

APHA's Health Reform Agenda and Comparison of Senate and House Bills as of September 18, 2009

| APHA REFORM PRINCIPLES ON ACCESS TO CARE   | SENATE HEALTH, EDUCATION, LABOR AND PENSIONS COMMITTEE  | HOUSE TRI-COMMITTEE  | SENATE COMMITTEE ON FINANCE   |
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| <p><b>Provide access to comprehensive coverage for all</b></p>                     | <ul style="list-style-type: none"> <li>- 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"> <li>o Individuals would pay a maximum of \$750 per year.</li> <li>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.</li> </ul> </li> <li>- 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.</li> </ul> | <ul style="list-style-type: none"> <li>- Requires "Shared responsibility payments" for employers not providing coverage and individuals not enrolled in insurance:                             <ul style="list-style-type: none"> <li>o Individuals are taxed 2.5% on adjusted income up to cost of average national premium for basic plan; hardship waivers for religious and financial reasons.</li> <li>o Establishes a payroll tax of 8% of the wages for employers who choose not to offer coverage. Exempts employers with payrolls under \$250,000 and establishes a graduated rate of contribution requirements (2%-6%) for those with payrolls between \$250,000 and \$400,000.</li> </ul> </li> <li>- Requires employers offering health insurance to automatically enroll employees into the plan with the lowest premium; requires that employees are able to opt-out of the plan.</li> <li>- Creates Health Choices Administration headed by Presidential appointment responsible for: establishing plan standards; establishing and operating HIE; 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.)</li> </ul> | <ul style="list-style-type: none"> <li>- 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"> <li>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).</li> <li>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.</li> </ul> </li> <li>- 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</li> </ul> |
| <p><b>Prohibit restrictions due to pre-existing condition or health status</b></p> | <ul style="list-style-type: none"> <li>- Prohibits preexisting condition exclusions or other discrimination based on health status for coverage.</li> <li>- 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.</li> </ul>   | <ul style="list-style-type: none"> <li>- Prohibits preexisting condition exclusions or other discrimination based on health status for plans or coverage.</li> <li>- Allows insurance rating variation only by family structure, geography, and age.</li> </ul>  | <ul style="list-style-type: none"> <li>- Prohibits preexisting condition exclusions or other discrimination based on health status for plans or coverage.</li> <li>- Allows insurance rating variation only by tobacco use, family structure, geography, and age.</li> <li>- 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.</li> </ul>   |

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| <p><b>Ensure affordable coverage</b></p> | <ul style="list-style-type: none"> <li>- 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"> <li>o Sliding scale subsidies available to individuals and families with incomes up to 400% of FPL.</li> <li>o Limits maximum out-of-pocket costs for subsidized plans.</li> <li>o Income tiers for cost sharing.</li> <li>o Federal government will create Gateways in states that do not establish one in the allotted 4-year period.</li> </ul> </li> </ul> | <ul style="list-style-type: none"> <li>- Creates Health Insurance Exchange for individuals and employers to purchase health insurance.               <ul style="list-style-type: none"> <li>o Employers must provide coverage or pay into 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.</li> <li>o Income tiers from 133%-400% of FPL for premium assistance. Cost sharing in the form of copayments rather than co-insurance; limits on cost sharing of \$5,000 per individual and \$10,000 per family.</li> </ul> </li> </ul> | <ul style="list-style-type: none"> <li>- 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"> <li>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.</li> <li>o "Young invincible" policy for catastrophic coverage for young adults</li> <li>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.</li> <li>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.</li> <li>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.</li> <li>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.</li> <li>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%.</li> </ul> </li> <li>- 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.</li> <li>- 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.</li> <li>- 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.</li> </ul> |

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| <p><b>Provide first dollar support for evidence-based clinical preventive services</b></p> | <p><u>Exchange Plans</u></p> <ul style="list-style-type: none"> <li>- 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.</li> <li>- Establishes a Medical Advisory Council to provide recommendations on essential health benefits and minimum</li> </ul> | <p><u>Exchange Plans</u></p> <ul style="list-style-type: none"> <li>- 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.</li> <li>- 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.</li> </ul> | <p><u>Exchange Plans</u></p> <ul style="list-style-type: none"> <li>- 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 design<sup>1</sup> is used.</li> </ul>   |
|  | <p><u>Medicare</u></p> <ul style="list-style-type: none"> <li>- Eliminates cost sharing for certain clinical preventive services.</li> </ul>   | <p><u>Medicare</u></p> <ul style="list-style-type: none"> <li>- Provides 100% reimbursement and eliminates cost sharing for Medicare covered preventive services;</li> <li>- Eliminates coinsurance for sigmoidoscopies; waives deductible for colorectal cancer screening test and related/subsequent procedures.</li> </ul>   | <p><u>Medicare</u></p> <ul style="list-style-type: none"> <li>- 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.</li> <li>- Authorizes one wellness visit every year for every Medicare beneficiary. No co-payment or deductible would apply.</li> <li>- 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.</li> <li>- Provides funding for CMS to improve provider education and patient awareness of covered preventive services.</li> <li>- Requires a GAO study to determine if any barriers exist that prevent the optimal utilization of covered primary, secondary and tertiary preventive services.</li> <li>- 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.</li> <li>- 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.</li> </ul> |
|  | <p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li>- No similar provision</li> </ul>  | <p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li>- Eliminates cost sharing for certain clinical preventive services.</li> <li>- Provides Medicaid coverage tobacco cessation drugs; and counseling services for pregnant women.</li> </ul>   | <p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li>- 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).</li> </ul>   |

