

APHA's Health Reform Agenda and Comparison of Senate and House Bills as of November 2, 2009

APHA REFORM PRINCIPLES ON ACCESS TO CARE	H.R. 3962 "THE AFFORDABLE HEALTH CARE FOR AMERICA ACT"	SENATE HEALTH, EDUCATION, LABOR AND PENSIONS COMMITTEE	SENATE COMMITTEE ON FINANCE
<p>Provide access to comprehensive coverage for all</p>	<ul style="list-style-type: none"> - Requires "Shared responsibility payments" for employers not providing coverage and individuals without coverage: <ul style="list-style-type: none"> o Sec. 501 Provides for a tax 2.5% on adjusted income up to cost of average national premium for basic plan for individuals without coverage; hardship waivers for religious and financial reasons. o Sec. 411. Requires employers offering health insurance to offer the option of coverage to all employees. o Sec. 412. Provides that an employer offering insurance must cover at least 72.5% of premium for an individual and 75% for family coverage. o Sec. 413. Requires Establishes a payroll tax of 8% of the wages for employers who do not offer coverage or whose employees decline employer's coverage and enters the Exchange via the affordability test. Exempts employers with payrolls under \$500,000 and establishes a graduated rate of contribution requirements (0%-8%) for those with payrolls between \$500,000 and \$750,000. Employers can make separate elections (to offer coverage or pay tax) for full-time and non-full-time employees. o Sec. 415-416. Require studies on impact of employer responsibility requirements and need for employer hardship exemption. - Sec. 241-244. Creates Health Choices Administration headed by Presidential appointment responsible for: establishing plan standards; establishing and operating Health Insurance Exchange; administering affordability credits; data collection for purposes of addressing disparities and improving quality; appointment of Qualified Health Benefits Plan Ombudsman (includes comprehensive coverage of preventive services, hospitalization, outpatient services, prescription drugs, rehabilitative services.) - Sec. 115. Provides State Health Access grants to reduce the uninsured prior to 2013. States must match 20% of funds (unless financial hardship is demonstrated). 	<ul style="list-style-type: none"> - Starting 2011 requires "Shared responsibility payments" for employers not providing coverage and individuals not enrolled in insurance. Some exemptions and hardship waivers for individuals. <ul style="list-style-type: none"> o Individuals would pay a maximum of \$750 per year. o Employers with more than 25 employees who do not offer qualifying coverage or who pay less than 60% of their employees' monthly premiums would be subject to a \$750 annual fee per uninsured full-time employees and \$375 per uninsured part-time employees. - Creates a temporary "Right Choices Program" through annual grants to states to provide uninsured individuals a "Right Choices Card" for health risk appraisals and possible treatment. 	<ul style="list-style-type: none"> - Beginning in 2013, requires all US citizens and legal residents would be required to have health insurance coverage or pay a penalty: <ul style="list-style-type: none"> o Individuals: \$750 per year (\$1500 maximum per family) for those at 100-300% FPL; \$950 per year (\$3800 max per family) for those above 300% FPL. Exemptions: Coverage is deemed unaffordable -lowest premium available exceeds 10% of income; hardship, religion, for Native Americans and for individuals below 100% FPL (also below 133% FPL for 2013 only). o Employers: Does not require employers to offer health insurance. Those with more than 50 full-time employees that do not offer health coverage must pay a fee for each employee who receives the tax credit for health insurance through an exchange; max of \$400 per employee. - Requires employers with 200 or more employees to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of employer coverage, however, if they are able to demonstrate that they have coverage from another source
<p>Prohibit restrictions due to pre-existing condition or health status</p>	<ul style="list-style-type: none"> - Sec. 211. Prohibits preexisting condition exclusions or other discrimination based on health status for plans or coverage beginning Jan. 1, 2013. Allows insurance rating variation only by family structure, geography, and age. - Sec. 214. Grants Health Choices Commissioner authority to set non-discrimination rules and ensure parity for mental health and substance use disorder benefits. - Sec. 106. Shortens look-back time for pre-existing conditions from 6 months to 30 days; shortens time for exclusion of benefits from 12 months to 3 months starting Jan 1, 2010. - Sec.101. Creates a National High-Risk Pool program to temporarily insure those uninsured because of pre-existing conditions. Terminates when funding (capped at \$5 million) is exhausted or when Exchange is functioning. 	<ul style="list-style-type: none"> - Prohibits preexisting condition exclusions or other discrimination based on health status for coverage. - Prohibits insurance rating variation by health status, gender, genetic information, disability, type of employment or claims history. Allows variation only by family structure, geography, actuarial value of health plan, and age. 	<ul style="list-style-type: none"> - Prohibits preexisting condition exclusions or other discrimination based on health status for plans or coverage. - Allows insurance rating variation only by tobacco use, family structure, geography, and age. - Creates a high-risk pool for uninsured individuals who have been denied health care coverage due to a pre-existing condition. The high-risk pool will exist until 2013. Authorizes \$5 billion to subsidize premiums in the pool.

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<p>Ensure affordable coverage</p>	<ul style="list-style-type: none"> - Sec.102. Amends the Public Health Service Act to require health insurers in the small and large group markets meet a medical loss ratio of not less than 85%, beginning Jan.1, 2010. Plans in the individual market must also meet 85% medical loss ration so long as it does not destabilize the existing individual market. If plan exceeds this limit, rebates to enrollees are required. - Sec. 301-310. Creates Health Insurance Exchange (HIE) for individuals and employers to purchase health insurance. Three main plans (basic, enhanced, premium) and premium plus which can offer extra benefits such as dental or vision coverage for adults, or other non-covered benefits. Employers must provide coverage or pay into HIE Trust Fund, which pays for subsidies with the exception of some small employers which will receive a credit to offset the cost of providing coverage. Establishes a "Consumer Operated and Oriented Plan Program (CO-OP)" non-profit health insurance cooperatives, and start-up loans. - Sec. 341-347. Creates affordability credits to purchase basic plan for those with incomes less than 400% of FPL through year 2; after that may be used for enhanced plan. <ul style="list-style-type: none"> o Affordability premium calculated on a sliding scale starting at 1.5% of income for those at or below 133% FPL and phasing out at 12% for those at 400% FPL. Annual limits on out-of-pocket from \$500 for an individual and \$1000 for a family at the lowest income tier to \$5,000 per individual and 10,000 per family at the highest income tier. o Affordability cost-sharing credits for those at or below 133% to 400% FPL. o Provides up to \$4 billion for territories that choose to participate in the Exchange. - Sec. 521. Sec. 521. Provides tax credit equal to 50% of the amount paid by a small employer, with phase out for those with 10-25 employees or an employer with average wages of \$20,000-\$40,000 per year. Employer may use credit for no more than two years. - Sec. 104. Establishes an annual review process by HHS Sec. for health insurance premium increases beginning Jan. 1, 2010. 	<ul style="list-style-type: none"> - Gives states and regions the option of creating "American Health Benefit Gateways" to facilitate the purchase of affordable coverage for small businesses and individuals. <ul style="list-style-type: none"> o Sliding scale subsidies available to individuals and families with incomes up to 400% of FPL. o Limits maximum out-of-pocket costs for subsidized plans. o Income tiers for cost sharing. o Federal government will create Gateways in states that do not establish one in the allotted 4-year period. 	<ul style="list-style-type: none"> - Requires states to establish an exchange for the individual market and a Small Business Health Options Program (SHOP) exchange for the small group market in 2010. The state exchanges would receive initial Federal funding but must be self-sustaining after the first year. <ul style="list-style-type: none"> o Four benefit categories would be available: bronze silver, gold and platinum. Out of pocket limits equal to those for Health Savings Accounts (HSAs)- \$5,950 for an individual; \$11,900 for a family in 2010. o "Young invincible" policy for catastrophic coverage for young adults o Beginning in 2013, tax credits would be available on a sliding scale basis for individuals and families between 134-300% FPL. Beginning in 2014, the credits are also available to individuals and families between 100-133% of poverty. Premium credits would be tied to the Silver plan. o Cost-sharing assistance is for those between 100-300% FPL. Out-of-pocket limit for those below 300% FPL is capped at a lower level than the HSA amount. o Individuals between 300-400% FPL would be eligible for a premium credit at a flat percent of income. Liability for premiums would be capped at 13% of income for the purchase of a Silver plan. Cost-sharing assistance would not be provided. o Tax credits would be available for tax years 2011 and 2012 for firms with fewer than 25 employees and average wages below \$40,000. o For tax years ending after December 31, 2012, small business tax credits will be available to new businesses and firms newly offering health coverage through an exchange once the exchange is established. Credits are again limited to firms with fewer than 25 employees and average wages below \$40,000, and the maximum credit available would be 50%. - In 2017, requires states to develop and submit to the Secretary a phase-in schedule for incorporating large employers (50+) into the state exchanges. The Secretary must develop regulations to address the potential for any risk selection issues associated with allowing larger employers into the state exchanges. Initial phase in for these firms would begin in plan years in 2018 and beyond. - Starting in 2015, states may form "health care choice compacts" to allow for the purchase of non-group health insurance across state lines. Such compacts may exist between two or more states. - Prohibit cost-sharing (including premiums, deductibles, copayments, co-insurance, etc.) for all American Indians and Alaska Natives (AI/ANs) with incomes at or below 300% FPL for state exchange plans and public programs.

