Federally Qualified Health Centers

Impact of the ACA and Health System Change on the Iowa Safety Net

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Public Policy Center

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Introduction

This is a report that inventories all the information we have collected on the providers, funding, staffing, and patients of Iowa’s Federally Qualified Health Centers (FQHCs). This information was collected as part of a study funded by The Commonwealth Fund to study the implications of the Affordable Care Act (ACA) on safety net health care providers. This report includes language from the ACA that relates to FQHCs.

FQHCs are health care providers that receive grant funding under Section 330 of the Public Health Service (PHS) Act, which is intended to provide funding opportunities for organizations to administer care to underserved populations. Community Health Centers, Migrant Health Centers, Health Care for the Homeless Programs, and Public Housing Primary Care Programs are eligible to receive Section 330 grants. An organization that receives Section 330 funding is automatically certified as an FQHC.

Benefits of being an FQHC include:

- Grant funding (up to $650,000 can be requested for start-up)
- Prospective Payment System reimbursement for services to Medicaid patients
- Cost-based reimbursement for services to Medicare patients
- Medical malpractice coverage through the Federal Tort Claims Act
- Eligibility to purchase prescription and non-prescription medications for outpatients at reduced cost through the 340B Drug Pricing Program
- National Health Service Corps (NHSC)  access
- Eligibility for the Vaccine for Children program
- Qualification for additional federal grants and programs.1

The FQHC Look-Alike Program is for entities that operate and provide services consistent with all statutory, regulatory, and policy requirements that apply to section 330-funded health centers, but do not receive funding under section 330.2 FQHC Look-Alikes, like FQHCs, additionally receive automatic designation as a Health Professional Shortage Area (HPSA) which makes them eligible to apply for NHSC personnel as well as eligible to receive J-1 visa physicians.3 The FQHC look-alikes also receive many of the same benefits as FQHCs including the following: Prospective Payment System reimbursement for services to Medicaid patients and eligibility to purchase prescription and non-prescription medications for outpatients at reduced cost through the 340B Drug Pricing Program.

The Health Resources and Services Administration (HRSA) expectations of FQHCs include 19 key program requirements from the following four operational domains: target population need, services provided, governance, and management and finance.4 Both FQHCs and FQHC Look-Alikes must be either a public entity or a private nonprofit and must have a board of directors comprised of a majority (at least 51%) of active, registered clients of the health center who are representative of those served by the center. Preventive medical, dental, mental health and substance abuse services must be provided
directly by the FQHC or by arrangement with another provider. FQHCs must also provide services that enable individuals to use the services of the health center, such as outreach, transportation, and language interpretation. Health center services must be available to all, regardless of ability to pay. FQHCs must use a sliding fee scale for uninsured patients with annual incomes between 100-200% of the Federal Poverty Level (FPL) and must provide a full discount to individuals and families with annual incomes at or below 100% FPL, although they may charge a nominal fee for such patients. 

**FQHC Providers in Iowa**

Currently, fourteen FQHCs operate in the state of Iowa, accounting for approximately 1 percent of the 1,124 FQHCs in the United States (Table 1). The 14 FQHCs include 13 Community Health Centers and one Migrant Health Center. Each of the 14 centers is an Iowa Safety Net member.

**Table 1. Iowa’s Federally Qualified Health Centers**

<table>
<thead>
<tr>
<th>Name</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Health Care, Inc.</td>
<td>Des Moines/ Marshalltown</td>
</tr>
<tr>
<td>Siouxland Community Health Center</td>
<td>Sioux City</td>
</tr>
<tr>
<td>Community Health Center, Inc.</td>
<td>Davenport</td>
</tr>
<tr>
<td>Community Health Centers of Southern Iowa, Inc.</td>
<td>Leon/Lamoni</td>
</tr>
<tr>
<td>Peoples Community Health Clinic, Inc.</td>
<td>Waterloo/Clarksville</td>
</tr>
<tr>
<td>United Community Health Center</td>
<td>Storm Lake</td>
</tr>
<tr>
<td>Community Health Center of Fort Dodge</td>
<td>Fort Dodge</td>
</tr>
<tr>
<td>Linn Community Care</td>
<td>Cedar Rapids</td>
</tr>
<tr>
<td>Crescent Community Health Center</td>
<td>Dubuque</td>
</tr>
<tr>
<td>All Care Health Center, Inc.</td>
<td>Council Bluffs</td>
</tr>
<tr>
<td>River Hills Community Health Center</td>
<td>Ottumwa/Centerville/Richland</td>
</tr>
<tr>
<td>Community Health Centers of Southeastern Iowa, Inc.</td>
<td>West Burlington/Keokuk/ Columbus City</td>
</tr>
<tr>
<td>Proteus, Inc. (Migrant Health Center)</td>
<td>Des Moines-based</td>
</tr>
<tr>
<td>Promise Community Health Center</td>
<td>Sioux Center</td>
</tr>
</tbody>
</table>


Iowa’s FQHC locations and FQHC-affiliated satellite clinics are shown in the following map (Figure 1). Figure 1 demonstrates the wide dispersal of Iowa’s Migrant Health Center (an FQHC) and the 13 Community Health Centers as well as the satellite clinics affiliated with the 14 main clinics.
FQHC Funding

The largest source of revenue for Iowa’s FQHCs comes from Medicaid (36 percent). Federal grants provide 31 percent of the total FQHC revenue, while private insurance provides 11 percent and patient self-pay accounts for 9 percent (Figure 2).

Source: Kaiser State Health Facts, 2010 data
Further information on revenue streams for the 13 FQHC grantees in Iowa is reported annually in the Uniform Data System Report from the Bureau of Primary Health Care (BPHC) - Health Resources and Services Administration (HRSA). According to the 2011 Iowa Report, total patient related revenue and other revenue received by FQHCs in Iowa in 2011 was around $100 million (Table 2). Total patient related revenue was $62.6 million, including almost $37 million from Medicaid, $10.8 million from private insurance, $8.5 million from self-pay, $5.9 million from Medicare, and $0.6 million from other public sources. Total “Other” (that is, non-patient related) revenue was $37.7 million in 2011, with over one half of that coming from BPHC grants ($20 million), $11.5 million from other federal grants, $5.3 million from non-federal grants and contracts, and $0.9 million from revenue not reported elsewhere.

