health Care Quality comprised on Federal agencies to collaborate on development and dissemination of quality initiatives consistent with the national strategy.

Senior representatives from the following Federal agencies must be part of the Working Group:

- (A) the Department of Health and Human Services;
- (B) the Centers for Medicare & Medicaid Services;
- (C) the National Institutes of Health;
- (D) the Centers for Disease Control and Prevention;
- (E) the Food and Drug Administration;
- (F) the Health Resources and Services Administration;
- (G) the Agency for Healthcare Research and Quality;
- (H) the Office of the National Coordinator for Health Information Technology;
- (I) the Substance Abuse and Mental Health Services Administration;
- (J) the Administration for Children and Families;
- (K) the Department of Commerce;
- (L) the Office of Management and Budget;
- (M) the United States Coast Guard;
- (N) the Federal Bureau of Prisons;
- (O) the National Highway Traffic Safety Administration;
- (P) the Federal Trade Commission;
- (Q) the Social Security Administration;
- (R) the Department of Labor;
- (S) the United States Office of Personnel Management;
- (T) the Department of Defense;
- (U) the Department of Education;
- (V) the Department of Veterans Affairs;
- (W) the Veterans Health Administration; and
- (X) any other Federal agencies and departments with activities relating to improving health care quality and safety, as determined by the President.

The Chair of the Working Group is the Secretary of the Department of Health and Human Services and Members of the Working Group can serve as Vice Chair of the Working Group on a rotating basis, as determined by the Group.

The Working Group must report to Congress by December 31, 2010 and then must report annually.

Subtitle B: Improving Medicare for Patients and Providers

Sec. 3107: Extension of Physician Fee Schedule Mental Health Add-on: Increases the payment rate for psychiatric services by 5 percent for two years, through the end of 2010.

Subtitle F: Health Care Quality Improvement

Sec. 3502: Grants or Contracts to Establish Community Health Teams to Support Patient-Centered Medical Home: Creates a program to establish and fund the development of community health teams to support the development of medical homes by increasing access to comprehensive, community based, coordinated care.

Sec. 3509: Office of Women's Health: Establishes an Office of Women's Health within the Office of the Commissioner of the Food and Drug Administration (FDA). The Director of the Office will be appointed by the Commissioner of the FDA. This Director will serve as a member of the Department of Health and Human Services Coordinating Committee on Women's Health.

Title IV—Prevention of Chronic Disease and Improving Public Health

Subtitle A: Modernizing Disease Prevention and Public Health

Sec. 4001: National Prevention, Health Promotion and Public Health Council: Creates an interagency council dedicated to promoting healthy policies at the federal level. The Council shall consist of representatives of federal agencies that interact with federal health and safety policy including:

- (1) the Secretary of Health and Human Services;
- (2) the Secretary of Agriculture;
- (3) the Secretary of Education;
- (4) the Chairman of the Federal Trade Commission;
- (5) the Secretary of Transportation;
- (6) the Secretary of Labor;
- (7) the Secretary of Homeland Security;
- (8) the Administrator of the Environmental Protection Agency;
- (9) the Director of the Office of National Drug Control Policy;
- (10) the Director of the Domestic Policy Council;
- (11) the Assistant Secretary for Indian Affairs;
- (12) the Chairman of the Corporation for National and Community Service; and
- (13) the head of any other Federal agency that the chairperson determines is appropriate.

The Council will establish a national prevention and health promotion strategy and develop interagency working relationships to implement the strategy. The Council will report by July 1, 2010 and then annually to Congress on health promotion activities of the Council and progress in meeting goals of the national strategy. Substance use disorders are listed as one of the national priorities to be included in the report to Congress and the President. Specifically, the legislation states that the Strategy should contain “a list of national priorities on health promotion and disease prevention to address lifestyle behavior

modification (smoking cessation, proper nutrition, appropriate exercise, mental health, behavioral health, substance use disorder, and domestic violence screenings) and the prevention measures for the 5 leading disease killers in the United States...” An Advisory Group to the Council composed of no more than 25 non-federal representatives will also be established to help develop policy and program recommendations.