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<p>Provide first dollar support for evidence-based clinical preventive services</p>	<p><u>Exchange Plans</u></p> <ul style="list-style-type: none"> - Sec. 222. Requires health plans to cover and not impose any cost sharing requirements on certain clinical preventive services and items including well baby and well child care. - Sec. 223. Establishes a Health Benefits Advisory Committee to provide recommendations on essential health benefits, minimum qualifying benefit package, recommendations regarding cost sharing to the Secretary of HHS; headed by Surgeon General. 	<p><u>Exchange Plans</u></p> <ul style="list-style-type: none"> - Requires health plans to cover and to impose minimal cost sharing requirements on certain clinical preventive services and items including well baby and well child care. - Establishes a Medical Advisory Council to provide recommendations on essential health benefits and minimum 	<p><u>Exchange Plans</u></p> <ul style="list-style-type: none"> - Requires health exchange plans to cover and not impose any cost sharing requirements on certain clinical preventive services and items including well baby and well child care, except in cases where value-based insurance design¹ is used.
	<p><u>Medicare</u></p> <ul style="list-style-type: none"> - Sec. 1305. Eliminates cost sharing for Medicare covered preventive services; - Sec. 1306. Waives deductible for colorectal cancer screening test and related/subsequent procedures. 	<p><u>Medicare</u></p> <ul style="list-style-type: none"> - Eliminates cost sharing for certain clinical preventive services. 	<p><u>Medicare</u></p> <ul style="list-style-type: none"> - Beginning in 2011, allows Medicare beneficiaries to complete a comprehensive health risk assessment (HRA) and visit a primary care provider to create a personalized prevention plan. - Authorizes one wellness visit every year for every Medicare beneficiary. No co-payment or deductible would apply. - Allows HHS Secretary to modify coverage of existing preventive services to the extent that the modification is consistent with USPSTF recommendations. The Secretary can withdraw Medicare coverage for services rated —D or harmful by USPSTF. - Provides funding for CMS to improve provider education and patient awareness of covered preventive services. - Requires a GAO study to determine if any barriers exist that prevent the optimal utilization of covered primary, secondary and tertiary preventive services. - Requires a GAO study and report to Congress on the impact of the coverage of adult immunizations under Part D on access to those immunizations by Medicare beneficiaries. - Authorizes and appropriates \$100 million over five years (starting Jan 1, 2011) for an initiative to provide incentives to Medicare beneficiaries who successfully complete certain healthy lifestyle programs. Programs would target the following risk factors: high blood pressure, high cholesterol; tobacco use, overweight or obesity, diabetes and falls.
	<p><u>Medicaid</u></p> <ul style="list-style-type: none"> - Sec. 1711. Eliminates cost sharing for certain clinical preventive services. - Sec. 1712. Prohibits Medicaid from excluding coverage tobacco cessation drugs. 	<p><u>Medicaid</u></p> <ul style="list-style-type: none"> - No similar provision 	<p><u>Medicaid</u></p> <ul style="list-style-type: none"> - Encourages state Medicaid programs to improve coverage of and access to recommended preventive services and immunizations by offering increased FMAP for those states who cover USPSTF and ACIP recommended services, and comprehensive tobacco cessation services for pregnant women (without cost sharing).

¹ Value-based insurance design (VBID) -- A benefit design that identifies clinically beneficial preventive screenings, lifestyle interventions, medications, immunizations, diagnostic tests and procedures, and efficacious treatments for which cost-sharing (co-payments or coinsurance and deductibles) should be eliminated or reduced due to their high value and effectiveness.

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Other Coverage	<ul style="list-style-type: none"> - Sec. 112. Requires guarantee issue and renewal of coverage and prohibits the use of rescissions expect in cases of fraud. - Sec.109 Prohibits insurers from using lifetime limits on coverage beginning Jan. 1. 2010.. - Sec.110. Prohibits employers from reducing post-retirement benefits to a level below that offered before retirement. - Sec. 111. Creates a temporary reinsurance program to provide eligible employers reimbursement for covering adults ages 55 to 64 (Establishes \$10 billion fund). - Sec. 105. Require health insurers to allow individuals up through age 26 to remain on their parent's plan beginning Jan. 1, 2010. Sec. 216 makes this option permanent. - Sec. 113. Extends COBRA eligibility until Exchange is functioning. 	<ul style="list-style-type: none"> - No annual or lifetime limit on coverage. - Creates a temporary reinsurance program to provide eligible employers reimbursement for covering adults ages 55 to 64. - Extends coverage to dependents up to age 26. - Creates "Community Living Assistance Services and Supports Act", a national voluntary insurance program for purchasing community living assistance services. - Supports developing a "Preventive Care Visit Card" encouraging the use of preventive services and promote health and wellness. - Allows extension of existing coverage to family members of employees. 	<ul style="list-style-type: none"> - No annual or lifetime limit on coverage (exchange plans). - Authorizes \$6 billion in funding for the Consumer Operated and Oriented Plan (CO-OP) program: <ul style="list-style-type: none"> o Non-profit, member-run health insurance companies that serve individuals in one or more states. o CO-Ops may operate on a state, regional or national level o CO-OP grantees would compete in the reformed individual and small group insurance markets. o Federal funds would be distributed as loans and grants. Loans would be provided to assist with start-up costs, and grants would be provided to meet state solvency requirements. - Authorizes \$30 million to establish a new competitive grant program to support consumer assistance organizations in each state. Grantee organizations would assist consumers in solving problems and navigating health insurance coverage transitions, as well as collect data on consumer encounters, and report to HHS on types of problems and inquiries
Strengthen Public Programs	<p><u>Medicare</u></p> <ul style="list-style-type: none"> - Sec. 1181. Phases in eliminating "doughnut hole" for Medicare Part D recipients beginning with a \$500 reduction in 2010 and completing phase-out by 2019. Pays for elimination of gap with funds raised from requiring drug manufactures to provide Medicaid rebates for drugs used by full dual-eligibles and low-income recipients - Sec. 1202. Eliminates Medicare Part D cost sharing for some non-institutionalized low-income - Sec. 1310. Transfers coverage of vaccines from Medicare Part D to Medicare Part B. 	<p><u>Medicare</u></p> <p>No similar provisions</p>	<p><u>Medicare</u></p> <ul style="list-style-type: none"> - Establish a discount program for beneficiaries who enroll in Part D and have drug spending that falls into the coverage gap. - Beginning July 1, 2010, eligible beneficiaries would automatically receive a 50 percent discount off the negotiated price for brand-name prescription drugs that are covered under Part D and covered by their plan's formulary or are treated as being on plan formularies through exceptions and appeals processes. - Creates an Independent Medicare Commission to develop and submit proposals to Congress aimed at extending the solvency of Medicare, slowing Medicare cost-growth, and improving the quality of care delivered to Medicare beneficiaries. The Commission would be required to submit a draft of its proposal to MedPAC and CBO by September 1, 2013.