Table 2. FQHC Revenue

<table>
<thead>
<tr>
<th>Patient Related Revenue</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Non-Managed Care</td>
<td>$24,720,997</td>
<td>$26,528,054</td>
<td>$30,199,058</td>
<td>$30,343,830</td>
</tr>
<tr>
<td>Medicaid Managed Care (capitated)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Medicaid Managed Care (fee-for-service)</td>
<td>$5,465,054</td>
<td>$5,700,521</td>
<td>$6,715,765</td>
<td>$6,770,806</td>
</tr>
<tr>
<td>Total Medicaid</td>
<td>$30,186,051</td>
<td>$32,228,575</td>
<td>$36,914,823</td>
<td>$37,114,636</td>
</tr>
<tr>
<td>Medicare Non-Managed Care</td>
<td>$5,550,317</td>
<td>$5,868,908</td>
<td>$5,829,829</td>
<td>$5,920,142</td>
</tr>
<tr>
<td>Medicare Managed Care (capitated)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Medicare Managed Care (fee-for-service)</td>
<td>$30,807</td>
<td>$17,392</td>
<td>$30,259</td>
<td>$47,469</td>
</tr>
<tr>
<td>Total Medicare</td>
<td>$5,581,124</td>
<td>$5,886,300</td>
<td>$5,860,088</td>
<td>$6,031,852</td>
</tr>
<tr>
<td>Other Public including Non-Medicaid CHIP (Non-Managed Care)</td>
<td>$652,954</td>
<td>$537,938</td>
<td>$561,983</td>
<td>$577,380</td>
</tr>
<tr>
<td>Other Public including Non-Medicaid CHIP (Managed Care Capitated)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other Public including Non-Medicaid CHIP (Managed Care fee-for-service)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total Other Public</td>
<td>$652,954</td>
<td>$537,938</td>
<td>$561,983</td>
<td>$577,380</td>
</tr>
<tr>
<td>Private Non-Managed Care</td>
<td>$9,828,832</td>
<td>$10,057,470</td>
<td>$10,734,883</td>
<td>$10,603,931</td>
</tr>
<tr>
<td>Private Managed Care (capitated)</td>
<td>$78,754</td>
<td>$81,346</td>
<td>$80,704</td>
<td>$130,123</td>
</tr>
<tr>
<td>Private Managed Care (fee-for-service)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total Private Insurance</td>
<td>$9,907,586</td>
<td>$10,138,816</td>
<td>$10,815,587</td>
<td>$10,734,054</td>
</tr>
<tr>
<td>Total Self-Pay</td>
<td>$7,626,222</td>
<td>$7,871,478</td>
<td>$8,499,171</td>
<td>$10,237,234</td>
</tr>
<tr>
<td>Total Patient-Related Revenue</td>
<td>$53,953,937</td>
<td>$56,663,107</td>
<td>$62,651,652</td>
<td>$64,695,156</td>
</tr>
<tr>
<td>Other Revenue</td>
<td>2009</td>
<td></td>
<td>2010</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>----------</td>
<td>---</td>
<td>----------</td>
<td>---</td>
</tr>
<tr>
<td></td>
<td>Amount</td>
<td>%</td>
<td>Amount</td>
<td>%</td>
</tr>
<tr>
<td>Migrant Health Center</td>
<td>$460,800</td>
<td>1.5</td>
<td>$416,600</td>
<td>1.2</td>
</tr>
<tr>
<td>Community Health Center</td>
<td>$16,522,587</td>
<td>54.1</td>
<td>$16,531,226</td>
<td>49.0</td>
</tr>
<tr>
<td>Health Care for the Homeless</td>
<td>$963,560</td>
<td>3.2</td>
<td>$1,109,313</td>
<td>3.3</td>
</tr>
<tr>
<td>Public Housing Primary Care</td>
<td>$0</td>
<td>0.0</td>
<td>$0</td>
<td>0.0</td>
</tr>
<tr>
<td>Capital Improvement Program Grants</td>
<td>$186,778</td>
<td>0.6</td>
<td>$144,074</td>
<td>0.4</td>
</tr>
<tr>
<td>Affordable Care Act (ACA) Capital Development Grants</td>
<td>$0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Total BPHC Grants</td>
<td>$18,133,725</td>
<td>59.4</td>
<td>$18,201,213</td>
<td>53.9</td>
</tr>
<tr>
<td>Ryan White Title III HIV Early Intervention</td>
<td>$929,745</td>
<td>3.0</td>
<td>$988,429</td>
<td>2.9</td>
</tr>
<tr>
<td>Other Federal Grants</td>
<td>$1,152,671</td>
<td>3.8</td>
<td>$992,656</td>
<td>2.9</td>
</tr>
<tr>
<td>Medicare and Medicaid EHR Incentive Payments for Eligible Providers</td>
<td>$0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>ARRA New Access Point &amp; Increased Demand for Services</td>
<td>$1,126,901</td>
<td>3.7</td>
<td>$2,982,337</td>
<td>8.8</td>
</tr>
<tr>
<td>ARRA Capital Improvement Project &amp; Facility Improvement Project</td>
<td>$1,822,615</td>
<td>6.0</td>
<td>$4,779,223</td>
<td>14.2</td>
</tr>
<tr>
<td>Total Other Federal Grants</td>
<td>$5,031,932</td>
<td>16.5</td>
<td>$9,742,645</td>
<td>28.9</td>
</tr>
<tr>
<td>State Government Grants and Contracts</td>
<td>$1,973,337</td>
<td>6.5</td>
<td>$1,630,488</td>
<td>4.8</td>
</tr>
<tr>
<td>State/Local Indigent Care Programs</td>
<td>$349,882</td>
<td>1.1</td>
<td>$404,572</td>
<td>1.2</td>
</tr>
<tr>
<td>Local Government Grants and Contracts</td>
<td>$676,703</td>
<td>2.2</td>
<td>$794,493</td>
<td>2.4</td>
</tr>
<tr>
<td>Foundation/Private Grants and Contracts</td>
<td>$3,289,860</td>
<td>10.8</td>
<td>$2,244,645</td>
<td>6.7</td>
</tr>
<tr>
<td>Total Non-Federal Grants and Contracts</td>
<td>$6,289,782</td>
<td>20.6</td>
<td>$5,074,198</td>
<td>15.0</td>
</tr>
<tr>
<td>Other Revenue (non-patient related revenue not reported elsewhere)</td>
<td>$1,090,482</td>
<td>3.6</td>
<td>$723,819</td>
<td>2.1</td>
</tr>
<tr>
<td>TOTAL OTHER REVENUE</td>
<td>$30,545,921</td>
<td>100</td>
<td>$33,741,875</td>
<td>100</td>
</tr>
<tr>
<td>Total Patient Related Revenue</td>
<td>$53,953,937</td>
<td>63.9</td>
<td>$56,663,107</td>
<td>62.7</td>
</tr>
<tr>
<td>Total Other Revenue</td>
<td>$30,545,921</td>
<td>36.1</td>
<td>$33,741,875</td>
<td>37.3</td>
</tr>
<tr>
<td>COMBINED TOTAL REVENUE</td>
<td>$84,499,858</td>
<td>100</td>
<td>$64,404,982</td>
<td>100</td>
</tr>
</tbody>
</table>

Trends in patient related revenue are shown in Figure 3. Since 2007, total patient related revenue for FQHCs has increased from $35.9 million to $64.7 million with steady increases seen from 2007 – 2009 followed by little change from 2009-2010 and then increasing again in 2011 and 2012. Between 2007 and 2012, the dollar amount of Medicaid as a percent of total revenue has fluctuated slightly while contributions to patient revenue from Medicare, private insurance, other public sources, and self-pay have remained steady.

Since 2009 the total amount of other (i.e., non-patient related) revenue for FQHCs has increased except for a slight decrease in 2012. The total dollar amount of Bureau of Primary Health Care (BPHC) grants increased by about 30 percent from 2009 to 2012. The total dollar amount of other federal grants more than doubled from 2009 to 2011, followed by a considerable reduction in 2012. The increase till 2011 was largely a result of the availability of American Recovery and Reinvestment Act grants as a revenue source in 2009-2010. In 2011-12, ARRA grants have reduced but Medicaid and Medicare HER incentive payments have increased. The amount received from non-federal grants and contracts varies between 2009 to 2012.
Financial costs by service area, as reported in the 2011 UDS for all FQHCs in Iowa, are shown in Table 3:

<table>
<thead>
<tr>
<th>Table 3. FQHC Financial Costs by Service Area, 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Accrued Cost</strong></td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td><strong>Financial Costs for Medical Care</strong></td>
</tr>
<tr>
<td>1 Medical Staff</td>
</tr>
<tr>
<td>2 Lab and X-ray</td>
</tr>
<tr>
<td>3 Medical/Other Direct</td>
</tr>
<tr>
<td>4 Total Medical Care Services (Sum lines 1-3)</td>
</tr>
<tr>
<td><strong>Financial Costs for Other Clinical Services</strong></td>
</tr>
<tr>
<td>5 Dental</td>
</tr>
<tr>
<td>6 Mental Health</td>
</tr>
<tr>
<td>7 Substance Abuse</td>
</tr>
<tr>
<td>8a. Pharmacy not including pharmaceuticals</td>
</tr>
<tr>
<td>8b. Pharmaceuticals</td>
</tr>
<tr>
<td>9 Other Professional</td>
</tr>
<tr>
<td>9a. Vision</td>
</tr>
<tr>
<td>10 Total Other Clinical Services (Sum lines 5-9a)</td>
</tr>
<tr>
<td><strong>Financial Costs of Enabling and Other Program Related Services</strong></td>
</tr>
<tr>
<td>11a. Case Management</td>
</tr>
<tr>
<td>11b. Transportation</td>
</tr>
<tr>
<td>11c. Outreach</td>
</tr>
<tr>
<td>11d. Patient and Community Education</td>
</tr>
<tr>
<td>11e. Eligibility Assistance</td>
</tr>
<tr>
<td>11f. Interpretation Services</td>
</tr>
<tr>
<td>11g. Other Enabling Services</td>
</tr>
<tr>
<td>11 Total Enabling Services Cost (Sum lines 11a-11g)</td>
</tr>
<tr>
<td>12 Other Related Services</td>
</tr>
<tr>
<td>13 Total Enabling and Other Services (Sum lines 11-12)</td>
</tr>
<tr>
<td><strong>Facility and Non-Clinical Support Services and Totals</strong></td>
</tr>
<tr>
<td>14 Facility</td>
</tr>
<tr>
<td>15 Non-Clinical Support Services</td>
</tr>
<tr>
<td>16 Total Facility and Non-Clinical Support Services (Sum lines 14 and 15)</td>
</tr>
<tr>
<td>17 Total Accrued Costs (Sum lines 4+10+13+16)</td>
</tr>
<tr>
<td>18 Value of Donated Facilities, Services and Supplies</td>
</tr>
<tr>
<td>19 Total with Donations (Sum lines 17 and 18)</td>
</tr>
</tbody>
</table>