Sec. 4002: Prevention and Public Health Fund: Establishes a Prevention and Public Health Investment Fund. The goal of the Fund is to provide an expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs. This will involve a dedicated and stable funding stream for prevention, wellness and public health activities. Authorized funding levels for the Fund are as follows: \$500 million in 2010; \$750 million in 2011; \$1 billion in 2012; \$1.25 billion in 2013; \$1.5 billion in 2014; \$2 billion in 2015 and each year after 2015.

Sec. 4003: Clinical and Community Preventive Services: Expands the efforts of and improves coordination between the following two task forces: the U.S. Preventive Services Task Force and the Community Preventive Services Task Force. The U.S. Preventive Services Task Force is an independent panel of experts in primary care and prevention that systematically review the evidence of effectiveness of clinical preventive services and develop recommendations for their use. These recommendations will be published in the Guide to Clinical Preventive Services. The Community Preventive Services Task Force uses a public health perspective to review the evidence of effectiveness of population-based prevention services such as tobacco cessation and develops recommendations for their use. The recommendations will be published in the Guide to Community Preventive Services. The two Task Forces are also expected to coordinate together on recommendations when appropriate.

Sec. 4004: Education and Outreach Campaign Regarding Preventive Benefit: Directs the Secretary to convene a national public/private partnership for the purposes of conducting a national prevention and public health promotion outreach and education campaign. The goal of the campaign is to raise awareness of activities and disseminate information to promote health and prevent diseases across the lifespan. No later than one year after enactment of the Act, the Secretary, acting through the Director of the Centers for Disease Control (CDC), will conduct a national media campaign on health promotion and disease prevention focusing on nutrition, physical activity and smoking cessation using science-based social research. The campaign shall, among other activities, describe “additional preventive care supported by the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, the Advisory Committee on Immunization Practices, and other appropriate agencies...” The campaign will be evaluated independently every two years. A website will also be established to help provide information to health providers and consumers.

Secretary will also provide guidance and relevant information to States and health care providers regarding preventive and obesity-related services that are available to Medicaid enrollees. Each State would be required to design a public awareness campaign to educate Medicaid enrollees regarding availability and coverage of such services. Not later than January 1, 2011 and every three years after until January 1, 2017, the Secretary of Health and Human Services will report to Congress on the effectiveness of these efforts.

Subtitle B: Increasing Access to Clinical Preventive Services

Sec. 4101: School-based Health Clinics: Establishes a new program to support school-based health clinics that provide comprehensive and accessible preventive and primary care services to medically underserved children and families. Eligible applicants are school-based health centers or a sponsoring facility of a school-based health center. Each school-based health center provide, at minimum, comprehensive primary health services. Mental health services (meant to include substance use disorder services) and assessments, to children and adolescents are included as comprehensive primary health services. Specifically, the definition of a comprehensive primary health services “means the core services offered by school-based health centers, which shall include the following: (A) PHYSICAL.—Comprehensive health assessments, diagnosis, and treatment of minor, acute, and chronic medical conditions, and referrals to, and follow-up for, specialty care and oral health services; (B) MENTAL HEALTH.—Mental health and substance use disorder assessments, crisis intervention, counseling, treatment, and referral to a continuum of services including emergency psychiatric care, community support programs, inpatient care and outpatient programs.”

The legislation includes some priority considerations. Specifically, priority would be given to the following applicants who demonstrate the ability to serve the following: “(A) Communities that have evidenced barriers to primary health care and mental health and substance use disorder prevention services for children and adolescents. (B) Communities with high per capita numbers of children and adolescents who are uninsured, underinsured, or enrolled in public health insurance programs. (C) Populations of children and adolescents that have historically demonstrated difficulty in accessing health and mental health and substance use disorder prevention services. “

\$50 million for FY 2010 to FY 2013 is authorized for this program.