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<p>Strengthen Public Programs</p>	<p><u>Medicaid</u></p> <ul style="list-style-type: none"> - Sec. 1701: <ul style="list-style-type: none"> o Expands Medicaid coverage to all individuals with incomes up to 150% FPL including childless adults. Provides states with 100% matching funds to cover the expansions in 2013-2014; then 91% thereafter. o Provides automatic Medicaid coverage to uninsured newborns for up to 60 days while eligibility is determined; 100% federal funding for this coverage. - Sec. 1748. Extends ARRA increase in federal matching payments to states with high unemployment rates for an additional six months. - Sec. 1771. Raises federal matching rate for all territories to the highest rate for any state and increases the ceiling for payments. Overall increase equal to \$10.35 billion over the period of 2011-2019. - Sec. 1703. Prohibits states from adopting eligibility standards, methodologies, or procedures in their Medicaid program that are more restrictive than those in effect as of June 16, 2009 - Sec. 1713. Grants state Medicaid programs the option of covering nurse home visitation services for first-time mothers and mothers of children under two. - Sec. 1714. Grants state Medicaid programs the option of creating a coverage option for family planning services for categorically needy groups. - Sec. 1724. Gives states the option of covering services provided at freestanding birth centers.. - Sec. 1731. Gives states the option of covering low-income persons with HIV under Medicaid; to be matched at an enhanced rate. (Sunsets on Jan. 1, 2013). - Sec. 1732. Extends one-year transitional Medicaid assistance (TMA) from Dec. 31, 2010 through Dec. 31, 2012. - Sec. 1726-1726A. Requires Medicaid to cover podiatrist and optometrist services. - Sec. 1729. Requires Medicaid to suspend, not terminate, eligibility for beneficiaries under age 19 during a period of incarceration in a public institution. - Sec. 1730B. Requires Medicaid to reimburse school-based health clinics on the same basis as FQHCs. - Sec. 1737. Requires Medicaid to continue to cover nonemergency transportation to medically necessary services as specified in regulations effect on June 1, 2008. - Sec. 1748. Allows Medicaid to cover individuals with family incomes up to \$150,000 who have orphan drug costs exceeding \$200,000 and have exhausted private prescription drug coverage. - Sec. 1785. Requires Sec. to issue guidance regarding outreach and enrollment for Medicaid and SCHIP targeted to vulnerable populations. 	<p><u>Medicaid</u></p> <ul style="list-style-type: none"> - Expands Medicaid coverage to all individuals with incomes up to 150% FPL. Individuals eligible for Medicaid not eligible for credits to purchase insurance through Gateway. Provides states with 100% Medicaid matching funds through 2015 to cover the expansion. 	<p><u>Medicaid</u></p> <ul style="list-style-type: none"> - Starting Jan 1, 2014 expands Medicaid to all individuals at or below 133% FPL. Those between 100-133% would have the option of Medicaid or exchange plan. Provides states with increased funding to cover expansions. - Gives states the option to cover non-elderly non-pregnant adults through a state plan amendment (SPA) at their current match rate starting January 2011. - Beginning in FY 2011, all territories’ FMAP rate would be increased from 50% to 55% and all spending caps would be increased by 30%. The cost of covering newly eligibles would not count towards the spending cap. - Starting January 1, 2013, requires states to offer premium assistance and wrap-around benefits to Medicaid beneficiaries who are offered employer coverage if it is cost-effective to do so, consistent with current law requirements. - Makes prescription drugs a mandatory benefit for the categorically and medically needy, effective January 1, 2014.

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Strengthen Public Programs	<p><u>CHIP</u></p> <ul style="list-style-type: none"> - Sec. 1733. Requires stand-alone CHIP programs to implement 12-month continuous eligibility for all enrollees with incomes below 20FPL beginning Jan 1, 2010. - Sec. 1703. Prohibits states from adopting eligibility standards, methodologies, or procedures in their CHIP program that are more restrictive than those in effect as of June 16, 2009. Maintenance of eligibility ends upon expiration of CHIP on December 31, 2013. 	<p><u>CHIP</u></p> <ul style="list-style-type: none"> - Individuals eligible for CHIP have the option of enrolling a qualified plan through a Gateway. 	<p><u>CHIP</u></p> <ul style="list-style-type: none"> - Requires states to maintain their current CHIP eligibility levels through 2012. - Beginning in 2013, CHIP beneficiaries would enroll in exchange plans and states would provide a "CHIP-wrap" to provide supplementary benefits, including EPSDT benefits for all children. A federal floor for CHIP income eligibility would be set for children and pregnant women at 250% FPL. - Appropriate \$25 million for HHS Sec. to carry out the Childhood obesity prevention demonstration project.
Strengthen funding for safety net	<ul style="list-style-type: none"> - Sec. 2101. Provides additional funding for community health centers: <ul style="list-style-type: none"> o \$1 billion FY2011 o \$1.5 billion FY2012 o \$2.5 billion FY2013 o \$3 billion FY2014 o \$4 billion FY2015 - Sec. 2512. Establishes a program to support nurse-managed health centers. Authorizes such sums as necessary for FY2011-2015 to carry out this section. - Sec. 2252. Reauthorizes programs to support telehealth network, resource centers, and provide incentives to coordinate telemedicine licensure activities among states. Authorizes \$10 million for FY2011 and such sums as necessary for FY2012-2015. 	<ul style="list-style-type: none"> - Increases funding for federally-qualified health centers gradually from \$2.9 billion in FY2010 to \$8.3 billion in FY2015. - Authorizes \$50 million for nurse managed health clinics to provide comprehensive primary care and wellness services in medically underserved communities 	No similar provisions
Create a public insurance plan	<ul style="list-style-type: none"> - Sec. 321-331. Requires HHS Sec to develop a public health insurance option Beg. 2013 as a choice available through the HIE; may offer basic, enhanced, premium and premium plans benefits; complies with same requirements as private plans in HIE. <ul style="list-style-type: none"> o Allows members of Congress to join. o Cost sharing, benefits package, provider networks, and consumer protections; premiums are geographically-adjusted and shall reflect full costs of operating and administering public option; o Appropriates \$2 billion to be amortized into premiums for the public option and recouped over the first 10 years of operation. Plans must be self-sustaining after the initial funding o HHS Sec. negotiates payment for providers, items and services; Medicare providers have choice to opt-out o All HIPAA, health information privacy, security, and electronic transaction protections apply. 	<ul style="list-style-type: none"> - Creates the "Community Health Insurance Option" to be offered through the Gateways and designed to provide value, choice, competition, and stability of affordable, high quality coverage. <ul style="list-style-type: none"> o Must cover essential health benefits (at minimum); states have options of requiring additional coverage (to be paid for by the state). o Sliding scale subsidies available to individuals and families with incomes up to 400% of FPL. o Limits maximum out-of-pocket costs. o Income tiers for cost sharing. - Establishes "Health Benefit Plan Start-Up Fund" to provide loans for the initial operations of the community health insurance option (must be repaid within 10 years). - Requires each state to establish "State Advisory Council" to provide recommendations on the operations and policies of the community health insurance option in the State 	No similar provisions