<sup>1</sup> 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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| <b>Other Coverage</b>                    | <ul style="list-style-type: none"> <li>- No annual or lifetime limit on coverage.</li> <li>- Creates a temporary reinsurance program to provide eligible employers reimbursement for covering adults ages 55 to 64.</li> <li>- Extends coverage to dependents up to age 26.</li> <li>- Creates "Community Living Assistance Services and Supports Act", a national voluntary insurance program for purchasing community living assistance services.</li> <li>- Supports developing a "Preventive Care Visit Card" encouraging the use of preventive services and promote health and wellness.</li> <li>- Allows extension of existing coverage to family members of employees.</li> </ul> | <ul style="list-style-type: none"> <li>- No annual or lifetime limit on coverage.</li> <li>- Creates a temporary reinsurance program to provide eligible employers reimbursement for covering adults ages 55 to 64 (Establishes \$10 billion fund).</li> </ul>   | <ul style="list-style-type: none"> <li>- No annual or lifetime limit on coverage (exchange plans).</li> <li>- Authorizes \$6 billion in funding for the Consumer Operated and Oriented Plan (CO-OP) program:               <ul style="list-style-type: none"> <li>o Non-profit, member-run health insurance companies that serve individuals in one or more states.</li> <li>o CO-Ops may operate on a state, regional or national level</li> <li>o CO-OP grantees would compete in the reformed individual and small group insurance markets.</li> <li>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.</li> </ul> </li> <li>- 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</li> </ul> |
| <b>Strengthen Public Programs</b>        | <p><u>Medicare</u></p> <p>No similar provisions</p>   | <p><u>Medicare</u></p> <ul style="list-style-type: none"> <li>- Provides Medicare coverage for marriage and family therapist and mental health counselor services.</li> <li>- Eliminates Medicare Part D cost sharing for some non-institutionalized low-income; Phases in decreasing "doughnut hole" for Medicare Part D recipients.</li> </ul> | <p><u>Medicare</u></p> <ul style="list-style-type: none"> <li>- Establish a discount program for beneficiaries who enroll in Part D and have drug spending that falls into the coverage gap.</li> <li>- 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.</li> <li>- 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.</li> </ul>   |

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|   | <p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li>- 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.</li> </ul>        | <p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li>- Expands Medicaid coverage to all individuals with incomes up to 133% FPL including childless adults. May enroll in health plan through HIE if enrolled 6 months prior to becoming Medicaid eligible. Provides states with 100% matching funds to cover the expansions.</li> <li>- Provides automatic Medicaid coverage to uninsured newborns for up to 60 days while eligibility is determined.</li> <li>- Grants states the option of covering nurse home visitation services for first-time mothers and mothers of young children.</li> <li>- Grants states the option of creating a coverage option for family planning services for categorically needy groups.</li> <li>- Gives states the option of covering services provided at freestanding birth centers.</li> <li>- Includes public health clinics under the Vaccines for Children Program and provides states with 100% Medicaid matching funds to cover this group.</li> <li>- Gives states the option of covering low-income persons with HIV under Medicaid (Option sunsets on January 1, 2013).</li> <li>- Extends Transitional Medical Assistance.</li> <li>- Extends prescription drug discounts to Medicaid Managed Care enrollees.</li> <li>- Reduces Medicaid matching rate by .5% for states with above average reductions in uninsured.</li> </ul> | <p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li>- 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.</li> <li>- 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.</li> <li>- 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.</li> <li>- 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.</li> <li>- Makes prescription drugs a mandatory benefit for the categorically and medically needy, effective January 1, 2014.</li> </ul> |
|   | <p><u>CHIP</u></p> <ul style="list-style-type: none"> <li>- Individuals eligible for CHIP have the option of enrolling a qualified plan through a Gateway.</li> </ul>  | <p><u>CHIP</u></p> <ul style="list-style-type: none"> <li>- Requires CHIP enrollees to enroll through HIE.</li> <li>- Requires stand-alone CHIP programs to implement 12-month continuous eligibility.</li> </ul>   | <p><u>CHIP</u></p> <ul style="list-style-type: none"> <li>- Requires states to maintain their current CHIP eligibility levels through 2012.</li> <li>- 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.</li> <li>- Appropriate \$25 million for the Secretary to carry out the Childhood obesity prevention demonstration project.</li> </ul>  |
| <p><b>Strengthen funding for safety net</b></p> | <ul style="list-style-type: none"> <li>- Increases funding for federally-qualified health centers gradually from \$2.9 billion in FY2010 to \$8.3 billion in FY2015.</li> <li>- Authorizes \$50 million for nurse managed health clinics to provide comprehensive primary care and wellness services in medically underserved communities</li> </ul> | <ul style="list-style-type: none"> <li>- Increases funding for community health centers. Authorizes (from the Public Health Investment Fund):             <ul style="list-style-type: none"> <li>o \$1 billion FY2010</li> <li>o \$1.5 billion FY2011</li> <li>o \$2.5 billion FY2012</li> <li>o \$3 billion FY2013</li> <li>o \$4 billion FY2014</li> </ul> </li> <li>- Requires QHBP to contract with essential community health providers.</li> </ul>  | <p>No similar provisions</p>  |