FQHC Revenue provided in the Uniform Data System presented here is reported on a cash basis as required by the BPHC. However, the FQHC Financial Costs by Service Area are presented on an accrual basis and exclude bad debt, as required by the BPHC. Therefore, a statewide cash flow analysis is presented below to show the net cash impact to the health centers. This cash flow analysis was prepared using each Iowa FQHC’s Form 990 Return for Organization Exempt from Tax, Part X Balance Sheets for the most recent three years available for public disclosure on GuideStar. This analysis shows Iowa FQHCs generated net cash from operating activities of $8.1 million in 2011/2012 as compared to $5.9 million in 2010/2011 and reinvested $7.4 million and $6.7 million of this cash into purchases of property and equipment in 2011/2012 and 2010/2011, respectively. Issuance of long-term debt net of debt payments also generated $1.0 million and $0.7 million in cash for Iowa FQHCs in 2011/2012 and 2010/2011, respectively, with a total increase in cash and cash equivalents statewide of $1.6 million in 2011/2012 and a total decrease of $48,744 in 2010/2011.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Amount</td>
<td>Percent</td>
</tr>
<tr>
<td>Operating Activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in net assets</td>
<td>$2,286,848</td>
<td>26%</td>
</tr>
<tr>
<td>Item not requiring operating activities cash flows</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depreciation</td>
<td>$2,957,332</td>
<td>33%</td>
</tr>
<tr>
<td>Changes in</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts and grants receivable</td>
<td>($1,068,269)</td>
<td>-12%</td>
</tr>
<tr>
<td>Prepaid expenses, inventory and other assets</td>
<td>($476,276)</td>
<td>-5%</td>
</tr>
<tr>
<td>Accounts payable and accrued expenses</td>
<td>$2,065,339</td>
<td>23%</td>
</tr>
<tr>
<td>Deferred revenue</td>
<td>$134,222</td>
<td>2%</td>
</tr>
<tr>
<td>Net cash provided by operating activities</td>
<td>$5,899,196</td>
<td>66%</td>
</tr>
<tr>
<td>Investing Activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purchase of property and equipment</td>
<td>($6,670,390)</td>
<td>-75%</td>
</tr>
<tr>
<td>Net cash used in investing activities</td>
<td>($6,670,390)</td>
<td>-75%</td>
</tr>
<tr>
<td>Financing Activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proceeds from issuance of long-term debt</td>
<td>$919,639</td>
<td>10%</td>
</tr>
<tr>
<td>Payments on long-term debt</td>
<td>($197,189)</td>
<td>-2%</td>
</tr>
<tr>
<td>Net cash provided by financing activities</td>
<td>$722,450</td>
<td>8%</td>
</tr>
<tr>
<td>Increase/(Decrease) in Cash and Cash Equivalents</td>
<td>($48,744)</td>
<td>-1%</td>
</tr>
<tr>
<td>CASH AND CASH EQUIVALENTS, BEGINNING OF YEAR</td>
<td>$8,920,955</td>
<td></td>
</tr>
<tr>
<td>CASH AND CASH EQUIVALENTS, END OF YEAR</td>
<td>$8,872,211</td>
<td></td>
</tr>
</tbody>
</table>
Staffing at the FQHCs

According to the Iowa Collaborative Safety Net Provider Network, the 13 Community Health Centers and one migrant health center employed 70.2 Full Time Equivalents (FTE) physicians (including M.D. and D.O.) and 66.9 FTE mid-level providers (including physician assistants and nurse practitioners).

UDS data from 2011 shows that the eleven FQHCs in Iowa were staffed by 138 FTE dental providers, which included 34 FTE dentists, 22 FTE dental hygienists and 82 FTE dental assistants, aides and techs. Other providers included 24 FTE Mental health providers and 32 FTE pharmacy personnel.

The 2011 UDS report assessed electronic health records usage in the FQHCs and the results are reported in the following table:

### Table 4. EHR use by FQHCs in Iowa, 2011

<table>
<thead>
<tr>
<th>Health Centers that have an EHR installed</th>
<th>Number of Grantees</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a. Available for all providers at all sites</td>
<td>8</td>
<td>61.5%</td>
</tr>
<tr>
<td>1b. Limited to some sites or some providers</td>
<td>1</td>
<td>7.7%</td>
</tr>
<tr>
<td><strong>Total Health Centers with EHR installed (Sum 1a + 1b)</strong></td>
<td>9</td>
<td>69.2%</td>
</tr>
<tr>
<td>1c. No EHR installed</td>
<td>4</td>
<td>30.8%</td>
</tr>
<tr>
<td><strong>Total Health Centers reported</strong></td>
<td>13</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EHR Functionalities (Among health centers with EHR installed)**</th>
<th>Number of Grantees*</th>
<th>% of Total*</th>
</tr>
</thead>
<tbody>
<tr>
<td>2a. Patient history and demographic information</td>
<td>9</td>
<td>100%</td>
</tr>
<tr>
<td>2b. Clinical notes</td>
<td>8</td>
<td>88.9%</td>
</tr>
<tr>
<td>2c. Computerized provider order entry (CPOE) for lab tests</td>
<td>9</td>
<td>100%</td>
</tr>
<tr>
<td>2d. Computerized provider order entry (CPOE) for radiology tests</td>
<td>8</td>
<td>88.9%</td>
</tr>
<tr>
<td>2e. Electronic entry of prescriptions</td>
<td>9</td>
<td>100%</td>
</tr>
<tr>
<td>2f. Reminders for guideline-based interventions or screening tests</td>
<td>9</td>
<td>100%</td>
</tr>
<tr>
<td>2g. Capability to exchange key clinical information among providers of care and patient-authorized entities electronically</td>
<td>7</td>
<td>77.8%</td>
</tr>
<tr>
<td>2h. Notifiable diseases: notification sent electronically</td>
<td>1</td>
<td>11.1%</td>
</tr>
<tr>
<td>2i. Reporting to immunization registries done electronically</td>
<td>3</td>
<td>33.3%</td>
</tr>
<tr>
<td>2j. Ability to provide patients with a copy of their health information on request</td>
<td>7</td>
<td>77.8%</td>
</tr>
<tr>
<td>2k. Capacity to provide clinical summaries for patients for each office visit</td>
<td>9</td>
<td>100%</td>
</tr>
<tr>
<td>2l. Protection of electronic health information</td>
<td>9</td>
<td>100%</td>
</tr>
</tbody>
</table>

**UDS Use Among Health Centers with an EHR installed**

<table>
<thead>
<tr>
<th>Number of Grantees</th>
<th>% of Total*</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Use an EHR to report clinical UDS data</td>
<td>5</td>
</tr>
</tbody>
</table>

* Includes Health Centers whose systems have the capability but is turned off or not used

** Meaningful Use functionalities include lines 2a, 2c, 2f, 2g, 2i, 2j, 2k and 2l

Patients Served

From 2007-2012, Iowa’s FQHCs have reported an increasing number of patients. In 2009, 108 delivery sites for the 13 FQHCs saw 154,020 patients during 556,862 encounters.\(^{18}\) In 2010, the number of patients increased 11 percent (172,312) and the number of encounters increased 8 percent (602,001).\(^{19}\) In 2011, the number of patients seen at the FQHCs in Iowa increased further by 4% (179,120) and number of encounters increased by 4 percent as well (627,380).\(^{20}\) In 2012, the number of patients seen at FQHCs modestly increased by 1.5 percent but total number of encounters decreased by 13 percent.\(^{21}\)

<table>
<thead>
<tr>
<th>Year</th>
<th>Community Health Centers</th>
<th>Total Patients</th>
<th>% Change from previous year</th>
<th>Total Encounters</th>
<th>% Change from previous year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>13</td>
<td>124,759</td>
<td>-</td>
<td>423,141</td>
<td>-</td>
</tr>
<tr>
<td>2008</td>
<td>13</td>
<td>137,830</td>
<td>10.5</td>
<td>488,598</td>
<td>15.5</td>
</tr>
<tr>
<td>2009</td>
<td>13</td>
<td>154,020</td>
<td>11.7</td>
<td>556,862</td>
<td>14.0</td>
</tr>
<tr>
<td>2010</td>
<td>13</td>
<td>172,312</td>
<td>11.9</td>
<td>602,001</td>
<td>8.1</td>
</tr>
<tr>
<td>2011</td>
<td>13</td>
<td>179,120</td>
<td>3.9</td>
<td>627,380</td>
<td>4</td>
</tr>
<tr>
<td>2012</td>
<td>14</td>
<td>181,781</td>
<td>1.5</td>
<td>544,585</td>
<td>-13.2</td>
</tr>
</tbody>
</table>

Source: HRSA, Bureau of Primary Care, 2012.