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<p>Shift reimbursement and other policies to promote primary care</p>	<p>Medicare</p> <ul style="list-style-type: none"> - Sec. 1303. Increases Medicare reimbursement rates by 5% for primary care services. - Sec. 1304. Increases the payment rate for nurse midwives for covered services from 65% of physician rate to 100%. - Sec. 1311. Expands Medicare reimbursement for preventive services furnished at federally qualified health centers. - Sec. 1159. Directs HHS Sec. to contract with IOM to conduct a study on geographic variation in health care spending. - Sec. 1160. Directs HHS Sec. to develop an implementation plan for changing Medicare payment systems; plan to be implemented starting 2013 unless Congress votes to disapprove it. - Sec. 1161 Reduces Medicare advantage benchmarks to fee-for-service levels over 3 years. Includes Medicare incentive payments for "efficient areas", which are geographic areas of low per capita spending to be phased in over 2011-2013. - Sec. 1301. Creates a 3 to 5-year Medicare "Accountable Care Organization (ACO) Pilot Program" to test different payment incentives models - Sec. 1302. Creates a 5-year Medicare "Medical Home Pilot Program" to evaluate the independent patient-centered and community-based medical home models. Provides \$1.8 billion for the program. - Sec. 1312. Creates a demonstration program for chronically ill Medicare beneficiaries to test a payment incentive and service delivery system using home-based primary care teams. - Sec. 1313. Allows certified diabetes educators to receive payment from Medicare directly for provision of outpatient self-management training services. <p>Medicaid</p> <ul style="list-style-type: none"> - Sec. 1721. Requires Medicaid programs to reimburse for primary care services at no less than 80% of Medicare rates in 2010; 90% in 2011; and 100% in 2012 and thereafter. Federal government would pay 100% of the incremental costs through 2014; then 90% thereafter. - Sec. 1722. Creates a 5-year Medicaid "Medical Home Pilot Program"; federal government would match costs of community care workers at 90% for first 2 years of the pilot program 75% for the next 3 years. Federal contribution not to exceed \$1.23 billion over 5 years. - Sec. 1730. Authorizes \$40 million for 2010-2015 for the Sec. to develop quality measures for maternity care and other adult care provided under Medicaid and SCHIP. 	<ul style="list-style-type: none"> - Restructures reimbursements to provide incentives for case management, care coordination, chronic disease management, medication and care compliance, and activities to prevent hospital readmission, improve patient safety and reduce medical errors. - Establish a program to provide grants to eligible entities to create community-based multidisciplinary health teams to support primary care practices within hospitals. 	<ul style="list-style-type: none"> - Establishes a bundled payment demonstration project under Medicaid in up to eight states to begin October 1, 2011. - Requires HHS Sec. to develop, test and evaluate alternative payment methodologies through a national, voluntary pilot program that is designed to provide incentives for providers to coordinate patient care across the continuum and to be jointly accountable for the entire episode of care starting in 2013. - Requires the HHS Sec. to create an Innovation Center within CMS to test, evaluate, and expand different payment structures and methodologies to foster patient-centered care, improve quality, and slow the rate of Medicare cost growth. - Provides primary care practitioners and general surgeons in shortage areas a 10% bonus for certain services for five years, beginning January 1, 2011. - Directs MedPAC to review payment adequacy for rural health care providers serving the Medicare program and provide a report to Congress by January 1, 2011.

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	<ul style="list-style-type: none"> - Sec. 1730A. Directs Sec. to allow Medicaid to pilot one or more of the models used in the Medicare ACO pilot program; administrative costs would be matched at 90% in the first two years; 75% in the last three. - Sec. 1744. Clarifies that Medicaid programs may receive federal matching payments for the costs of graduate medical education. - Sec. 1746. Requires Medicaid programs to annually submit to CMS information on the determination of provider payment rates. - Sec. 1747. Directs GAO to study and report to Congress by Feb. 15, 2011 on the federal Medicaid matching formula and the use of federal Medicaid funds on administrative expenses. - Sec. 1784. Provides start-up funds (\$11.8 billion) for the Medicaid and CHIP Payment and Access Commission - 		
Ensure cultural competency	<ul style="list-style-type: none"> - Sec. 1222. Directs HHS Sec. to conduct a study that examines the extent to which Medicare service providers utilize, offer, or make available language services for beneficiaries who are limited English proficient (LEP) and ways that Medicare should develop payment systems for language services. - Sec. 1223. Directs HHS Sec. to contract with the IOM to conduct a study on the impact of language access to services to the health and health care of populations with LEP. - Sec. 1723. Provides 75% federal matching rate for the costs of translation or interpretation services for Medicaid eligible adults with LEP. 	<ul style="list-style-type: none"> - Requires reimbursement policies to promote culturally and linguistically appropriate care. - Establishes a 5-year national public education campaign on oral healthcare and prevention and require that all activities are culturally/linguistically appropriate. - Provides grants to support the training of mental health service providers under the requirement that institutions receiving support will prioritize training in cultural and linguistic competence. - Directs HHS Sec. to collaborate with experts in minority health and cultural competence to support the development and evaluation of cultural competence curricula, including standard measures and self-assessment methodologies for health care providers and organizations, and disseminate model curricula through an Internet Clearinghouse. 	No similar provisions
Sustain investment in health information technology (HIT)	No similar provisions	<ul style="list-style-type: none"> - Directs HHS Secretary in consultation with the HIT Policy Committee and the HIT Standards Committee to develop interoperable and secure standards and protocols that facilitate enrollment of individuals in Federal and State programs. - Authorizes grants for implementation of HIT standards and protocols identifies by the HIT Policy and Standards Committees. 	No similar provisions

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<p>Other quality</p>	<ul style="list-style-type: none"> - Sec. 1441-1443. Directs Sec. to establish national priorities for performance improvement. Based on the national priorities, the Sec. shall develop, test and update new patient-centered and population-based quality measures for the assessment of health services; authorizes \$25 million. - Sec. 1444-1445. Ensures that quality measures are endorsed by a consensus-based entity; authorizes \$12 million for 2010-2012. - Sec. 1236. Creates a demonstration program that uses decision aids and other technologies to help patients and consumers - Sec. 1401. Establishes a "Center on Comparative Effectiveness Research" within AHRQ to conduct, support, and synthesize research on outcomes, effectiveness, and appropriateness of health care services and procedures to identify ways in which diseases and conditions can be best prevented, diagnosed, treated and managed clinically. Creates an independent "Comparative Effectiveness Research Commission" to oversee and evaluate the activities of the Center. - Sec. 1802. Creates a "Comparative Effectiveness Research Trust Fund". Funds would be transferred from the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, and from the Medicare Prescription Drug Account: <ul style="list-style-type: none"> o \$90 million FY2011 o \$100 million FY2012 o \$110 million FY2013 - Sec. 1905 Requires CMS to establish a dedicated office or program to improve coordination of services for Medicare-Medicaid dual-eligibles - Sec. 1907. Establishes a Center for Medicare and Medicaid Innovation within CMS to research, develop, test and expand innovative payment and delivery arrangements. 	<ul style="list-style-type: none"> - Requires GAO to conduct an ongoing assessment of Gateway activities. - Creates a "Center for Health Outcomes Research" and Evaluation to collect, conduct and support research comparing health outcomes, effectiveness, and appropriateness of health services and procedures. - Supports comparative effectiveness research on drugs, devices, medical and surgical procedures, screenings and other health interventions. - Creates a "Patient Safety Research Center" to identify, evaluate and disseminate information on best practices to providers and patients. 	<ul style="list-style-type: none"> - Effective July 1, 2011, prohibits Federal payments to states for Medicaid services related to health care acquired conditions. - Establishes the Medicaid Quality Measurement Program which would expand upon existing quality measures, identify gaps in current quality measurement, establish priorities for the development and advancement of quality measures and consult with relevant stakeholders. - Establishes a value-based purchasing program for hospitals starting in 2011. Under this program, a percentage of hospital payment would be tied to hospital performance on quality measures related to common and high-cost conditions, such as cardiac, surgical and pneumonia care. - Improves the Physician Quality Reporting Initiative (PQRI) program, by requiring all eligible health professionals to participate by 2011, establishing payment incentives for physicians to appropriately order high-cost imaging services, expanding the Medicare physician feedback program, and penalizing physicians who utilize significantly more resources than their peers. - Requiring the HHS. Sec to implement quality measure reporting programs for certain providers in 2011. Providers who do not successfully participate in the program would be subject to a reduction in their annual market basket update. - Creates an Interagency Working Group on Health Care Quality to be convened by the President to collaborate and consult on fulfilling the national quality improvement strategy and priorities. - Allows groups of Medicare providers who voluntarily meet certain statutory criteria, including quality measurements, to be recognized as accountable care organizations (ACOs) and be eligible to share in the cost-savings they achieve for the Medicare program. Beginning on Jan. 1, 2012, eligible ACOs would have the opportunity to qualify for an incentive bonus. - Establishes a three-year pilot "Community Care Transitions Program. Beginning in 2011, the HHS. Sec would fund eligible hospitals and community-based partnership organizations to provide patient-centered, evidence-based care transition services to Medicare beneficiaries at the highest risk of preventable re-hospitalization. <p>Authorizes the establishment of a "Patient-Centered Outcomes Research Institute" to assist patients, clinicians, purchasers, and policy makers in making informed health decisions by advancing the quality and relevance of clinical evidence through research and evidence synthesis.</p>