Sec. 4103: Medicare Coverage of Annual Wellness Visit Providing Personalized Prevention Plan: Provides coverage under Medicare with no-co-payment or deductible for an annual wellness visit and personalized prevention plan services. Services included would be a comprehensive health risk assessment. The personalized prevention plan would take into account the findings of the risk assessment. One specific part of the risk assessment would include: “A list of risk factors and conditions for which primary, secondary, or tertiary prevention interventions are recommended or are underway, including any mental health conditions or any such risk factors or conditions that have been identified through an initial preventive physical examination (as described under subsection (ww)(1)), and a list of treatment options and their associated risks and benefits.”

Sec. 4104: Removal of Barriers to Preventive Services in Medicare: Waives beneficiary coinsurance requirements for most preventive services, requiring Medicare to cover 100 percent of the costs. Services for which no coinsurance or deductible would be required are the personalized prevention plan services and any covered preventive service if it is recommended with a grade of A or B by the U.S. Preventive Services Task Force.

Sec. 4105: Evidence-based Coverage of Preventive Services in Medicare: Authorizes the Secretary to modify the coverage of any currently covered preventive service in the Medicare program to the extent to which the modification is consistent with the U.S. Preventive Services Task Force’s recommendations.

Sec. 4106: Improving Access to Preventive Services for Eligible Adults in Medicaid: The current Medicaid State option to provide other diagnostic, screening, preventive, and rehabilitation services would be expanded to include: (1) any clinical preventive service recommended with a grade of A or B by the U.S. Preventive Services Task Force; and (2) with respect to adults, immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) and their administration.

Sec. 4107: Coverage of Comprehensive Tobacco Cessation Services for Pregnant Women in Medicaid: States are required to provide Medicaid coverage for counseling and pharmacotherapy to pregnant women for cessation of tobacco use. Cost-sharing for these services is prohibited.

Sec. 4108: Incentives for Prevention of Chronic Diseases in Medicaid: The Secretary would award grants to States to provide incentives for Medicaid beneficiaries to participate in programs providing incentives for healthy lifestyles. These programs must be comprehensive and must address the needs of Medicaid eligible beneficiaries and must have demonstrated success in helping individuals lower cholesterol and/or blood pressure, lose weight, quit smoking and address co-morbidities which would include depression. \$100,000,000 authorized for the 5-year period beginning on January 1, 2011.

Subtitle C: Creating Healthier Communities

Sec. 4201: Community Transformation Grants: Authorizes the Secretary, through the Director of CDC, to award competitive grants to eligible entities, which would include State and local governmental agencies, for programs that promote individual and community health and prevent the incidence of chronic disease. Communities can carry out programs to prevent and reduce the incidence of chronic diseases associated with overweight and obesity, mental health, tobacco use, or other activities that are consistent with the goals of promoting healthy communities. Such sums are authorized for this program.

Sec. 4202: Healthy Aging, living well, evaluation of community-based prevention and wellness programs for Medicare beneficiaries: Authorizes the Secretary, acting through the Director of Center of Disease Control (CDC), to provide grants to States or large local health departments to conduct 5-year pilot programs in the 55 to 64 year old population. Pilot programs would evaluate chronic disease risk factors, conduct evidence-based public health interventions and ensure that individuals identified with chronic disease or at risk for chronic disease receive clinical treatment to reduce risk. Mental health and substance use disorder screenings would be included as a public health intervention. Specifically, the legislation states that the types of interventions include the following: “Intervention activities conducted under this subparagraph may include efforts to improve nutrition, increase physical activity, reduce tobacco use and substance abuse, improve mental health, and promote healthy lifestyles among the target population.”

This program allows State and local health departments to enter into agreements with community health centers or rural health clinics and mental health and substance use disorder service providers. Specifically, the legislations states the following:

“PUBLIC HEALTH INTERVENTION PROGRAM.—A State or local health department shall use amounts received under a grant under this subsection to enter into contracts with community health centers or rural health clinics and mental health and substance use disorder service providers to assist in the referral/treatment of at risk patients to community resources for clinical follow-up and to help determine eligibility for other public programs.”

This section also authorizes CMS to conduct a comprehensive assessment of community-based disease self-management programs that help control chronic diseases. The Secretary would then develop a plan for improving access to services for Medicare beneficiaries. Such sums would be authorized.