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|--|---|---|------------------------------|
| <p><b>Create a public insurance plan</b></p> | <ul style="list-style-type: none"> <li>- 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"> <li>o Must cover essential health benefits (at minimum); states have options of requiring additional coverage (to be paid for by the state).</li> <li>o Sliding scale subsidies available to individuals and families with incomes up to 400% of FPL.</li> <li>o Limits maximum out-of-pocket costs.</li> <li>o Income tiers for cost sharing.</li> </ul> </li> <li>- 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).</li> <li>- 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</li> </ul> | <ul style="list-style-type: none"> <li>- Only available through the HIE; may offer basic, enhanced, premium and premium plans benefits; complies with same requirements as private plans in HIE</li> <li>- Cost sharing, benefits package, provider networks, and consumer protections; premiums shall reflect full costs of operating and administering public option;</li> <li>- Affordability credits to purchase basic plan through year 3 with incomes less than 400% of FPL; after that may be used for enhanced plan.</li> </ul> | <p>No similar provisions</p> |

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| APHA REFORM PRINCIPLES ON QUALITY OF CARE                                    | SENATE HEALTH, EDUCATION, LABOR AND PENSIONS COMMITTEE   | HOUSE TRI-COMMITTEE   | Senate Finance Committee  |
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| <p><b>Shift reimbursement and other policies to promote primary care</b></p> | <ul style="list-style-type: none"> <li>- 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.</li> <li>- Establish a program to provide grants to eligible entities to create community-based multidisciplinary health teams to support primary care practices within hospitals.</li> </ul>   | <ul style="list-style-type: none"> <li>- Includes Medicare incentive payments for "efficient areas", which are geographic areas of low per capita spending; Increases Medicare reimbursement rates for primary care services.</li> <li>- Requires HHS Secretary to develop quality scores for Medicare Advantage plans.</li> <li>- Improves coordination of services for Medicare-Medicaid dual-eligibles</li> <li>- Creates a 3 to 5-year Medicare "Accountable Care Organization Pilot Program" to test different payment incentives models</li> <li>- Creates a 5-year Medicare "Medical Home Pilot Program" to evaluate the independent patient-centered and community-based medical home models.</li> <li>- Creates a 5-year Medicaid "Medical Home Pilot Program"; increases up 90% for first 2 years of the pilot program) or 75% (for the next 3 years) the matching percentage for administrative expenditures. Federal contribution not to exceed \$1.23 billion over 5 years.</li> </ul> | <ul style="list-style-type: none"> <li>- Establishes a bundled payment demonstration project under Medicaid in up to eight states to begin October 1, 2011.</li> <li>- Requires Secretary 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.</li> <li>- Requires the Secretary 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.</li> <li>- Provides primary care practitioners and general surgeons in shortage areas a 10% bonus for certain services for five years, beginning January 1, 2011.</li> <li>- 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.</li> </ul> |
| <p><b>Ensure cultural competency</b></p>                                     | <ul style="list-style-type: none"> <li>- Requires reimbursement policies to promote culturally and linguistically appropriate care.</li> <li>- Establishes a 5-year national public education campaign on oral healthcare and prevention and require that all activities are culturally/linguistically appropriate.</li> <li>- 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.</li> <li>- Directs HHS Secretary 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.</li> </ul> | <ul style="list-style-type: none"> <li>- Directs HHS Secretary 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.</li> <li>- After the study, creates a 3-year demonstration project to promote access for Medicare beneficiaries with LEP by providing reimbursement for culturally and linguistically appropriate services (\$16 million per year).</li> <li>- Charges IOM to conduct a study on the impact of language access to services to the health and health care of populations with LEP.</li> </ul>   | <p>No similar provisions</p>  |
| <p><b>Sustain investment in health information technology (HIT)</b></p>      | <ul style="list-style-type: none"> <li>- 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.</li> <li>- Authorizes grants for implementation of HIT standards and protocols identifies by the HIT Policy and Standards Committees.</li> </ul>   | <p>No similar provisions</p>  | <p>No similar provisions</p>  |