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APHA REFORM PRINCIPLES ON POPULATION HEALTH AND PREVENTION	H.R. 3962 "THE AFFORDABLE HEALTH CARE FOR AMERICA ACT"	SENATE HEALTH, EDUCATION, LABOR AND PENSIONS COMMITTEE	SENATE FINANCE COMMITTEE
<p>Invest in population and community-based prevention, education and outreach programs.</p>	<p><u>General Prevention and Wellness Programs</u></p> <ul style="list-style-type: none"> - Sec. 3111. Establishes and "Prevention and Wellness Trust" (PWT) and authorizes (from the public health investment fund): <ul style="list-style-type: none"> o \$2.4 billion FY2011 o \$2.8 billion FY2012 o \$3.1 billion FY2013 o \$3.4 billion FY2014 o \$3.6 billion FY2015 - Sec. 3121 Directs HHS Sec. to develop a "National Prevention and Wellness Strategy" to improve the Nation's health through evidenced-based clinical and community-based prevention and wellness activities including core public health infrastructure improvement activities. - Sec. 3151 Establishes a grant program to provide evidence-based community based prevention and wellness services in priority areas identified in the National Prevention and Wellness Strategy. Funding builds up from \$1.065 billion in FY2011 to \$1.6 billion in FY2015. - Sec. 2511. Establishes a grant program to support school-based health clinics. Specifies that funding supplements (rather than supplants) existing federal and non-federal funding to SBHCs. Authorizes \$50 million for FY2011 and such sums as necessary for FY2012-2015. - Sec. 2530. Establishes a new training program for community health workers to promote positive health behaviors in medically underserved communities. Authorizes \$30 million for each year FY2011-2015. - Sec. 2535. Establishes a new program to prevent overweight and obesity among children. Authorizes \$10 million for FY2011 and such sums as necessary for FY2012-2015. 	<p><u>General Prevention and Wellness Programs</u></p> <ul style="list-style-type: none"> - Directs HHS Sec. to plan and implement a national public-private partnership for a prevention and health promotion outreach and education campaign to raise public awareness of health improvement across the life span. - Creates "Community Transformation" grants to state and local governmental agencies and community based organizations for the implementation, evaluation, and dissemination of proven evidence-based community preventive health activities to reduce chronic disease rates, address health disparities, and develop stronger evidence-base of effective prevention. - Provides for grants to State or local health departments to carry out 5-year pilot programs to provide public health community interventions, screenings, and where necessary, clinical referrals for individuals who are between 55 and 64 years of age - Creates a grant program to implement "Medication Management" services for the treatment of chronic diseases. - Creates a program to fund "Community Health Teams" to support the development of medical homes by increasing access to comprehensive, community based, coordinated care. - Creates the "Healthy Aging, Living Well program to program is to improve the health status of the pre-Medicare-eligible population to help control chronic disease and reduce Medicare costs. The CDC would provide grants to states or large local health departments to conduct 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. 	<p><u>General Prevention and Wellness Programs</u></p> <ul style="list-style-type: none"> - Reduces restrictions on the number of eligible counties that may participate in the demonstration project on community health integration models in certain rural counties. - Directs the HHS. Sec. to develop criteria for healthy lifestyle programs using relevant, evidence-based resources. After the Sec. develops criteria, states could design a proposal and apply for funds to provide incentives to Medicaid enrollees who successfully complete healthy lifestyle programs. Authorizes \$100 million in funding for these grants during a five-year period beginning on January 1, 2011. - Creates a new Medicaid state plan option under which Medicaid enrollees with at least two chronic conditions or with one chronic condition and at risk of developing another chronic condition, could designate a provider as their health home. Provides an enhanced match of 90% for two years and small planning beginning on January 1, 2011. After two years there would be an independent evaluation of the impact of this option on reducing hospital admissions.

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<p>Invest in population and community-based prevention, education and outreach programs.</p>	<p><u>Prevention Taskforce</u></p> <ul style="list-style-type: none"> - Sec.3131. Converts USPSTF to "Task Force on Clinical Preventive Services" to review the scientific evidence on the benefits, effectiveness, appropriateness, and costs of clinical preventive services; develop evidence-based recommendations; and identify gaps in clinical preventive services research and recommend priority areas for research activities. - Sec. 3132. Develops a "Task Force on Community Preventive Services" to review the scientific evidence related to the benefits, effectiveness, appropriateness, and costs of community preventive services; provide evidence-based recommendations and identify gaps in community preventive services research and recommend priority areas for research activities. - Total funding (from PWT) for Taskforces: \$30 million each year for FY2011-2015. 	<p><u>Prevention Taskforce</u></p> <ul style="list-style-type: none"> - Directs CDC Director to convene an independent "Community Preventive Services Task Force" to review the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of community preventive interventions and recommendations, to be published in the "Guide to Community Preventive Services"; should take appropriate steps to coordinate its work with the USPSTF and the Advisory Committee on Immunization Practices, including the examination of how each task force's recommendations interact at the nexus of clinic and community. 	<p><u>Prevention Taskforce</u></p> <p>No similar provision</p>
	<p><u>Prevention Research</u></p> <ul style="list-style-type: none"> - Sec. 3141 Directs CDC and NIH directors to coordinate prevention and wellness research activities taking into consideration priority areas identified in the National Prevention and Wellness Strategy and by the Task Force on Clinical Preventive Services and the Task Force of Community Preventive Services. - Sec. 3142. Provides support for CDC research on community preventive services. - Sec. 3143. Funds research on incentivizing healthy behaviors and inclusion of incentives in essential benefits packages or community prevention and wellness programs. - Total funding (from PWT) builds up from \$155 million in FY2011 to \$355 million in FY2015. 	<p><u>Prevention Research</u></p> <ul style="list-style-type: none"> - Directs HHS/CDC to fund research in the area of public health services and systems that examines evidence-based practices relating to prevention, with a particular focus on high priority areas as identified by the Sec. in the National Prevention Strategy or Healthy People 2020 and including comparing community-based public health interventions in terms of effectiveness and cost. 	<p><u>Prevention Research</u></p> <p>No similar provision</p>
	<p><u>Oral Health</u></p> <p>Plans in the Exchange are required to include oral health services (as defined by an expert panel) for children under 21 years of age.</p>	<p><u>Oral Health</u></p> <ul style="list-style-type: none"> - Establishes a 5-year national public education campaign on oral healthcare prevention. - Provides demonstration grants to demonstrate the effectiveness of research-based dental caries disease management activities. - Directs HHS Sec. to update and improve Pregnancy Risk Assessment Monitoring System (PRAMS) as it relates to oral health. - Plans in the exchange are required to provide oral care for children. 	<p><u>Oral Health</u></p> <p>No similar provision</p>
<p>Invest in population and</p>			