Patient Demographics

Insurance Status/Income Level

According to the National Association of Community Health Centers (NACHC), compared to the general population, more patients who used FQHCs in Iowa during 2010 are uninsured, below 200% of the Federal Poverty Level (FPL), and living in rural areas (Figure 4). Iowa patients who used FQHCs during 2010 are also more likely to be enrolled in Medicaid, but less likely to be enrolled in Medicare compared to the general population. FQHC patients in Iowa were also more likely to be racial-ethnic minorities and reside in rural areas.\(^{22}\)
The Iowa Collaborative Safety Net Provider Network reports that the largest proportions of FQHC patients are covered by Medicaid (Table 6). Approximately one third of FQHC patients were either uninsured or self-pay. Additionally, less than one quarter of FQHC patients had private insurance as their principal insurance.23

### Table 6. Insurance Coverage for unduplicated patients in 2009-2012

<table>
<thead>
<tr>
<th>Insurance</th>
<th>2009</th>
<th>%</th>
<th>2010</th>
<th>%</th>
<th>2011</th>
<th>%</th>
<th>2012</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>49,782</td>
<td>32</td>
<td>56,200</td>
<td>32.6</td>
<td>69,566</td>
<td>38</td>
<td>75,522</td>
<td>42</td>
</tr>
<tr>
<td>Medicare</td>
<td>10,555</td>
<td>7</td>
<td>12,138</td>
<td>7</td>
<td>11,374</td>
<td>6</td>
<td>11,579</td>
<td>6</td>
</tr>
<tr>
<td>Other Public Insurance</td>
<td>612</td>
<td>1</td>
<td>746</td>
<td>0.4</td>
<td>1,302</td>
<td>1</td>
<td>788</td>
<td>0</td>
</tr>
<tr>
<td>Private/Commercial Insurance</td>
<td>34,259</td>
<td>22</td>
<td>36,158</td>
<td>21</td>
<td>36,013</td>
<td>20</td>
<td>34,155</td>
<td>19</td>
</tr>
<tr>
<td>Uninsured/Self Pay/Private Pay</td>
<td>58,812</td>
<td>38</td>
<td>67,070</td>
<td>39</td>
<td>63,213</td>
<td>35</td>
<td>59,737</td>
<td>33</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>154,020</strong></td>
<td><strong>100</strong></td>
<td><strong>172,312</strong></td>
<td><strong>100</strong></td>
<td><strong>181,468</strong></td>
<td><strong>100</strong></td>
<td><strong>181,781</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Race
A majority of (unduplicated) patients seen during 2010 at Community Health Centers in Iowa were classified as White/Caucasian (81%), eight percent of patients were classified as Black/African American, and Asian/Pacific Islanders compose 2 percent of patients at Iowa CHCs. However, in the year 2011, the FQHCs saw fewer White patients (72%), more Black/African American (12%) and Asian/Pacific Islanders (3%). The race distribution of FQHC patients in 2012 remained similar to 2011, with 73.6% of total patients being Whites, 12.2% Black/African Americans and 3% Asian/Pacific Islanders (Figure 5).

Ethnicity
Sixty six percent of (unduplicated) patients visiting Iowa’s CHCs during 2010 were neither Hispanic nor Latino while 18 percent of patients that identify as either Hispanic or Latino. However in 2011, the FQHCs in Iowa saw more Hispanic/Latino patients (21%), and fewer non-Hispanic/non-Latino patients (78%). In 2012 too, the ethnic distribution of FQHC patients stayed same as 2011, with 21% Hispanic/Latino patients and 77% non-Hispanic/non-Latino patients (Figure 6).
Age

The 6-17 year old age group represents the largest proportion (18.5%) of (unduplicated) patients seen at FQHCs in Iowa during 2012. Age groups 0-5 years and 25-34 years represent the second largest proportion of patients (about 15% each). Patients 65 and older represent 5.5 percent of the total number of patients, which is the smallest proportion among all age groups. This age distribution of patients was very similar to that of patients seen in 2010 and 2011.

Source: Iowa Collaborative Safety Net Provider Network, CY 2012
Sex
Of the 181,781 patients served by Iowa CHCs in 2012, the majority (56%) were female. The ratio of male and female patients has been consistent in recent years.

Primary language
Approximately 11 percent of all Iowa FQHC patients spoke a language other than English.

Health Status
The most common primary diagnoses for all FQHC visits during 2010 were the following chronic health conditions:

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Visits</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Mellitus</td>
<td>27,639</td>
<td>10,031</td>
</tr>
<tr>
<td>Hypertension</td>
<td>25,189</td>
<td>13,452</td>
</tr>
<tr>
<td>Depression/Mood disorders</td>
<td>13,609</td>
<td>5,936</td>
</tr>
<tr>
<td>Otitis Media/Eustachian tube disorders</td>
<td>10,181</td>
<td>6,984</td>
</tr>
<tr>
<td>Heart disease</td>
<td>6,075</td>
<td>2,292</td>
</tr>
</tbody>
</table>


In 2012, the most common diagnoses at all FQHC visits were: Diabetes Mellitus, Hypertension, Routine infant/child health check, Depressive disorder and Overweight/obesity.

The types of medical conditions presented by FQHCs patients as well as preventive and chronic disease management services provided by FQHCs have varied from 2010 to 2012 as follows:

<table>
<thead>
<tr>
<th>Medical Conditions</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension 3</td>
<td>21.10%</td>
<td>22.60%</td>
<td>22.30%</td>
<td>5.60%</td>
</tr>
<tr>
<td>Diabetes 4</td>
<td>10.80%</td>
<td>11.90%</td>
<td>12.20%</td>
<td>13.70%</td>
</tr>
<tr>
<td>Asthma</td>
<td>2.70%</td>
<td>2.70%</td>
<td>5.30%</td>
<td>95.60%</td>
</tr>
<tr>
<td>HIV</td>
<td>0.50%</td>
<td>0.50%</td>
<td>0.90%</td>
<td>90.60%</td>
</tr>
</tbody>
</table>

Prenatal

| Prenatal Patients | 2,569 | 2,820 | 2,528 | -1.60% |
| Prenatal patients who delivered | 1,440 | 1,627 | 1,476 | 2.50% |

Quality of Healthcare Indicators/Health Outcomes

<table>
<thead>
<tr>
<th>Perinatal Health</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Prenatal Care (First Prenatal Visit in 1st Trimester)</td>
<td>75.50%</td>
<td>77.30%</td>
<td>80.10%</td>
<td>6.10%</td>
</tr>
<tr>
<td>Low Birth Weight</td>
<td>6.70%</td>
<td>7.30%</td>
<td>6.40%</td>
<td>-4.90%</td>
</tr>
</tbody>
</table>

Preventive Health Screening & Services

| Cervical Cancer Screening | 54.20% | 49.90% | 47.20% | -12.80% |
| Adolescent Weight Screening and Follow Up | - | 34.40% | 34.70% | - |
From 2010 to 2012, the type of service provided that has increased the most is mental health services, followed by dental services (Table 9).

Preventive dental services, including check-ups, cleanings and fluoride treatments, were the most common dental procedures provided at Iowa FQHCs during 2010 (Table 10).
<table>
<thead>
<tr>
<th>Service</th>
<th>Column 1</th>
<th>Column 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluoride treatment</td>
<td>34,826</td>
<td>25,539</td>
</tr>
<tr>
<td>Restorative Services</td>
<td>30,612</td>
<td>15,794</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>11,882</td>
<td>9,485</td>
</tr>
<tr>
<td>Rehabilitative services</td>
<td>4,401</td>
<td>2,933</td>
</tr>
<tr>
<td>(Root canals, Gum treatment,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crowns, Bridges, Braces)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sealants</td>
<td>3,873</td>
<td>3,259</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>2,975</td>
<td>2,527</td>
</tr>
</tbody>
</table>

Impact of the ACA on FQHCs

The Patient Protection and Affordable Care Act (“ACA”) utilizes the definition for FQHCs that is already in use, which depends on the clinic receiving money through the Public Health Service Act. The ACA expands the Medicaid and CHIP Payment and Access Commission’s (“MACPAC”) duties including reviewing and assessing payments to FQHCs.

Financing care at FQHCs

Regarding financing, the ACA substantially alters payments to FQHCs by establishing a prospective payment system for FQHCs. Currently, FQHCs are reimbursed based on reasonable costs. The Secretary is authorized by the ACA to develop the prospective program’s details accounting for the type, intensity, and duration of services. During the first year of the prospective payment system, aggregated payments will equal 100 percent of the estimated reasonable costs assuming the PPS was not implemented.

PPS payment during subsequent years will be based on the prior year’s payment rates increased by either the percentage increase based on the Medicare economic increase (for only the first year after PPS implementation) or by the percentage increase in a market basket of FQHC goods and services (identified by regulations and applied in years after the first post-implementation year).

The Affordable Care Act also directly impacts FQHC financing; the ACA authorizes specific amounts for each year from 2010 to 2015 beginning at $3 billion and ending at $8.3 billion, respectively. The ACA also authorizes appropriations to FQHCs 2016 and beyond. Compared to the years prior to 2016, authorized amounts in 2016 and after are determined by a formula based on the increase in costs for patients served by FQHCs multiplied by the increase in the number of patients served by FQHCs.