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| <p><b>Other quality</b></p>               | <ul style="list-style-type: none"> <li>- Requires GAO to conduct an ongoing assessment of Gateway activities.</li> <li>- 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.</li> <li>- Supports comparative effectiveness research on drugs, devices, medical and surgical procedures, screenings and other health interventions.</li> <li>- Creates a "Patient Safety Research Center" to identify, evaluate and disseminate information on best practices to providers and patients.</li> </ul> | <ul style="list-style-type: none"> <li>- Directs AHRQ to enter into agreements with qualified entities to develop quality measures for health services.</li> <li>- 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.</li> <li>- Creates an independent "Comparative Effectiveness Research Commission" to oversee and evaluate the activities of the Center.</li> <li>- 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"> <li>o \$90 million FY2010</li> <li>o \$100 million FY2011</li> <li>o \$110 million FY2012</li> </ul> </li> </ul> | <ul style="list-style-type: none"> <li>- Effective July 1, 2011, prohibits Federal payments to states for Medicaid services related to health care acquired conditions.</li> <li>- 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.</li> <li>- 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.</li> <li>- 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.</li> <li>- Requiring the Secretary 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.</li> <li>- 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.</li> <li>- 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.</li> <li>- Establishes a three-year pilot "Community Care Transitions Program. Beginning in 2011, the Secretary 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.</li> </ul> <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  | SENATE HEALTH, EDUCATION, LABOR AND PENSIONS COMMITTEE   | HOUSE TRI-COMMITTEE   | SENATE FINANCE COMMITTEE   |
|---|--|---|--|
| <p><b>Invest in population and community-based prevention, education and outreach programs.</b></p> | <p><u>General Prevention and Wellness Programs</u></p> <ul style="list-style-type: none"> <li>- Directs HHS Secretary 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.</li> <li>- 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.</li> <li>- 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</li> <li>- Creates a grant program to implement "Medication Management" services for the treatment of chronic diseases.</li> <li>- Creates a program to fund "Community Health Teams" to support the development of medical homes by increasing access to comprehensive, community based, coordinated care.</li> <li>- 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.</li> </ul> | <p><u>General Prevention and Wellness Programs</u></p> <ul style="list-style-type: none"> <li>- Directs HHS Secretary 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.</li> <li>- Establishes and "Prevention and Wellness Trust" (PWT) and authorizes: <ul style="list-style-type: none"> <li>o \$2.4 billion FY2010</li> <li>o \$2.8 billion FY2011</li> <li>o \$3.1 billion FY2012</li> <li>o \$3.4 billion FY2013</li> <li>o \$3.5 billion FY2014</li> <li>o \$3.6 billion FY2015</li> <li>o \$3.7 billion FY2016</li> <li>o \$3.9 billion FY2017</li> <li>o \$4.3 billion FY2018</li> <li>o \$4.6 billion FY2019</li> </ul> </li> <li>- Authorizes funding (from PWT) for "Community-Based Prevention and Wellness Services" 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 \$1.1 billion in FY2010 to \$2.3 billion in FY2019.</li> <li>- 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 FY2010.</li> </ul> | <p>Reduces restrictions on the number of eligible counties that may participate in the demonstration project on community health integration models in certain rural counties.</p> <ul style="list-style-type: none"> <li>- Directs the Secretary to develop criteria for healthy lifestyle programs using relevant, evidence-based resources. After the Secretary 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.</li> <li>- 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.</li> </ul> |
| <p><b>Invest in</b></p>   |  |   |  |