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community-based prevention, education and outreach programs.	<p><u>Immunizations</u></p> <ul style="list-style-type: none"> - Sec. 1725. Includes public health clinics under the Vaccines for Children Program - Sec. 2524. Establishes a new grant program of demonstration projects to study the feasibility of using elementary and secondary education schools as influenza vaccination centers. Authorizes such sums as necessary for FY2011-2015 to carry out this section. 	<p><u>Immunizations</u></p> <ul style="list-style-type: none"> - Directs the CDC Director to establish a demonstration program to award grants to States to improve the provision of recommended immunizations for all ages using evidence-based, population-based interventions for high-risk populations. <ul style="list-style-type: none"> o No more than 4 years after demonstration program, Sec. must report on its effectiveness - Grants HHS Sec. Ability to negotiate and enter into contracts with manufacturers of vaccines for the purchase and delivery of vaccines for adults. - Allows states to purchase adult vaccines directly from manufacturers at price negotiated by the HHS Sec.. - Reauthorizes the section 317 program 	<p><u>Immunizations</u></p> <p>See "Medicare" under "Provide first dollar support for evidence-based clinical preventive services"</p>
	<p><u>Worksite Wellness</u></p> <p>Sec. 112. Establishes a wellness grant program for small employers.</p>	<p><u>Worksite Wellness</u></p> <ul style="list-style-type: none"> - Directs the CDC Director to establish a workplace wellness promotion campaign. - Directs CDC Director to conduct a national worksite health policies and programs survey to assess employer based health policies and programs. - Creates workplace wellness demonstrations. 	<p><u>Worksite Wellness</u></p> <p>No similar provision</p>
Develop more accurate fiscal scoring for prevention and early intervention services	No provision	No provision	No provision
Require a health impact assessment (HIA) for all new federal policies and programs	No provision	<ul style="list-style-type: none"> - Establishes a program at the CDC National Center of Environmental Health to collect and disseminate evidence-based practices relating to HIAs; manage capacity building grants, technical assistance, and training on the use of HIAs. 	No similar provision
Establish health goals and outcomes and require an annual "State of the Nation's Health" report card.	<ul style="list-style-type: none"> - Sec. 2401-2403. Creates a Center for Quality Improvement to identify, develop, evaluate, and implement best practices. Establishes an Assistant Secretary for Health Information within HHS to develop, collect data, and report on "Key National Indicators" regarding the performance of the nation's health and health care. Authorizes (from PHIF) \$300 million each year for FY2011-2015 to carry out sections 2401-2402. 	<ul style="list-style-type: none"> - Directs the National Academy of Sciences to establish a "Commission on Key National Indicators" to develop and conduct comprehensive oversight of a "Key National Indicators System". 	No similar provision

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<p>Other Prevention and Population Health</p>	<ul style="list-style-type: none"> - Sec. 2572. Requires nutrition labeling standard menu items at chain restaurants and of articles of food sold from vending machines. - Sec. 2525. Reauthorizes the Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) program and removes the three-state limitation on participation. Authorizes funding that builds up from \$70 million for FY2011 to \$85 million for FY2015. - Sec. 2526. Establishes a new program for states to provide evidence-based education to reduce teen pregnancy and sexually transmitted infections. Authorizes \$50 million for each year for FY2011-2015. - Sec. 2527. Establishes a new program to address the unmet needs of children and adults with autism and related developmental disabilities. Authorizes \$17 million for FY2011 and such sums as necessary for FY2012-2015. - Sec. 2528. Establishes a new program to implement medication therapy management services provided by licenses pharmacists as a collaborative approach to treating chronic diseases. - Sec. 2529. Encourages HHS Sec, to expand activities on postpartum conditions. Authorizes such sums as may be necessary for FY2011-2013 to carry out this section. - Sec. 2532. Establishes a new program to support pilot projects for reducing infant mortality. Authorizes \$10 million each year for FY2011-2015. - Sec. 2537. Establishes a national demonstration program to evaluate the effectiveness of medical-legal partnership to assist with navigating health-related programs and activities. - Sec. 2561. Requires the HHS Sec. to contract the IOM to convene a Conference on Pain. Authorizes \$500,000 each year FY2011-2012. - Sec. 2562 Encourages NIH Director to expand, through the Pain Consortium, a program of basic and clinical research on pain. - Sec. 2563. Requires HHS Sec. to implement a national education outreach and awareness campaign on pain management. Authorizes \$2 million for FY2011 and \$4 million for each year FY2012-2015. - Sec. 2581. Establishes a new, voluntary insurance program for purchasing community living assistance services and support (CLASS) for individuals with functional limitations. 	<ul style="list-style-type: none"> - Requires nutrition labeling standard menu items at chain restaurant and of articles of food sold from vending machines. - Establishes a "National Prevention, Health Promotion and Public Health Council" a multidisciplinary group of professionals (including Secretaries of health, transportation, environment, education, agriculture, housing) to provide coordination and leadership at the Federal level with respect to prevention, wellness and health promotion practices, the public health system, and integrative health care. Council will also develop and make public a national prevention, health promotion and public health strategy and provide annual reports to Congress from July 2010 through July 2015. - Establishes a "Coordinated Environmental Public Health Network". This network will build upon and coordinate among existing environmental and health data collection systems and create state environmental public health networks to track the incidence, prevalence, and trends of priority chronic conditions and potentially related environmental exposures, paying particular attention to low income and minority communities. 	<p>No similar provisions</p>

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APHA REFORM PRINCIPLES ON HEALTH DISPARITIES	H.R. 3962 "THE AFFORDABLE HEALTH CARE FOR AMERICA ACT"	SENATE HEALTH, EDUCATION, LABOR AND PENSIONS COMMITTEE	SENATE FINANCE
<p>Support effective strategies to reduce health disparities</p>	<ul style="list-style-type: none"> - Sec. 1904. Provides state grants to create home visitation programs for families with young children and families expecting children. Authorizes: <ul style="list-style-type: none"> o \$50 million FY2010 o \$100 million FY2011 o \$150 million FY2012 o \$200 million FY2013 o \$250 million FY2014 - Sec. 3151. Requires that 50% of funds for prevention and wellness services be used for programs aimed at addressing a specific health disparity - Sec. 1785. Requires HHS Sec. to issue guidance regarding outreach and enrollment for Medicaid and SCHIP targeted to vulnerable populations. - Sec. 2534. Establishes a new program to support community-based collaborative care networks to offer coordinated and integrated health care services for low-income populations and medically underserved communities. Authorizes such sums as necessary for FY2011-2015 to carry out this section. - Sec. 2592 Requires the development of standards for accessible medical equipment and requires relevant agencies to ensure that all entities covered by the Affordable Health Choices Act meet requirements of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act. - Sec. 3101 makes amendments to the Indian Health Care Improvement act, including programs to increase representation of Indians within health care professions; scholarship and loan repayment programs; establish community health representative and community health aide programs; provides funding for health promotion and disease prevention services; improves health care payment and service delivery systems; and improves accessibility and availability of health services to urban Indians. 	<ul style="list-style-type: none"> - Directs the Architectural and Transportation Barriers Compliance Board to establish standards for accessible medical diagnostic equipment by persons with disabilities. - Amends the Public Services Act to support the development, evaluation, and dissemination of model curricula for cultural competency, prevention, and public health proficiency for working with individuals with disabilities training for use in health professions schools and continuing education programs. - Includes reducing health disparities as a "National Strategy for Quality Improvement in Health Care" 	<ul style="list-style-type: none"> - Requires states, as a condition for receiving the MCH block grant, to conduct a needs assessment to identify communities that are at risk for poor maternal and child health and have few quality home visitation programs. States would be required to submit the results of their needs assessment and their proposed activities to the Secretary. - Establishes a new state grant program for early childhood home visitation. <ul style="list-style-type: none"> o \$50 million FY2010 o \$300 million FY2011 o \$450 million FY2012 o \$700 million FY2013 o \$1.5 billion FY2014