Not specific to FQHCs, but the development of Accountable Care Organizations, authorized under the ACA, could have important indirect implications for FQHCs. Though the first ACOs will be specific to Medicare populations (a relatively small proportion of FQHC patients), Medicaid and private payers are also investigating similar payment models. The role for FQHCs in these ACOs will be important. If they are viewed as poor risks because their populations are sicker or harder to manage, they may have challenges incorporating into these new systems.

Similarly, how FQHCs function relative to state insurance exchanges. Most of the public insurance expansion will be for adults through the Medicaid program, a key constituency of the FQHCs. Also, plans in the Exchanges are supposed to have a “sufficient number” of “essential community providers” in their networks. Since this does not mean all, and it is not clear how the adequacy will be determined, FQHCs will need to be vigilant for plans in their area.
Iowa, like many states, is developing Medicaid Health Homes under the 2703 State Plan Amendment piece of the ACA. Some FQHCs are already participating, others are considering. Many Iowa FQHCs have some experience as health homes through participation in the IowaCare program however this is a limited provider, limited benefit program and not as comprehensive as the Medicaid Health Home program. Identifying opportunities

Workforce issues

In an attempt to address the primary care worker shortage at FQHCs, Congress established a family nurse practitioner training program in the ACA.38 The training program provides one year of training at an eligible center for any nurse practitioner who is either licensed or eligible for licensure and demonstrates a commitment to a career as an FQHC primary care provider.39 The ACA does not define, nor provide the Secretary authority to explain, how a nurse practitioner demonstrates commitment.

Similar to the nurse practitioner training, the ACA authorizes payment to area health education centers.40 Included in the required activities is the provision that area health education centers must utilize field placements of health care providers in order to prepare the providers for serving in underserved areas or areas of health disparities; one possible field placement is with FQHCs.41

An additional training program focused on primary care that potentially impacting FQHCs is authorized by Section 5301 of the ACA.42 This ACA section enhances grants to eligible institutions for primary care training, and grant applicants having formal agreements (or joint applications) with FQHCs located in underserved areas will be given priority when awarding grants.43 The potential impact of this section would be to bring more health care students into FQHCs.

In another training program established by the ACA, graduate nurse demonstration project funding is authorized for 5 hospitals having written agreements with a school of nursing and a non-hospital community-based care setting, which includes FQHCs.44 Participating FQHCs are reimbursed according to the ACA for reasonable costs associated with providing training to the graduate nurses.45

Finally, the ACA establishes a grant for developing teaching health centers in order to prepare primary care residents.46 An FQHC is explicitly defined by the ACA as a teaching health center.47 Grants under this section are limited to three years and a total award of $500,000.48 Funds from the grant can be used for:

- Establishing, or expanding, a primary care residency training program;
- Curriculum development;
- Recruitment, training, and retention of residents and faculty;
- Accreditation
- Faculty salaries; and
- Technical assistance.

Further, a teaching health center listed as a sponsoring institution can be reimbursed for direct and indirect expenses for either the expansion or establishment of a medical resident training program.49
Direct costs are calculated according to: payments per resident multiplied by the number of residents in
the center’s residency program. Additionally, indirect medical education expenses are also reimbursed
to a teaching health center.

Care delivery issues

The ACA encourages health institutions to network with other health institutions. The ACA also
encourages FQHCs to network with other health institutions by establishing grants for community-based
collaborative care networks. The community-based networks must include a hospital in addition to an
FQHC. The ACA does not explicitly provide for grant amounts. Priority is given to community-based
networks that provide a broad range of services to high volumes of low-income people.

The ACA requires health insurers offering qualified plans to cover specific health service categories
within the essential health benefits package. If an enrollee to a qualified health plan receives services
from an FQHC, the health insurer offering the qualified health plan must pay, at a minimum, the amount
the health insurer would have received from either Medicare or Medicaid to the FQHC.

--Oral health at FQHCs

Similar to the primary care training but focusing on oral health, the ACA establishes grants for
institutions and individuals training for careers in general, pediatric, or public health dentistry. Grant
applicants having formal agreements with FQHCs located in underserved areas will be given priority
when awarding grants under this ACA section.

Further, the ACA authorizes grants to a maximum of 15 eligible entities in order improve access to
dental health services in rural and underserved areas. The demonstration program provides grants to
the eligible entities for not less than $4 million (total) and a maximum of 5 years. The grants fund
training programs for alternative dental health care providers who include: community dental health
 coordinators, advance practice dental hygienists, primary care physicians, dental therapists, and dental
health aides. FQHCs are explicitly included in the ACA as eligible entities. Further, eligible entities
must be within either a program accredited by the Commission on Dental Accreditation or a dental
education program in an accredited institution.

1 FQHC FAQ from the Rural Assistance Center updated 08/3/10. Accessed from
2 FQHC Look-Alike Program http://bphc.hrsa.gov/about/lookalike/index.html
3 FQHC FAQ from the Rural Assistance Center updated 08/3/10. Accessed from
5 FQHC FAQ from the Rural Assistance Center updated 08/3/10. Accessed from


7 Iowa Primary Care Association, About Iowa PCA. Accessed from http://iowapca.com/displaycommon.cfm?an=1; on 9/8/11;


8 Kaiser State Health Facts includes data for FQHCs that meet federal health center grant requirements and are required to report administrative, clinical and other information to the federal Bureau of Primary Health Care. FQHC Look-Alikes are not included because they do not receive federal health center grants and do not report to the Bureau of Primary Health Care.


10 Kaiser State Health Facts includes data for FQHCs that meet federal health center grant requirements and are required to report administrative, clinical and other information to the federal Bureau of Primary Health Care. FQHC Look-Alikes are not included because they do not receive federal health center grants and do not report to the Bureau of Primary Health Care.

11 Uniform Data Systems reports include data for FQHCs that meet federal health center grant requirements and are required to report administrative, clinical and other information to the federal Bureau of Primary Health Care. FQHC Look-Alikes are not included because they do not receive federal health center grants and do not report to the Bureau of Primary Health Care.


14 The Iowa Collaborative Safety Net Provider Network defines Community Health Centers (CHCS or Federally Qualified Health Centers) as health care delivery sites that are community-based, patient-directed, and serve populations with limited access to health care. Data for the 14 Community Health Centers in Iowa include 13 FQHCs and 1 FQHC Look-Alike.

15 Iowa Collaborative Safety Net Provider Network CY 2011 Data Report


Bureau of Primary Care – Health Resources and Services Administration

Bureau of Primary Care - Health Resources and Services Administration

National Association of Community Health Centers Iowa Health Center Fact Sheet. Accessed from

National Association of Community Health Centers Key Health Center Data by State, 2009. Accessed from

Iowa Collaborative Safety Net Provider Network CY 2009 Data Report p29

Iowa Collaborative Safety Net Provider Network CY 2012 Data Report

Iowa Collaborative Safety Net Provider Network CY 2010 Data Report, Iowa Collaborative Safety Net Provider
Network CY 2011 Data Report

Uniform Data Systems Aggregated, 2010

ACA Section 5002(b)(1)(17)
ACA Section 2801(a)(1)(B)(i)(I)(bb)
ACA Sections 10501(i)(3)(A)-(C)

CCH’s Law, Explanation, and Analysis of the Patient Protection and Affordable Care Act, Including Reconciliation
Impact, Volume 1. Wolter Kluwers: Chicago, IL.

ACA Section 10501(j)(3)(A).
ACA Section 10501(j)(3)(A).
ACA Section 10501(j)(3)(A).
ACA Section 5601(a).
ACA Section 5601(a).
ACA Section 5601(a).
ACA Section 5601(a).
ACA Section 10501(e)
ACA Section 10501(e)(a); ACA Sections 10501(e)(f)(1)(A) and (B).
ACA Section 5403(a).
ACA Section 5403(a).
ACA Section 5301.
ACA Section 5301.
ACA Sections 5509(a)(1)(A), (e)(5).
ACA Section 5509(a)(2)(A).
ACA Section 5508(a).
ACA Section 5508(a).
ACA Section 5508(a).
ACA Section 5508(c).
ACA Section 5508(c).
ACA Section 5508(c).
ACA Section 10333.
ACA Section 10333.
ACA Section 10333.
ACA Sections 1302(a),(b).
ACA Section 1302(g).
ACA Section 5303(2).
ACA Section 5303(2).
ACA Section 5304.
ACA Section 5304.
ACA Section 5304.
ACA Section 5304.