Sec. 4206: Demonstration Project Concerning Individualized Wellness Plans: Authorizes a pilot program that provides at-risk populations who utilize community health centers with a comprehensive risk-factor assessment and an individualized wellness plan designed to reduce risk factors for preventable conditions. Alcohol and tobacco cessation counseling and services are included. Such sums are authorized to carry out this program.

Title V—Health Care Workforce

Subtitle A—Purpose and Definitions

Sec. 5001: Purpose: Improve access to and delivery of health care services to all individuals, with emphasis on low income, uninsured, underserved, minority, health disparity and rural populations by any number of mechanisms such as increasing the number of qualified healthcare workforce.

Sec. 5002: Definitions: This section includes definitions of different types of workforce personnel, including a mental health service professional which is defined as: “an individual with a graduate or post graduate degree from an accredited institution of higher education in psychiatry, psychology, school psychology, behavioral pediatrics, psychiatric nursing, social work, school social work, substance abuse disorder prevention and treatment, marriage and family counseling, school counseling, or professional counseling.” A definition of a paraprofessional child and adolescent mental health worker is also included. A paraprofessional child and adolescent mental health worker means an “individual who is not a mental or behavioral health service professional, but who works at the first stage of contact with children and families who are seeking mental or behavioral health services, including substance abuse prevention and treatment services.

Subtitle B: Innovations in the Health Care Workforce

Sec. 5101: National Health Care Workforce Commission: Establishes a National Commission tasked with reviewing health care workforce and projected workforce needs. The overall goal of the Commission is to provide comprehensive, unbiased information to Congress and the Administration about how to align federal health workforce resources with national needs. The Commission would be composed of 15 members appointed by Comptroller General. Qualifications to be on the Commission include the following: national recognition for their expertise in health care labor market analysis, including health care workforce analyst, health care finance and economics, health care facility management, health care plans and integrated delivery systems, health care workforce education and training, health care philanthropy, providers of health care services, and other related fields. The membership of the Commission should include no less than one representative from the following fields:

- Health care workforce and health professionals
- Employers, including representatives of small businesses and self-employed individuals
- Third-party payers
- Individuals skilled in the conduct and interpretation of health care services and health economics research

- Representatives of consumers
- Labor unions
- State or local workforce investment boards; and
- Educational institutions

The Commission would be tasked with current health care workforce needs. Priority areas for this evaluation specifically include:

“(i) Integrated health care workforce planning that identifies health care professional skills needed and maximizes the skill sets of health care professionals across disciplines.

(ii) An analysis of the nature, scopes of practice, and demands for health care workers in the enhanced information technology and management workplace.

(iii) An analysis of how to align Medicare and Medicaid graduate medical education policies with national workforce goals.

(iv) The education and training capacity, projected demands, and integration with the health care delivery system of each of the following:

- (I) Nursing workforce capacity at all levels.
- (II) Oral health care workforce capacity at all levels.
- (III) Mental and behavioral health care workforce capacity at all levels.
- (IV) Allied health and public health care workforce capacity at all levels.
- (V) Emergency medical service workforce capacity, including the retention and recruitment of the volunteer workforce, at all levels.
- (VI) The geographic distribution of health care providers as compared to the identified health care workforce needs of States and regions.”

A report containing the results and/or recommendations from the Commission is due by not later than October 1 of each year and by not later than April 1 of each year, the Commission must submit a report to Congress and the Administration containing a review of, and recommendations on, at a minimum one high priority area.

This section also includes definitions of health care workforce and health professionals. Specifically, these terms are defined as:

“The term health care workforce ’includes all health care providers with direct patient care and support responsibilities, such as physicians, nurses, nurse practitioners, primary care providers, preventive medicine physicians, optometrists, ophthalmologists, physician assistants, pharmacists, dentists, dental hygienists, and other oral healthcare professionals, allied health professionals, doctors of chiropractic, community health workers, health care paraprofessionals, direct care workers, psychologists and other behavioral and mental health professionals (including substance abuse prevention and treatment providers), social workers, physical and occupational therapists, certified nurse midwives, podiatrists, the

EMS workforce (including professional and volunteer ambulance personnel and firefighters who perform emergency medical services), licensed complementary and alternative medicine providers, integrative health practitioners, public health professionals, and any other health professional that the Comptroller General of the United States determines appropriate.”