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| <b>APHA REFORM PRINCIPLES ON POPULATION HEALTH AND PREVENTION</b>                  | <b>SENATE HEALTH, EDUCATION, LABOR AND PENSIONS COMMITTEE</b>   | <b>HOUSE TRI-COMMITTEE</b>  | <b>SENATE FINANCE COMMITTEE</b>                                |
|--|---|---|--|
| <b>population and community-based prevention, education and outreach programs.</b> | <p><u>Prevention Taskforce</u></p> <ul style="list-style-type: none"> <li>- 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.</li> </ul> | <p><u>Prevention Taskforce</u></p> <ul style="list-style-type: none"> <li>- Authorizes \$30 million per year (from PWT) for FY210-14 to:                             <ul style="list-style-type: none"> <li>o Develop a "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.</li> <li>o Develop 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.</li> </ul> </li> </ul> | <p><u>Prevention Taskforce</u></p> <p>No similar provision</p> |
|  | <p><u>Prevention Research</u></p> <ul style="list-style-type: none"> <li>- 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 Secretary in the National Prevention Strategy or Healthy People 2020 and including comparing community-based public health interventions in terms of effectiveness and cost.</li> </ul>  | <p><u>Prevention Research</u></p> <ul style="list-style-type: none"> <li>- Authorizes funding (from PWT) for Prevention and Wellness Research in 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. Funding builds up from \$100 million in FY2010 to \$383 million in FY2019.</li> </ul>  | <p><u>Prevention Research</u></p> <p>No similar provision</p>  |
|  | <p><u>Oral Health</u></p> <ul style="list-style-type: none"> <li>- Establishes a 5-year national public education campaign on oral healthcare prevention.</li> <li>- Provides demonstration grants to demonstrate the effectiveness of research-based dental caries disease management activities.</li> <li>- Directs HHS Sec. to update and improve Pregnancy Risk Assessment Monitoring System (PRAMS) as it relates to oral health.</li> </ul>   | <p><u>Oral Health</u></p> <p>No similar provision</p>   | <p><u>Oral Health</u></p> <p>No similar provision</p>          |
| <b>Invest in population and</b>  |   |   |  |

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| APHA REFORM PRINCIPLES ON POPULATION HEALTH AND PREVENTION  | SENATE HEALTH, EDUCATION, LABOR AND PENSIONS COMMITTEE   | HOUSE TRI-COMMITTEE  | SENATE FINANCE COMMITTEE   |
|---|--|--|--|
| <p><b>community-based prevention, education and outreach programs.</b></p>  | <p><u>Immunizations</u></p> <ul style="list-style-type: none"> <li>- 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"> <li>o No more than 4 years after demonstration program, Secretary must report on its effectiveness</li> </ul> </li> <li>- Grants HHS Sec. Ability to negotiate and enter into contracts with manufacturers of vaccines for the purchase and delivery of vaccines for adults.</li> <li>- Allows states to purchase adult vaccines directly from manufacturers at price negotiated by the Secretary.</li> <li>- Reauthorizes the section 317 program</li> </ul> | <p><u>Immunizations</u></p> <ul style="list-style-type: none"> <li>- Expands access to vaccines.</li> <li>- Includes public health clinics under the vaccines for children program.</li> </ul>   | <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> <ul style="list-style-type: none"> <li>- Directs the CDC Director to establish a workplace wellness promotion campaign.</li> <li>- Directs CDC Director to conduct a national worksite health policies and programs survey to assess employer based health policies and programs.</li> <li>- Creates workplace wellness demonstrations.</li> </ul>   | <p><u>Worksite Wellness</u></p> <p>No similar provision</p>  | <p><u>Worksite Wellness</u></p> <p>No similar provision</p>  |
| <p><b>Develop more accurate fiscal scoring for prevention and early intervention services</b></p>                   | <p>No provision</p>  | <p>No provision</p>  | <p>No provision</p>  |
| <p><b>Require a health impact assessment (HIA) for all new federal policies and programs</b></p>                    | <ul style="list-style-type: none"> <li>- 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.</li> </ul>   | <p>No similar provision</p>  | <p>No similar provision</p>  |
| <p><b>Establish health goals and outcomes and require an annual "State of the Nation's Health" report card.</b></p> | <ul style="list-style-type: none"> <li>- 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".</li> </ul>  | <ul style="list-style-type: none"> <li>- 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.</li> </ul> | <p>No similar provision</p>  |

APHA's Health Reform Agenda and Comparison of Senate and House Bills as of September 18, 2009

| <b>APHA REFORM PRINCIPLES ON POPULATION HEALTH AND PREVENTION</b> | <b>SENATE HEALTH, EDUCATION, LABOR AND PENSIONS COMMITTEE</b>  | <b>HOUSE TRI-COMMITTEE</b>   | <b>SENATE FINANCE COMMITTEE</b> |
|---|--|------------------------------|---------------------------------|
| <b>Other Prevention and Population Health</b>                     | <ul style="list-style-type: none"> <li>- Requires nutrition labeling standard menu items at chain restaurant and of articles of food sold from vending machines.</li> <li>- 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.</li> <li>- 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.</li> </ul> | <p>No similar provisions</p> | <p>No similar provisions</p>    |