ACA Section 5304 amending Subpart X of part D of title III of the Public Health Service Act (42 U.S.C. Sections 256f et seq.)
Legal Review of the Impact of the ACA on FQHCs

Below is a list of the components of the ACA where there is language specific to FQHCs. Some of these provisions are difficult to understand without

Affordable Care Act Statutory Text Relating to FQHCs

Section 1900 of the Social Security Act as amended (indicated by italicized text) by ACA Section 2801 and the HRA:

(b) DUTIES.
(1) REVIEW OF ACCESS POLICIES FOR ALL STATES AND ANNUAL REPORTS.—MACPAC shall
(A) review policies of the Medicaid program established under this title (in this section
referred to as Medicaid) and the State Health Insurance Program established under title XXI
(in this section referred to as CHIP) affecting access to covered items and services, including
topics described in paragraph (2);
(B) make recommendations to Congress, the Secretary, and States
concerning such access
policies;
(C) by not later than March 15 of each year (beginning with 2010), submit a report to
Congress containing the results of such reviews and MACPAC’s recommendations concerning
such policies; and
(D) by not later than June 15 of each year (beginning with 2010), submit a report to
Congress containing an examination of issues affecting Medicaid and CHIP, including the
implications of changes in health care delivery in the United States and in the market for
health care services on such programs.
(2)
* * *
(A)
* * *
(i) the factors affecting expenditures for the efficient provision of items and services
in different sectors, including the process for updating payments to medical, dental, and
health professionals, hospitals, residential and long-term care providers, providers of home and
community based services, Federally-qualified health centers and rural health clinics, managed
care entities, and providers of other covered items and services;
* * *
(iii) the relationship of such factors and methodologies to access and quality of care
for Medicaid and CHIP beneficiaries (including how such factors and methodologies enable
such beneficiaries to obtain the services for which they are eligible, affect, provider supply, and affect
providers that serve a disproportionate share of low-income and other vulnerable
populations).
(B) ELIGIBILITY POLICIES.—Medicaid and CHIP eligibility policies, including a determination of
the degree to which Federal and State policies provide health care coverage to needy populations.
(C) ENROLLMENT AND RETENTION PROCESSES.—Medicaid and CHIP enrollment and retention
processes, including a determination of the degree to which Federal and State policies encourage the
enrollment of individuals who are eligible for such programs and screen out individuals who are
ineligible, while minimizing the share of program expenses devoted to such processes.
(D) COVERAGE POLICIES.—Medicaid and CHIP benefit and coverage policies, including a determination
of the degree to which Federal and State policies provide access to the services enrollees
require to improve and maintain their health and functional status.

(E) QUALITY OF CARE.—Medicaid and CHIP policies as they relate to the quality of care provided under those programs, including a determination of the degree to which Federal and State policies achieve their stated goals and interact with similar goals established by other purchasers of health care services.

(F) INTERACTION OF MEDICAID AND CHIP PAYMENT POLICIES WITH HEALTH CARE DELIVERY GENERALLY.—
The effect of Medicaid and CHIP payment policies on access to items and services for children and other Medicaid and CHIP populations other than under this title or title XXI and the implications of changes in health care delivery in the United States and in the general market for health care items and services on Medicaid and CHIP.

(G) INTERACTIONS WITH MEDICARE AND MEDICAID.—Consistent with paragraph (11), the interaction of policies under Medicaid and the Medicare program under title XVIII, including with respect to how such interactions affect access to services, payments, and dual eligible individuals.

(H) OTHER ACCESS POLICIES.—The effect of other Medicaid and CHIP policies on access to covered items and services, including policies relating to transportation and language barriers and preventive, acute, and long-term services and supports.

(3) RECOMMENDATIONS AND REPORTS OF STATE-SPECIFIC DATA.—MACPAC shall—
(A) review national and State-specific Medicaid and CHIP data; and
(B) submit reports and recommendations to Congress, the Secretary, and States based on such reviews.

(4) CREATION OF EARLY-WARNING SYSTEM.—MACPAC shall create an early-warning system to identify provider shortage areas, as well as other factors that adversely affect, or have the potential to adversely affect, access to care by, or the health care status of, Medicaid and CHIP beneficiaries. MACPAC shall include in the annual report required under paragraph (1)(D) a description of all such areas or problems identified with respect to the period addressed in the report.

(5) COMMENTS ON CERTAIN SECRETARIAL REPORTS AND REGULATIONS.—(A) CERTAIN SECRETARIAL REPORTS.—If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to access policies, including with respect to payment policies, under Medicaid or CHIP, the Secretary shall transmit a copy of the report to MACPAC. MACPAC shall review the report and, not later than 6 months after the date of submittal of the Secretary’s report to Congress, shall submit to the appropriate committees of Congress and the Secretary written comments on such report. Such comments may include such recommendations as MACPAC deems appropriate.

(B) REGULATIONS.—MACPAC shall review Medicaid and CHIP regulations and may comment through submission of a report to the appropriate committees of Congress and the Secretary, on any such regulations that affect access, quality, or efficiency of health care.

(6) AGENDA AND ADDITIONAL REVIEWS.—MACPAC shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding MACPAC’s agenda and progress towards achieving the agenda. MACPAC may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under this title or title XXI as may be requested by such chairmen and members and as MACPAC deems appropriate.

(7) AVAILABILITY OF REPORTS.—MACPAC shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

(8) APPROPRIATE COMMITTEE OF CONGRESS.—For purposes of this section, the term appropriate committees of Congress means the Committee on Energy and Commerce of the House of
Representatives and the Committee on Finance of the Senate.

(9) VOTING AND REPORTING REQUIREMENTS.—With respect to each recommendation contained in
a report submitted under paragraph (1), each member of MACPAC shall vote on the recommendation,
and MACPAC shall include, by member, the results of that vote in the report containing
the recommendation.

(10) EXAMINATION OF BUDGET CONSEQUENCES.—Before making any recommendations,
MACPAC shall examine the budget consequences of such recommendations, directly or through
consultation with appropriate expert entities, and shall submit with any recommendations, a report on
the Federal and State-specific budget consequences of the recommendations.

(11) CONSULTATION AND COORDINATION WITH MEDPAC.—(A) IN GENERAL.—MACPAC shall
consult with the Medicare Payment Advisory Commission (in this paragraph referred to as ‘MedPAC’) established under section 1805 in carrying out its duties under this section, as appropriate and particularly
with respect to the issues specified in paragraph (2) as they relate to those Medicaid beneficiaries who are dually eligible for Medicaid and the Medicare program under title XVIII, adult Medicaid beneficiaries (who are not dually eligible for Medicare), and beneficiaries under Medicare. Responsibility for analysis of
and recommendations to change Medicare policy regarding Medicare beneficiaries, including Medicare beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with MedPAC.

(B) INFORMATION SHARING.—MACPAC and MedPAC shall have access to deliberations and records of the other such entity, respectively, upon the request of the other such entity.

(12) CONSULTATION WITH STATES.—MACPAC shall regularly consult with States in carrying out its
duties under this section, including with respect to developing processes for carrying out such duties, and shall ensure that input from States is taken into account and represented in MACPAC’s recommendations and reports.

(13) COORDINATE AND CONSULT WITH THE FEDERAL COORDINATED HEALTH CARE OFFICE.—MACPAC
shall coordinate and consult with the Federal Coordinated Health Care Office established under section 2602 of the Patient Protection and Affordable Care Act before making any recommendations regarding dual eligible individuals.

(14) PROGRAMMATIC OVERSIGHT VESTED IN THE SECRETARY.—MACPAC’s authority to make recommendations
in accordance with this section shall not affect, or be considered to duplicate, the Secretary’s authority to carry out Federal responsibilities with respect to Medicaid and CHIP.

(c) * * *

(2) * * *

(A) IN GENERAL.—The membership of MACPAC shall include individuals who have had direct experience as enrollees or parents or caregivers of enrollees in Medicaid or CHIP and individuals with
national recognition for their expertise in Federal safety net health programs, health finance and economics, actuarial science, health plans and integrated delivery systems, reimbursement for health care, health information technology, and other providers of health services, public health, and other related fields, who provide a mix of different professions, broad geographic representation, and a balance between urban and rural representation.

(B) INCLUSION.—The membership of MACPAC shall include (but not be limited to) physicians,
dentists, and other health professionals, employers, third-party payers, and individuals with expertise
in the delivery of health services. Such membership shall also include representatives of children, pregnant women, the elderly, individuals with disabilities, caregivers, and dual eligible individuals, current or former representatives of State agencies responsible for administering Medicaid, and current or former representatives of State agencies responsible for administering CHIP.

(d) seek such assistance and support as may be required in the performance of its duties from appropriate Federal and State departments and agencies;

(e) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—MACPAC may secure directly from any department or agency of the United States and, as a condition for receiving payments under sections 1903(a) and 2105(a), from any State agency responsible for administering Medicaid or CHIP, information necessary to enable it to carry out this section. Upon request of the Chairman, the head of that department or agency shall furnish that information to MACPAC on an agreed upon schedule.