The term “health professionals” includes—

(A) dentists, dental hygienists, primary care providers, specialty physicians, nurses, nurse practitioners, physician assistants, psychologists and other behavioral and mental health professionals (including substance abuse prevention and treatment providers), social workers, physical and occupational therapists, public health professionals, clinical pharmacists, allied health professionals, doctors of chiropractic, community health workers, school nurses, certified nurse midwives, podiatrists, licensed complementary and alternative medicine providers, the EMS workforce (including professional and volunteer ambulance personnel and firefighters who perform emergency medical services), and integrative health practitioners;

(B) national representatives of health professionals;

(C) representatives of schools of medicine, osteopathy, nursing, dentistry, optometry, pharmacy, chiropractic, allied health, educational programs for public health professionals, behavioral and mental health professionals (as so defined), social workers, pharmacists, physical and occupational therapists, oral health care industry dentistry and dental hygiene, and physician assistants;

(D) representatives of public and private teaching hospitals, and ambulatory health facilities, including Federal medical facilities; and

(E) any other health professional the Comptroller General of the United States determines appropriate.”

5102: State Health Care Workforce Development Grants: Authorizes the Secretary to award planning and implementation grants, through Health Resources and Services Administration (HRSA), for the purpose of enabling State partnerships to complete comprehensive planning and to carry out activities leading to coherent and comprehensive health care workforce development strategies at the State and local levels. \$8,000,000 is authorized for planning grants in FY 2010 with such sums authorized after that; \$150,000,000 is authorized for implementation grants in FY 2010 with such sums authorized after 2010. Each implementation grant recipient must pay at least a 25% in-kind or cash match to receive funds.

Sec. 5103: Health Care Workforce Assessment: This section codifies the existing National Center for Health Workforce Analysis and establishes several regional centers for workforce analysis to collect, analyze and report data related to primary care workforce programs.

Subtitle C: Increasing the Supply of the Health Care Workforce

Sec. 5203: Healthcare Workforce Loan Repayment Programs: Establishes a pediatric specialty loan repayment program under which the eligible individual agrees to be employed full time for at least two years specifically the individual would be “providing pediatric medical subspecialty, pediatric surgical specialty, or child and adolescent mental and behavioral health care, including substance abuse prevention and treatment services.” For this program, the Secretary of Health and Human Services would enter into

contracts with qualified health professionals who “agree to provide pediatric medical subspecialty, pediatric surgical specialty, or child and adolescent mental and behavioral health care in an area with a shortage of the specified pediatric subspecialty that has a sufficient pediatric population to support such pediatric subspecialty, as determined by the Secretary; and (2) the Secretary agrees to make payments on the principal and interest of undergraduate, graduate, or graduate medical education loans of professionals described in paragraph (1) of not more than \$35,000 a year for each year of agreed upon service under such paragraph for a period of not more than 3 years during the qualified health professional’s— (A) participation in an accredited pediatric medical subspecialty, pediatric surgical specialty, or child and adolescent mental health subspecialty residency or fellowship; or (B) employment as a pediatric medical subspecialist, pediatric surgical specialist, or child and adolescent mental health professional serving an area or population described in such paragraph.”

Eligible individuals for this loan repayment program are pediatric medical specialists, pediatric surgical specialists, and child and adolescent mental and behavioral health professionals. These professionals are defined as:

“For purposes of contracts with respect to child and adolescent mental and behavioral health care, the term ‘qualified health professional’ means a health care professional who—(i) has received specialized training or clinical experience in child and adolescent mental health in psychiatry, psychology, school psychology, behavioral pediatrics, psychiatric nursing, social work, school social work, substance abuse disorder prevention and treatment, marriage and family therapy, school counseling, or professional counseling; (ii) has a license or certification in a State to practice allopathic medicine, osteopathic medicine, psychology, school psychology, psychiatric nursing, social work, school social work, marriage and family therapy, school counseling, or professional counseling; or (iii) is a mental health service professional who completed (but not before the end of the calendar year in which this section is enacted) specialized training or clinical experience in child and adolescent mental health described in clause (i).”