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| APHA REFORM PRINCIPLES ON HEALTH DISPARITIES  | SENATE HEALTH, EDUCATION, LABOR AND PENSIONS COMMITTEE  | HOUSE TRI-COMMITTEE  | SENATE FINANCE  |
|---|---|--|---|
| <p><b>Support effective strategies to reduce health disparities</b></p>               | <ul style="list-style-type: none"> <li>- Directs the Architectural and Transportation Barriers Compliance Board to establish stands for accessible medical diagnostic equipment by persons with disabilities.</li> <li>- 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.</li> <li>- Includes reducing health disparities as a "National Strategy for Quality Improvement in Health Care"</li> </ul>   | <ul style="list-style-type: none"> <li>- Allows for states to apply for grants to create home visitation programs for families with young children and families expecting children. Authorizes:               <ul style="list-style-type: none"> <li>o \$150 million FY2010</li> <li>o \$250 million FY2011</li> <li>o \$350 million FY2012</li> <li>o \$450 million FY2013</li> <li>o \$550 million FY2014</li> </ul> </li> <li>- Includes reducing disparities as a quality improvement measure.</li> <li>- Requires that 50% of funds for prevention and wellness services be used for programs aimed at addressing a specific health disparity.</li> </ul> | <ul style="list-style-type: none"> <li>- 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.</li> <li>- Establishes a new state grant program for early childhood home visitation.               <ul style="list-style-type: none"> <li>o \$50 million FY2010</li> <li>o \$300 million FY2011</li> <li>o \$450 million FY2012</li> <li>o \$700 million FY2013</li> <li>o \$1.5 billion FY2014</li> </ul> </li> </ul>   |
| <p><b>Fund research to better understand the underlying causes of disparities</b></p> | <ul style="list-style-type: none"> <li>- 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.</li> <li>- Establishes Office on Women's Health within HHS.</li> <li>- 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</li> </ul> | <ul style="list-style-type: none"> <li>- Requires Health Choices Administration to collect data on health disparities.</li> <li>- 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.</li> </ul>  | <ul style="list-style-type: none"> <li>- 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.</li> <li>- Requires CMS to collect primary language data on CHIP enrollees and their parents.</li> <li>- Require CMS to collect data on individuals with disabilities.</li> <li>- Requires that Federally-funded population surveys collect sufficient data on racial and ethnic subgroups</li> <li>- Requires HHS to share health disparities data, measures, and analyses with other relevant agencies.</li> <li>- Ensures all appropriate privacy and security safeguards are followed for activities relating to health disparities data collection, analysis, and sharing.</li> </ul> |

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| APHA REFORM PRINCIPLES ON PUBLIC HEALTH INFRASTRUCTURE                 | SENATE HEALTH, EDUCATION, LABOR AND PENSIONS COMMITTEE  | HOUSE TRI-COMMITTEE   | SENATE FINANCE               |
|--|---|---|------------------------------|
| <p><b>Address chronic underfunding of the public health system</b></p> | <ul style="list-style-type: none"> <li>- 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"> <li>o \$2 billion FY2010</li> <li>o \$4 billion FY2011</li> <li>o \$6 billion FY2012</li> <li>o \$8 billion FY2013</li> <li>o \$10 billion FY2014 and each fiscal year thereafter</li> </ul> </li> </ul> | <ul style="list-style-type: none"> <li>- 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"> <li>o \$4.6 billion FY2010</li> <li>o \$5.6 billion FY2011</li> <li>o \$6.9 billion FY2012</li> <li>o \$7.8 billion FY2013</li> <li>o \$9 billion FY2014</li> <li>o \$9.4 billion FY2015</li> <li>o \$10.1 billion FY2016</li> <li>o \$10.8 billion FY2017</li> <li>o \$11.8 billion FY2018</li> <li>o \$12.7 billion FY2019</li> </ul> </li> <li>- Authorizes \$400 per year for FY2010-2019 (from PWT) for "Core Public Health Infrastructure and Activities at CDC"</li> <li>- Authorizes funding (from PWT) for "Core Public Health Infrastructure and Activities for State and Local Health Departments" (this include funding to establish a voluntary public health accreditation program to State and local health departments and public health laboratories). Funding builds up from \$800 million FY2010 to \$1.9 billion FY2019.               <ul style="list-style-type: none"> <li>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"> <li>▪ Grants awarded by formula to each state</li> <li>▪ Funds will only supplement, not supplant funds already appropriated</li> </ul> </li> </ul> </li> </ul> | <p>No similar provisions</p> |
| <p><b>Expand the public health and primary care workforce</b></p>      | <p><u>National Health Services Corps</u></p> <ul style="list-style-type: none"> <li>- 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</li> <li>- Establishes a Ready Reserve Corps for service in time of national emergency.</li> </ul>   | <p><u>National Health Services Corps</u></p> <ul style="list-style-type: none"> <li>- 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 \$98 million in FY2019</li> <li>- 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 \$291 million in FY2019.</li> </ul>  | <p>No similar provisions</p> |