(f) FUNDING

(1) REQUEST FOR APPROPRIATIONS
MACPAC shall submit requests for appropriations (other than for fiscal year 2010) in the same manner as the Comptroller General of the United States submits requests for appropriations, but amounts appropriated for MACPAC shall be separate from amounts appropriated for the Comptroller General of the United States.

(2) AUTHORIZATION
There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.

(3) FUNDING FOR FISCAL YEAR 2010.—

(A) IN GENERAL.—
Out of any funds in the Treasury not otherwise appropriated, there is appropriated to MACPAC to carry out the provisions of this section for fiscal year 2010, $9,000,000.

(B) TRANSFER OF FUNDS.—
Notwithstanding section 2104(a)(13), from the amounts appropriated in such section for fiscal year 2010, $2,000,000 is hereby transferred and made available in such fiscal year to MACPAC to carry out the provisions of this section.

(4) AVAILABILITY.—
Amounts made available under paragraphs (2) and (3) to MACPAC to carry out the provisions of this section shall remain available until expended.
“(1) assess access to health care for beneficiaries of Federal health care systems in Alaska; and
“(2) develop a strategy for the Federal Government to improve delivery of health care to Federal beneficiaries in the State of Alaska.
“(c) MEMBERSHIP.—The Task Force shall be comprised of Federal members who shall be appointed, not later than 45 days after the date of enactment of this Act, as follows:
“(1) The Secretary of Health and Human Services shall appoint one representative of each of the following:
“(A) The Department of Health and Human Services.
“(B) The Centers for Medicare and Medicaid Services.
“(C) The Indian Health Service.
“(2) The Secretary of Defense shall appoint one representative of the TRICARE Management Activity.
“(3) The Secretary of the Army shall appoint one representative of the Army Medical Department.
“(4) The Secretary of the Air Force shall appoint one representative of the Air Force, from among officers at the Air Force performing medical service functions.
“(5) The Secretary of Veterans Affairs shall appoint one representative of each of the following:
“(A) The Department of Veterans Affairs.
“(B) The Veterans Health Administration.
“(6) The Secretary of Homeland Security shall appoint one representative of the United States Coast Guard.
“(d) CHAIRPERSON.—One chairperson of the Task Force shall be appointed by the Secretary at the time of appointment of members under subsection (c), selected from among the members appointed under paragraph (1).
“(e) MEETINGS.—The Task Force shall meet at the call of the chairperson.
“(f) REPORT.—Not later than 180 days after the date of enactment of this Act, the Task Force shall submit to Congress a report detailing the activities of the Task Force and containing the findings, strategies, recommendations, policies, and initiatives developed pursuant to the duty described in subsection (b)(2). In preparing such report, the Task Force shall consider completed and ongoing efforts by Federal agencies to improve access to health care in the State of Alaska.
“(g) TERMINATION.—The Task Force shall be terminated on the date of submission of the report described in subsection (f).”.
(c) Section 399V of the Public Health Service Act, as added by section 5313, is amended—
(1) in subsection (b)(4), by striking “identify, educate, refer, and enroll” and inserting “identify and refer”; and
(2) in subsection (k)(1), by striking “,” as defined by the Department of Labor as Standard Occupational Classification.
(d) Section 738(a)(3) of the Public Health Service Act (42 U.S.C. 293b(a)(3)) is amended by inserting “schools offering physician assistant education programs,” after “public health.”
(e) Subtitle D of title V of this Act is amended by adding at the end the following:

“SEC. 5316. DEMONSTRATION GRANTS FOR FAMILY NURSE PRACTITIONER TRAINING PROGRAMS.
“(a) ESTABLISHMENT OF PROGRAM.—The Secretary of Health and Human Services (referred to in this section as the ‘Secretary’) shall establish a training demonstration program for family nurse practitioners (referred to in this section as the ‘program’) to employ and provide 1-year training for nurse practitioners who have graduated from a nurse practitioner program for careers as primary care providers in Federally qualified health centers (referred to in this section as ‘FQHCs’) and nurse-managed health clinics (referred to in this section as ‘NMHCs’).
“(b) PURPOSE.—The purpose of the program is to enable each grant recipient to—
“(1) provide new nurse practitioners with clinical training to enable them to serve as primary care providers in FQHCs and NMHCs;
“(2) train new nurse practitioners to work under a model of primary care that is consistent with the principles set forth by the Institute of Medicine and the needs of vulnerable populations; and
“(3) create a model of FQHC and NMHC training for nurse practitioners that may be replicated nationwide.
“(c) GRANTS.—The Secretary shall award 3-year grants to eligible entities that meet the requirements established by the Secretary, for the purpose of operating the nurse practitioner primary care programs described in subsection (a) in such entities.
“(d) ELIGIBLE ENTITIES.—To be eligible to receive a grant under this section, an entity shall—
“(1)(A) be a FQHC as defined in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa)); or
“(B) be a nurse-managed health clinic, as defined in section 330A–1 of the Public Health Service Act (as added by section 5208 of this Act); and
“(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.
“(e) PRIORITY IN AWARDING GRANTS.—In awarding grants under this section, the Secretary shall give priority to eligible entities that—
“(1) demonstrate sufficient infrastructure in size, scope, and capacity to undertake the requisite training of a minimum
of 3 nurse practitioners per year, and to provide to each awardee 12 full months of full-time, paid employment and benefits consistent with the benefits offered to other full-time employees of such entity;

“(2) will assign not less than 1 staff nurse practitioner or physician to each of 4 precepted clinics;

“(3) will provide to each awardee specialty rotations, including specialty training in prenatal care and women’s health, adult and child psychiatry, orthopedics, geriatrics, and at least 3 other high-volume, high-burden specialty areas;

“(4) provide sessions on high-volume, high-risk health problems and have a record of training health care professionals in the care of children, older adults, and underserved populations; and

“(5) collaborate with other safety net providers, schools, colleges, and universities that provide health professions training.

“(f) ELIGIBILITY OF NURSE PRACTITIONERS.—

“(1) IN GENERAL.—To be eligible for acceptance to a program funded through a grant awarded under this section, an individual shall—

“(A) be licensed or eligible for licensure in the State in which the program is located as an advanced practice registered nurse or advanced practice nurse and be eligible or board-certified as a family nurse practitioner; and

“(B) demonstrate commitment to a career as a primary care provider in a FQHC or in a NMHC.

“(2) PREFERENCE.—In selecting awardees under the program, each grant recipient shall give preference to bilingual candidates that meet the requirements described in paragraph (1).

“(3) DEFERRAL OF CERTAIN SERVICE.—The starting date of required service of individuals in the National Health Service Corps Service program under title II of the Public Health Service Act (42 U.S.C. 202 et seq.) who receive training under this section shall be deferred until the date that is 22 days after the date of completion of the program.

“(g) GRANT AMOUNT.—Each grant awarded under this section shall be in an amount not to exceed $600,000 per year. A grant recipient may carry over funds from 1 fiscal year to another without obtaining approval from the Secretary.

“(h) TECHNICAL ASSISTANCE GRANTS.—The Secretary may award technical assistance grants to 1 or more FQHCs or NMHCs that have demonstrated expertise in establishing a nurse practitioner residency training program. Such technical assistance grants shall be for the purpose of providing technical assistance to other recipients of grants under subsection (c).
“(i) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 through 2014.”

(f)(1) Section 399W of the Public Health Service Act, as added by section 5405, is redesignated as section 399V–1.

(2) Section 399V–1 of the Public Health Service Act, as so redesignated, is amended in subsection (b)(2)(A) by striking “and the departments of 1 or more health professions schools in the State that train providers in primary care” and inserting “and the departments that train providers in primary care in 1 or more health professions schools in the State”.

(3) Section 934 of the Public Health Service Act, as added by section 3501, is amended by striking “399W” each place such term appears and inserting “399V–1”.

(4) Section 935(b) of the Public Health Service Act, as added by section 3503, is amended by striking “399W” and inserting “399V–1.”

(g) Part P of title III of the Public Health Service Act 42 U.S.C. 280g et seq.), as amended by section 10411, is amended by adding at the end the following:

“SEC. 399V–3. NATIONAL DIABETES PREVENTION PROGRAM.
“(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a national diabetes prevention program (referred to in this section as the ‘program’) targeted at adults at high risk for diabetes in order to eliminate the preventable burden of diabetes.

“(b) PROGRAM ACTIVITIES.—The program described in subsection (a) shall include—
“(1) a grant program for community-based diabetes prevention program model sites;
“(2) a program within the Centers for Disease Control and Prevention to determine eligibility of entities to deliver community-based diabetes prevention services;
“(3) a training and outreach program for lifestyle intervention instructors; and
“(4) evaluation, monitoring and technical assistance, and applied research carried out by the Centers for Disease Control and Prevention.

“(c) ELIGIBLE ENTITIES.—To be eligible for a grant under subsection (b)(1), an entity shall be a State or local health department, a tribal organization, a national network of community-based nonprofits focused on health and wellbeing, an academic institution, or other entity, as the Secretary determines.