Priority consideration is given to subspecialists and providers of adolescent mental health and behavioral health (including substance use disorder services) services who are or will be working in a Health Professional Shortage area, Medically Underserved Area or with a Medically Underserved Population.

\$30,000,000 is authorized for fiscal years 2010 to 2014.

Sec. 5204: Public Health Workforce Recruitment and Retention Program: Offers loan repayment to public health students and workers in exchange for working at least three years at a federal, State, local or tribal public health agency. \$195,000,000 is authorized for fiscal year 2010 with such sums authorized for fiscal years 2011 to 2015.

Sec. 5206: Grants for State and Local Programs: Awards scholarships to mid-career public and allied health professionals employed in public and allied health positions at the Federal, State, tribal or local level to receive additional training in public or allied health fields. \$60 million is authorized for this program for fiscal year 2010 and such sums for fiscal years 2010 to 2015.

Subtitle D: Enhancing Health Care Workforce Education and Training

Sec. 5302: Training Opportunities for Direct Care Workers: Authorizes funding over three years to establish new training opportunities for direct care workers providing long-term care services and supports, which would include facilities for those individuals with mental retardation as well as home and community based settings. \$10 million is authorized for fiscal years 2011 to 2013.

Sec. 5306: Mental and Behavioral Health Education and Training Grants: Awards grants to schools for the development, expansion, or enhancement of training programs in social work, graduate psychology, professional training in child and adolescent mental health, and pre-service or in-service training to paraprofessionals in child and adolescent mental health. Substance use disorder prevention and treatment services would be included within this section. For fiscal years 2010 to 2013, \$8 million is authorized for training in social work; \$12 million is authorized in training for psychology; \$10 million is authorized in training for child and adolescent mental health; and \$5 million is authorized in paraprofessional adolescent and child work

Sec. 5313: Grants to Promote the Community Health Workforce: Authorizes the Secretary, through the Director of CDC, to award grants to States, public health departments, clinics, hospitals, Federally qualified health centers and other nonprofits to promote positive health behaviors and outcomes in medically underserved areas through the use of community health workers. Community health workers offer interpretation and translation services, provide culturally appropriate health education and information, offer informal counseling and guidance on health behaviors, advocate for individuals and community needs and can provide some direct primary care services and screenings. Such sums as necessary are authorized for fiscal years 2010 to 2014.

Sec. 5315: United States Public Health Sciences Track: Directs the Surgeon General to establish a U.S. Public Health Sciences Track to train physicians, dentists, nurses, physician assistants, mental and behavioral health specialists, and public health professionals emphasizing team-based service, public health, epidemiology, and emergency preparedness and response in affiliated institutions. Students receive tuition remission and a stipend and are accepted as Commission Corps officers in the U.S. Public Health Service for two years. The Surgeon General, based on the recommendations of the National Health Care Workforce Commission, will establish Federal tuition remission rates to be used by the Track to provide reimbursement to affiliated and other participating health professions institutions for the cost of educational services provided by such institutions to Track students. The Surgeon General, based on the recommendations of the National Health Care Workforce Commission will establish and update Federal stipend rates for payment to students under this part.

Subtitle E: Supporting the Existing Health Care Workforce

Sec. 5403: Interdisciplinary, Community-based Linkages: Authorizes funding to establish community-based training and education grants for Area Health Education Centers (AHEC) and Programs. These programs target individuals seeking careers in the health professions from urban and rural medically underserved communities. Coordination with mental health and behavioral health facilities is included in this section. \$125 million is authorized for each fiscal year 2010 to 2014.