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| APHA REFORM PRINCIPLES ON PUBLIC HEALTH INFRASTRUCTURE            | SENATE HEALTH, EDUCATION, LABOR AND PENSIONS COMMITTEE   | HOUSE TRI-COMMITTEE   | SENATE FINANCE   |
|---|--|---|--|
| <p><b>Expand the public health and primary care workforce</b></p> | <p><u>Workforce Planning</u></p> <ul style="list-style-type: none"> <li>- 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.</li> <li>- Establishes a "National Center for Health Workforce Analysis"</li> <li>- 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).</li> </ul>   | <p><u>Workforce Planning</u></p> <ul style="list-style-type: none"> <li>- Creates an "Advisory Committee on Health Care Workforce Evaluation and Assessment" to:                             <ul style="list-style-type: none"> <li>o Within one year: Make recommendations on data consistency and enumerations.</li> <li>o Within two years: Make recommendations on supply and diversity of workforce and policies to carry out those recommendations</li> <li>o Every two years: update recommendations.</li> </ul> </li> <li>- Establishes a "National Center for Health Workforce Analysis"</li> <li>- Provides grants to develop and implement interdisciplinary training and practice models.</li> <li>- Authorizes funding (from PHIF) that builds up from \$91 million in FY2010 to \$141 million in FY2019.</li> </ul>   | <p><u>Workforce Planning</u></p> <ul style="list-style-type: none"> <li>- 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.</li> </ul> |
|   | <p><u>Public Health Workforce</u></p> <ul style="list-style-type: none"> <li>- 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"> <li>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</li> <li>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</li> <li>o Participants will receive up to \$35,000 for loan repayment for each year of service</li> </ul> </li> <li>- Creates a training program for mid-career public health professionals (\$30 million each year FY2010-2014)</li> <li>- Establishes a youth public health program to expose and recruit high school students into health careers, with a focus on careers in public health.</li> <li>- Directs the Surgeon General to establish a "U.S. Public Health Sciences Track" to train various health care and public 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.</li> <li>- For FY2010 through 2013 authorizes:                             <ul style="list-style-type: none"> <li>o \$5 million for epidemiology fellowship</li> <li>o \$5 million for laboratory fellowship training</li> <li>o \$5 million for Public Health Informatics Fellowship Program</li> <li>o \$24.5 million for expanding the Epidemic Intelligence Service</li> </ul> </li> </ul> | <p><u>Public Health Workforce</u></p> <ul style="list-style-type: none"> <li>- Establishes a "Public Health Workforce Corps" to ensure an adequate supply of public health professionals to eliminate critical public health workforce shortages. 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.</li> <li>- Establishes a "Public Health Workforce Loan Repayment Program"                             <ul style="list-style-type: none"> <li>o Must agree to at least 2 years of service</li> <li>o Participants receive up to \$35,000 in loan repayment for each year of service</li> </ul> </li> <li>- Establishes a "Public Health Workforce Scholarship Program" for individuals agreeing to serve full-time as part of a Federal, State, local, or tribal health agency. Program provides scholarships for every year of committed service, as well as stipend.</li> <li>- Authorizes funding that builds up from \$51 million in FY2010 to \$79 million in FY2019.</li> </ul> | <p>No similar provisions</p>   |