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<p>Fund research to better understand the underlying causes of disparities</p>	<ul style="list-style-type: none"> - Sec. 241. Requires Health Choices Administration to collect data on health disparities. - Sec. 1709. Directs the new Assistant Secretary for Health Information to set standards for data collection on and to facilitate and coordinate analyses of health disparities within HHS and in collaboration with other departments. 	<ul style="list-style-type: none"> - Requires all federally conducted or supported health care or public health program to collect data on race and ethnicity, gender, geographic location, socioeconomic status (including education, employment or income), primary language, disability status data for applicants, recipients, or beneficiaries; The Secretary will analyze the data to detect and monitor trends in health disparities. - Establishes Office on Women's Health within HHS. - Charges the CDC Director to enter into cooperative agreements with State, territorial, and tribal units of government to establish oral health leadership and program guidance, oral health data collection and interpretation, (including determinants of poor oral health among vulnerable populations), a multi-dimensional delivery system for oral health, and to implement science-based programs to improve oral health 	<ul style="list-style-type: none"> - Establishes uniform categories for collecting data on race and ethnicity, gender and primary language. The OMB Directive 15 standards and the OMB policy for aggregation and allocation of subgroups for race and ethnicity data would apply to Medicaid. - Requires CMS to collect primary language data on CHIP enrollees and their parents. - Require CMS to collect data on individuals with disabilities. - Requires that Federally-funded population surveys collect sufficient data on racial and ethnic subgroups - Requires HHS to share health disparities data, measures, and analyses with other relevant agencies. - Ensures all appropriate privacy and security safeguards are followed for activities relating to health disparities data collection, analysis, and sharing.

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<p>Address chronic underfunding of the public health system</p>	<ul style="list-style-type: none"> - Sec. 2002. Establishes a "Public Health Investment Fund"(PHIF); specifies that the Fund supplements (rather than supplants) existing public health funding. In order for the PHIF to receive money certain existing programs must be funded at FY08 levels; and the PWT must receive at least \$650 million. Authorizes: <ul style="list-style-type: none"> o \$4.6 billion FY2011 o \$5.6 billion FY2012 o \$6.9 billion FY2013 o \$7.8 billion FY2014 o \$9 billion FY2015 - Sec. 3161. Establishes a grant program to support Core Public Health Infrastructure and Activities for State and Local Health Departments (this includes funding to establish a voluntary public health accreditation program to State and local health departments and public health laboratories). Funding (from PWT) builds up from \$800 million FY2011 to \$1.9 billion FY2015. <ul style="list-style-type: none"> o At least 50% of the funding for will go to State health departments; at least 30% for competitive grants for State, local, and tribal health departments with priority given to those with demonstrated core public health infrastructure needs. <ul style="list-style-type: none"> ▪ Grants awarded by formula to each state ▪ Funds will only supplement, not supplant funds already appropriated - Sec. 3162. Establishes a grant program support Core Public Health Infrastructure and Activities at CDC; Funding (from PWT) is \$350 million per year from FY2011-2015. 	<ul style="list-style-type: none"> - Establishes a "Prevention and Public Health Investment Fund" to provide for 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. Authorizes: <ul style="list-style-type: none"> o \$2 billion FY2010 o \$4 billion FY2011 o \$6 billion FY2012 o \$8 billion FY2013 o \$10 billion FY2014 and each fiscal year thereafter 	<p>No similar provisions</p>
<p>Expand the public health and primary care workforce</p>	<p><u>National Health Services Corps</u></p> <ul style="list-style-type: none"> - Sec. 2201-2202: <ul style="list-style-type: none"> o Increases loan repayment amount to \$50,000 plus an amount to be determined by the Secretary in FY2012. Amends National Health Service Corps requirements to allow completion of obligation through part-time service; and allows clinical teaching to count as clinical practice for up to 20% of obligated service. Funding (from PHIF) builds from \$63 million in FY2010 to \$77 million in FY2015. o Authorizes funding (from PHIF) for scholarship and loan repayment programs in the National Health Service Corps that builds up from \$254 million in FY2010 to \$306 million in FY2015. 	<p><u>National Health Services Corps</u></p> <ul style="list-style-type: none"> - Increases funding for National Health Service Corps gradually from \$320 million in FY 2010 to \$1.1 billion in FY2015. For FY2016, and each subsequent year, increases based on average cost of health professional education and number of professionals working in shortage areas - Establishes a Ready Reserve Corps for service in time of national emergency. 	<p>No similar provisions</p>

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<p>Expand the public health and primary care workforce</p>	<p><u>Workforce Planning</u></p> <ul style="list-style-type: none"> - Sec.2261. Creates an "Advisory Committee on Health Care Workforce Evaluation and Assessment" to: <ul style="list-style-type: none"> o Within one year: Make recommendations on data consistency and enumerations. o Within two years: Make recommendations on supply and diversity of workforce and policies to carry out those recommendations o Every two years: update recommendations. - Sec. 2271. Requires the Secretary to collect data on the supply, diversity and geographic distribution of the health care workforce. 	<p><u>Workforce Planning</u></p> <ul style="list-style-type: none"> - Establishes a "National Health Care Workforce Commission" to disseminate information on current and projected health care workforce supply and demand, education and training capacity, retention programs, recommendations on a fiscally sustainable workforce. - Establishes a "National Center for Health Workforce Analysis" <p>Establishes a competitive health care workforce development grant program to enable State partnerships for completing comprehensive planning and to carry out activities leading to coherent and comprehensive health care workforce development strategies at the State and local levels (up to \$150,000 per state).</p>	<p><u>Workforce Planning</u></p> <ul style="list-style-type: none"> - Creates a Workforce Advisory Committee to develop and present a national workforce strategy to the Secretary and the Congress that will set the nation on a path toward recruiting, training and retaining a health workforce that meets the nation's current and future health care needs.
	<p><u>Public Health Workforce</u></p> <ul style="list-style-type: none"> - Sec. 2231. Establishes a "Public Health Workforce Corps" to ensure an adequate supply of public health professionals--To be carried out by HRSA Administrator; CDC would be responsible for developing a methodology for placing and assigning Corps participants. Specifies that methodology must allow for placement and assignment in state, local and tribal health departments. - Sec 2232 Provides funding to support public health training programs. - Sec. 2234 Provides funding to support prevent medicine training. - Sec. 2235 Authorizes funding for sections 2231-2234 (from PHIF): <ul style="list-style-type: none"> o \$51 million FY2011 o \$57 million FY2012 o \$59 million FY2013 o \$62 million FY2014 - Sec. 2555. Clarifies that dental health facilities are among the medical providers whose emergency preparedness should be addressed by the National Health Security strategy, and that emergency training programs may be carried out at federal dental facilities. - Sec. 2556. Clarifies that "emergency response provider" includes emergency dental personnel, agencies, and authorities. 	<p><u>Public Health Workforce</u></p> <ul style="list-style-type: none"> - Creates a Public Health Workforce Loan Repayment Program (\$195 million FY2010 and such sums as may be necessary for FY 2011-2015) <ul style="list-style-type: none"> o To be eligible, must be enrolled in accredited academic educational institution, in final year at said institution, and have accepted employment with Federal, state, or local public health agency o Individuals enter into contracts of at least 3 years and must agree, when appropriate, to a relocate to a priority service area in exchange for additional loan repayment incentive o Participants will receive up to \$35,000 for loan repayment for each year of service - Creates a training program for mid-career public health professionals (\$30 million each year FY2010-2014) - Establishes a youth public health program to expose and recruit high school students into health careers, with a focus on careers in public health. - Directs the Surgeon General to establish a "U.S. Public Health Sciences Track" to train various health professionals emphasizing team-based service, public health, epidemiology, and emergency preparedness and response in affiliated institutions. Students would receive tuition remission and a stipend and are accepted as Commission Corps officers in the U.S. Public Health Service with a 2 year service commitment for each year of school covered. - For FY2010 through 2013 authorizes: <ul style="list-style-type: none"> o \$5 million for epidemiology fellowship o \$5 million for laboratory fellowship training o \$5 million for Public Health Informatics Fellowship Program o \$24.5 million to expand the Epidemic Intelligence Service 	<p>No similar provisions</p>