Sec. 5405: Primary Care Extension Program: Acting through the Director of AHRQ, creates a Primary Care Extension Program to educate and provide technical assistance to primary care providers about evidence-based therapies, preventive medicine, health promotion, chronic disease management and mental health (which includes substance abuse prevention and treatment services). AHRQ will award planning and program grants to State hubs including the State health department, State level entities administering Medicare and Medicaid and at least one health professions school. All appropriate Federal agencies including SAMHSA need to be consulted in carrying out this program. \$120 million is authorized to carry out this program for fiscal years 2011 and 2012; such sums would be authorized for fiscal years 2013 and 2014.

Subtitle G: Improving Access to Health Care Services

Sec. 5601: Spending on Federally Qualified Health Centers: Authorizes the following appropriations: \$2.98 billion in FY 2010; \$3.86 billion in FY 2011; \$4.99 billion in FY 2012; \$6.44 billion in FY 2013; \$7.33 billion in FY 2014; \$8.33 billion in FY 2015.

Sec. 5604: Co-Locating Primary and Specialty Care in Community-Mental Health Settings: Authorizes \$50 million in grants for coordinated and integrated services through the co-location of primary and specialty care in community-based mental and behavioral health settings.

Title VI—Transparency and Program Integrity

Subtitle D: Patient-Centered Outcomes Research

Sec. 6301: Patient-Centered Outcomes Research: Establishes a private, not for profit entity governed by a public-private sector board entitled the Patient-Centered Outcomes Research Institute tasked with identifying priorities for and providing for conduct of comparative outcomes research. The Agency for Healthcare Research and Quality (AHRQ) is tasked to disseminate research findings of the Institute as well as other government-funded research to train researchers in comparative research methods and to build data capacity for comparative effectiveness research.

Sec. 6302: Federal Coordinating Council for Comparative Effectiveness Research: Upon date on enactment, this provision would sunset the Federal Coordinating Council created in the American Recovery and Reinvestment Act of 2010.

Title VII—Improving Access to Innovative Medical Therapies

Subtitle B: Affordable Medicines for Children and Underserved Communities

Sec. 7101: Expanded Participation in 340B Program: Extends the 340B drug discount outpatient program to children's, cancer and critical access hospitals, as well as certain sole community hospitals and rural referral centers. It does not expand the program for existing 340B hospitals to cover inpatient drugs and it exempts orphan drugs from required discounts for new 340B entities.

This expansion DOES NOT include MH/SUD block grant treatment providers receiving SAPT Block Grant funds.

Title X—Strengthening Quality, Affordable Healthcare for All Americans

Subtitle C: Provisions Related to Title III

Sec. 10333: Community-based Collaborative Care Networks: Provides grants to develop networks of providers to deliver coordinated care to low income populations. Such sums will be authorized for fiscal years 2010 to 2015.

Subtitle D: Provisions Relating to Title IV

Sec. 10410: Centers of Excellence for Depression: Directs the Administrator of SAMHSA to award grants to centers of excellence in the treatment of depressive disorders. \$100,000,000 is authorized for fiscal years 2011 to 2015 and \$150,000,000 is authorized for fiscal years 2016 to 2020.

Subtitle E: Provisions Relating to Title V

Sec. 10503: Community Health Centers and National Health Service Corps Fund: Establishes a community health centers and National Health Service corps fund. The Fund will create an expanded and sustained national investment in community health centers under section 330 of the Public Health Service Act and the National Health Service Corps. The following amounts will be transferred to the Secretary of Health and Human Services to provide enhanced funding for the community health center program under section 330 of the Public Health Service Act—

- (A) \$1,000,000,000 for fiscal year 2011;
- (B) \$1,200,000,000 for fiscal year 2012;
- (C) \$1,500,000,000 for fiscal year 2013;
- (D) \$2,200,000,000 for fiscal year 2014; and
- (E) \$3,600,000,000 for fiscal year 2015; and

The following amounts will be transferred to the Secretary of Health and Human Services to provide enhanced funding for the National Health Service Corps—

- (A) \$290,000,000 for fiscal year 2011;
- (B) \$295,000,000 for fiscal year 2012;
- (C) \$300,000,000 for fiscal year 2013;
- (D) \$305,000,000 for fiscal year 2014