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| APHA REFORM PRINCIPLES ON PUBLIC HEALTH INFRASTRUCTURE            | SENATE HEALTH, EDUCATION, LABOR AND PENSIONS COMMITTEE   | HOUSE TRI-COMMITTEE  | SENATE FINANCE  |
|---|--|--|---|
| <p><b>Expand the public health and primary care workforce</b></p> | <p><u>Workforce Diversity</u></p> <ul style="list-style-type: none"> <li>- Authorizes \$50 million for Centers of Excellence for FY 2010-2015.</li> <li>- Authorizes \$125 million for FYs2010-2014 for the Health Care Professionals Training for Diversity program.</li> <li>- Authorizes \$5 million for FYs2010-2014 for continuing educational support for health professionals serving in underserved communities.</li> </ul>  | <p><u>Workforce Diversity</u></p> <ul style="list-style-type: none"> <li>- Authorizes funding (from PHIF) that builds up from \$90 million in FY2010 to \$140 million in FY2019 to:                             <ul style="list-style-type: none"> <li>o Increase funding for Centers of Excellence for training minorities in health professions.</li> <li>o Increase funding for educational assistance, loan repayment, and faculty loan programs for minority populations studying and working in health professions.</li> <li>o Grants to promote cultural competency for health professionals</li> </ul> </li> </ul>   | <p><u>Workforce Diversity</u></p> <ul style="list-style-type: none"> <li>- Establishes competitive demonstration grant programs to help low-income individuals obtain the education and training needed high-demand health care jobs.</li> </ul>  |
|   | <p><u>Primary Care</u></p> <ul style="list-style-type: none"> <li>- Establishes a "Pediatric specialty loan repayment program" (\$30 million each year FY2010-14)                             <ul style="list-style-type: none"> <li>o Priority given to those who will work in high-priority and underserved communities</li> </ul> </li> <li>- 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.</li> <li>- 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)</li> <li>- Authorizes \$10.8 million per year through 2014 for geriatric education and training</li> <li>- Authorizes \$10 million for "Geriatric Career Incentive" programs.</li> </ul> | <p><u>Primary Care</u></p> <ul style="list-style-type: none"> <li>- Create the "Preventive Medicine and Public Health Training Grant Program" through HRSA, to provide training to graduate medical residents in preventive medicine specialties.                             <ul style="list-style-type: none"> <li>o Eligible entities are accredited schools of public health, public health departments, schools of medicine, public or private hospitals</li> <li>o Money used to plan, develop, and operate residency programs for preventive medicine or public health, including the development of curricula and to provide financial assistance, including tuition and stipends, to resident physicians who plan to specialize in preventive medicine or public health</li> </ul> </li> <li>- Creates 5-year grants for institutions to provide training, and financial assistance for traineeships and fellowships for medical students, interns, practicing physicians or other medical personnel who plan to work or specialize in primary care. Also includes grants for faculty loan repayment.</li> <li>- Creates 5-year capacity building grants for accredited primary care academic units.</li> </ul> | <p><u>Primary Care</u></p> <ul style="list-style-type: none"> <li>- 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.</li> <li>- 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.</li> </ul> |
|   | <p><u>Nursing</u></p> <ul style="list-style-type: none"> <li>- Authorizes \$338 million in FY2010 for advanced nursing education grants and nursing faculty loan repayment \$338 million for FY2010.</li> </ul>  | <p><u>Nursing</u></p> <ul style="list-style-type: none"> <li>- Establishes several grant programs to increase nursing workforce.</li> <li>- Authorizes \$220 million each year (from PHIF) for FY2010-14 for nursing scholarship, loan repayment and faculty loan programs and public service announcements.</li> <li>- Provides grants for providing cultural competency training to nurses</li> </ul>  |   |

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| APHA REFORM PRINCIPLES ON PUBLIC HEALTH INFRASTRUCTURE            | SENATE HEALTH, EDUCATION, LABOR AND PENSIONS COMMITTEE   | HOUSE TRI-COMMITTEE   | SENATE FINANCE   |
|---|--|---|--|
| <p><b>Expand the public health and primary care workforce</b></p> | <p><u>Dentistry</u></p> <ul style="list-style-type: none"> <li>- Authorizes \$30 million in FY2010 to support and develop dental training programs.</li> <li>- 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 )</li> </ul>  | <p><u>Dentistry</u></p> <ul style="list-style-type: none"> <li>- 5-year grants to institutions to provide training, and financial assistance for traineeships and fellowships for general, public health or pediatric dentistry students, interns, residents, practicing dentists or dental hygienists. Also includes grants for faculty loan repayment.</li> </ul> |  |
|   | <p><u>Other workforce</u></p> <ul style="list-style-type: none"> <li>- 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.</li> <li>- Allied Health Loan Forgiveness Program (\$30 million each year FY2010-2014)</li> <li>- For FY 2010-2013, authorizes:               <ul style="list-style-type: none"> <li>o \$8 million for training in social work</li> <li>o \$10 million for training in graduate psychology</li> <li>o \$10 million for training in professional child and adolescent mental health</li> <li>o \$5 million for training in paraprofessional child and adolescent work</li> </ul> </li> </ul> | <p><u>Other Workforce</u></p> <p>No similar provisions</p>  | <p><u>Other Workforce</u></p> <ul style="list-style-type: none"> <li>- 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.</li> </ul> |