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APHA REFORM PRINCIPLES ON PUBLIC HEALTH INFRASTRUCTURE	H.R. 3962 "THE AFFORDABLE HEALTH CARE FOR AMERICA ACT"	SENATE HEALTH, EDUCATION, LABOR AND PENSIONS COMMITTEE	SENATE FINANCE
<p>Expand the public health and primary care workforce</p>	<p><u>Workforce Diversity</u></p> <ul style="list-style-type: none"> - Sec. 2241. Provides scholarship and loan payment support for individuals from disadvantaged backgrounds serving in the health professions. - Sec. 2243. Requires HHS Sec to coordinate workforce diversity and cultural and linguistic competency activities. - Sec. 2251. Establishes a new program to promote cultural and linguistic competence among health care professionals. - Sec. 2252. Establishes a new program to develop interdisciplinary training programs - Sec. 2281. Authorizes funding (from PHIF): <ul style="list-style-type: none"> o That builds up from \$90 million in FY2011 to \$110 million in FY2015 for workforce diversity programs including Centers for Excellence and programs in sections 2241 and 2243. o That builds up from \$87 million in FY2011 to \$113 million in FY2015 for program in sections 2251, 2252, 2261 and 2271. 	<p><u>Workforce Diversity</u></p> <ul style="list-style-type: none"> - Authorizes \$50 million for Centers of Excellence for FY 2010-2015. - Authorizes \$125 million for FYs2010-2014 for the Health Care Professionals Training for Diversity program. - Authorizes \$5 million for FYs2010-2014 for continuing educational support for health professionals serving in underserved communities. 	<p><u>Workforce Diversity</u></p> <ul style="list-style-type: none"> - Establishes competitive demonstration grant programs to help low-income individuals obtain the education and training needed high-demand health care jobs.
	<p><u>Primary Care</u></p> <ul style="list-style-type: none"> - Sec. 2211 Establishes a loan repayment program to address health care needs in "health profession needs areas" not currently recognized as shortage areas; 90% of funding must be used to train primary care providers. - Sec. 2234. Create the "Preventive Medicine and Public Health Training Grant Program" through HRSA, to provide training to graduate medical residents in preventive medicine specialties. - Sec. 2213 Creates capacity building grants for primary care training programs. - Sec. 2214 Creates a program to develop training programs for medical residents in community-based settings. - Sec. 2216 Authorizes funding (from PHIF) for programs in sections 2213-2215: <ul style="list-style-type: none"> o \$240 million FY2011 o \$253 million FY2012 o \$265 million FY2013 o \$278 million FY2014 o \$292 million FY2015 - Sec. 2217 Directs GAO to conduct a study on effectiveness of scholarship and loan repayment programs no later than 12 months after enactments - Sec. 1501. Directs Sec. to redistribute unfilled residency positions and direct those slots to primary care . 	<p><u>Primary Care</u></p> <ul style="list-style-type: none"> - Establishes a "Pediatric specialty loan repayment program" (\$30 million each year FY2010-14) <ul style="list-style-type: none"> o Priority given to those who will work in high-priority and underserved communities - Authorizes \$125 million per year through 2014 for primary care training grants. Authorizes \$338 million in FY2010 for advanced nursing education grants and nursing faculty loan repayment \$338 million for FY2010. - Establishes a "Primary Care Extension Program" to provide support and assistance to and educate primary care providers about preventive medicine, health promotion, chronic disease management, mental health services, and evidence-based and evidence-informed therapies and techniques, in order to enable providers to incorporate such matters into their practice and to improve community health by working with community-based health connectors (\$140 million FYs2010-2011) - Authorizes \$10.8 million per year through 2014 for geriatric education and training - Authorizes \$10 million for "Geriatric Career Incentive" programs. 	<p><u>Primary Care</u></p> <ul style="list-style-type: none"> - Establish a policy to redistribute currently unused residency training slots as a way to encourage increased training, particularly in the areas of primary care and general surgery. This would provide increased flexibility in laws and regulations governing graduate medical education funding in the Medicare program. - Increases graduate medical education (GME) training positions through a slot re-distribution program for currently unused training slots and priority would be given to increasing training in primary care and general surgery.

APHA's Health Reform Agenda and Comparison of Senate and House Bills as of November 2, 2009

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<p>Expand the public health and primary care workforce</p>	<p><u>Nursing</u></p> <ul style="list-style-type: none"> - Sec. 2221. Authorizes funding (from PHIF) that builds up from \$115 million in FY2011 to \$140 million in FY2015\$ nursing scholarship, loan repayment and faculty loan programs and public service announcements. - Sec. 2521. Establishes a program at the Department of Labor to address projected nurse shortages, increase the capacity for educating nurses, and support nurse training programs. Authorizes such sums as necessary for FY2011-2015 to carry out this section. - Sec. 2536. Establishes a demonstration program to reduce the student-to-nurse ration in public elementary and secondary schools. Authorizes such sums as necessary for FY2011-2015 to carry out this section. 	<p><u>Nursing</u></p> <ul style="list-style-type: none"> - Authorizes \$338 million in FY2010 for advanced nursing education grants and nursing faculty loan repayment \$338 million for FY2010. 	<p><u>Nursing</u></p> <p>No provision</p>
	<p><u>Dentistry</u></p> <ul style="list-style-type: none"> - Sec. 2215 Provides funding to support training programs for primary dentistry. 	<p><u>Dentistry</u></p> <ul style="list-style-type: none"> - Authorizes \$30 million in FY2010 to support and develop dental training programs. - Establishes demonstrations to create programs to train, or to employ, alternative dental health care providers to increase access to dental health care services in rural and other underserved communities (At least \$4 million per grant) 	<p><u>Dentistry</u></p> <p>No provision</p>
	<p><u>Other Workforce</u></p> <ul style="list-style-type: none"> - Sec. 2252. Establishes a new training program for mental and behavioral health professionals. Authorizes \$10 million for each year FY2011-2015. Requires that at least 15% of funds are used for training programs in psychology. - Sec. 2533. Establishes a new program to support health sciences curricula in public secondary schools to prepare students for careers in health professions. Authorizes such sums as necessary for FY2011-2015 to carry out this section. - Sec. 2589. Creates and advisory panel and pilot program to improve working conditions and training for the long-term care workforce. Increases authorization for the Family Caregiver Support Program to \$260 million for each year FY2011-2013. - Sec. 2590. Establishes a new program for the Sec. of Labor to support online training of health care workers. Authorizes \$50 million for each year FY2011-2020. 	<p><u>Other Workforce</u></p> <ul style="list-style-type: none"> - Directs the HHS Secretary to award grants for community health workers to educate underserved and high-risk communities on health risk factors, who promote good health behaviors, and who help people enroll in SCHIP program, Medicare, and Medicaid. - Allied Health Loan Forgiveness Program (\$30 million each year FY2010-2014) - For FY 2010-2013, authorizes: <ul style="list-style-type: none"> o \$8 million for training in social work o \$10 million for training in graduate psychology o \$10 million for training in professional child and adolescent mental health o \$5 million for training in paraprofessional child and adolescent work 	<p><u>Other Workforce</u></p> <ul style="list-style-type: none"> - Includes demonstration grants for up to six states to develop training and certification programs for personal and home care aides. Authorizes \$5 million per year for each year FY2010-2012.