“(d) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2010 through 2014.”.
Section 1834 of the Social Security Act (42 U.S.C. 1395m) as amended by the ACA sections 4105 and 10501:

“(o) DEVELOPMENT AND IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.—

“(1) DEVELOPMENT.—

“(A) IN GENERAL.—The Secretary shall develop a prospective payment system for payment for Federally qualified health center services furnished by Federally qualified health centers under this title. Such system shall include a process for appropriately describing the services furnished by Federally qualified health centers and shall establish payment rates for specific payment codes based on such appropriate descriptions of services. Such system shall be established to take into account the type, intensity, and duration of services furnished by Federally qualified health centers. Such system may include adjustments, including geographic adjustments, determined appropriate by the Secretary.

“(B) COLLECTION OF DATA AND EVALUATION.—By not later than January 1, 2011, the Secretary shall require Federally qualified health centers to submit to the Secretary such information as the Secretary may require in order to develop and implement the prospective payment system under this subsection, including the reporting of services using HCPCS codes.

“(2) IMPLEMENTATION.—

“(A) IN GENERAL.—Notwithstanding section 1833(a)(3)(A), the Secretary shall provide, for cost reporting periods beginning on or after October 1, 2014, for payments of prospective payment rates for Federally qualified health center services furnished by Federally qualified health centers under this title in accordance with the prospective payment system developed by the Secretary under paragraph (1).

“(B) PAYMENTS.—

“(i) INITIAL PAYMENTS.—The Secretary shall implement such prospective payment system so that the estimated aggregate amount of prospective payment rates (determined prior to the application of section 1833(a)(1)(Z)) under this title for Federally qualified health center services in the first year that such system is implemented is equal to 100 percent of the estimated amount of reasonable costs (determined without the application of a per visit payment limit or productivity screen and prior to the application of section 1866(a)(2)(A)(ii)) that would have occurred for such...
services under this title in such year if the system
had not been implemented.
“(ii) PAYMENTS IN SUBSEQUENT YEARS.—Payment
rates in years after the year of implementation of
such system shall be the payment rates in the previous
year increased—
“(I) in the first year after implementation of
such system, by the percentage increase in the
MEI (as defined in section 1842(i)(3)) for the year
involved; and
“(II) in subsequent years, by the percentage
increase in a market basket of Federally qualified
health center goods and services as promulgated
through regulations, or if such an index is not
available, by the percentage increase in the MEI
(as defined in section 1842(i)(3)) for the year
involved.
“(C) PREPARATION FOR PPS IMPLEMENTATION.—Notwithstanding
any other provision of law, the Secretary may
establish and implement by program instruction or otherwise
the payment codes to be used under the prospective
payment system under this section.’

Subtitle G of title V of the ACA is amended by adding at the following at the end of Subtitle G, Title V:
“SEC. 5606. STATE GRANTS TO HEALTH CARE PROVIDERS WHO PROVIDE
SERVICES TO A HIGH PERCENTAGE OF MEDICALLY
UNDERSERVED POPULATIONS OR OTHER SPECIAL POPULATIONS.
“(a) IN GENERAL.—A State may award grants to health care
providers who treat a high percentage, as determined by such
State, of medically underserved populations or other special populations
in such State.
“(b) SOURCE OF FUNDS.—A grant program established by a
State under subsection (a) may not be established within a department,
agency, or other entity of such State that administers the
Medicaid program under title XIX of the Social Security Act (42
U.S.C. 1396 et seq.), and no Federal or State funds allocated to
such Medicaid program, the Medicare program under title XVIII
of the Social Security Act (42 U.S.C. 1395 et seq.), or the TRICARE
program under chapter 55 of title 10, United States Code, may
be used to award grants or to pay administrative costs associated
with a grant program established under subsection (a).”

Part C of title VII of the Public Health Service Act (42U.S.C. 293k et seq.) is amended, in part, by ACA
Section 10501:
“Subpart II—Training in Underserved
Communities
“SEC. 749B. RURAL PHYSICIAN TRAINING GRANTS.
“(a) IN GENERAL.—The Secretary, acting through the Administrator
of the Health Resources and Services Administration, shall
establish a grant program for the purposes of assisting eligible
entities in recruiting students most likely to practice medicine
in underserved rural communities, providing rural-focused training
and experience, and increasing the number of recent allopathic
and osteopathic medical school graduates who practice in underserved
rural communities.

“(b) ELIGIBLE ENTITIES.—In order to be eligible to receive a
grant under this section, an entity shall—
“(1) be a school of allopathic or osteopathic medicine accredited
by a nationally recognized accrediting agency or association
approved by the Secretary for this purpose, or any combination
or consortium of such schools; and
“(2) submit an application to the Secretary that includes
a certification that such entity will use amounts provided to
the institution as described in subsection (d)(1).

“(c) PRIORITY.—In awarding grant funds under this section,
the Secretary shall give priority to eligible entities that—
“(1) demonstrate a record of successfully training students,
as determined by the Secretary, who practice medicine in underserved
rural communities;
“(2) demonstrate that an existing academic program of
the eligible entity produces a high percentage, as determined
by the Secretary, of graduates from such program who practice
medicine in underserved rural communities;
“(3) demonstrate rural community institutional partnerships,
through such mechanisms as matching or contributory
funding, documented in-kind services for implementation, or
existence of training partners with interprofessional expertise
in community health center training locations or other similar
facilities; or
“(4) submit, as part of the application of the entity under
subsection (b), a plan for the long-term tracking of where the
graduates of such entity practice medicine.

“(d) USE OF FUNDS.—
“(1) ESTABLISHMENT.—An eligible entity receiving a grant
under this section shall use the funds made available under
such grant to establish, improve, or expand a rural-focused
training program (referred to in this section as the ‘Program’)
meeting the requirements described in this subsection and to
carry out such program.
“(2) STRUCTURE OF PROGRAM.—An eligible entity shall—
“(A) enroll no fewer than 10 students per class year
into the Program; and
“(B) develop criteria for admission to the Program that
gives priority to students—
“(i) who have originated from or lived for a period
of 2 or more years in an underserved rural community;
and
“(ii) who express a commitment to practice medicine in an underserved rural community.
“(3) CURRICULA.—The Program shall require students to enroll in didactic coursework and clinical experience particularly applicable to medical practice in underserved rural communities, including—
“(A) clinical rotations in underserved rural communities, and in applicable specialties, or other coursework or clinical experience deemed appropriate by the Secretary; and
“(B) in addition to core school curricula, additional coursework or training experiences focused on medical issues prevalent in underserved rural communities.
“(4) RESIDENCY PLACEMENT ASSISTANCE.—Where available, the Program shall assist all students of the Program in obtaining clinical training experiences in locations with postgraduate programs offering residency training opportunities in underserved rural communities, or in local residency training programs that support and train physicians to practice in underserved rural communities.
“(5) PROGRAM STUDENT COHORT SUPPORT.—The Program shall provide and require all students of the Program to participate in group activities designed to further develop, maintain, and reinforce the original commitment of such students to practice in an underserved rural community.
“(e) ANNUAL REPORTING.—An eligible entity receiving a grant under this section shall submit an annual report to the Secretary on the success of the Program, based on criteria the Secretary determines appropriate, including the residency program selection of graduating students who participated in the Program.
“(f) REGULATIONS.—Not later than 60 days after the date of enactment of this section, the Secretary shall by regulation define ‘underserved rural community’ for purposes of this section.
“(g) SUPPLEMENT NOT SUPPLANT.—Any eligible entity receiving funds under this section shall use such funds to supplement, not supplant, any other Federal, State, and local funds that would otherwise be expended by such entity to carry out the activities described in this section.
“(h) MAINTENANCE OF EFFORT.—With respect to activities for which funds awarded under this section are to be expended, the entity shall agree to maintain expenditures of non-Federal amounts for such activities at a level that is not less than the level of such expenditures maintained by the entity for the fiscal year preceding the fiscal year for which the entity receives a grant under this section.
“(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $4,000,000 for each of the fiscal years 2010
Section 768 of the Public Health Service Act (42 U.S.C.295c) is amended, in part, by ACA Section 10501 to read as follows:

SEC. 768. PREVENTIVE MEDICINE AND PUBLIC HEALTH TRAINING GRANT PROGRAM.

“(a) GRANTS.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and in consultation with the Director of the Centers for Disease Control and Prevention, shall award grants to, or enter into contracts with, eligible entities to provide training to graduate medical residents in preventive medicine specialties.

“(b) ELIGIBILITY.—To be eligible for a grant or contract under subsection (a), an entity shall be—

“(1) an accredited school of public health or school of medicine or osteopathic medicine;
“(2) an accredited public or private nonprofit hospital;
“(3) a State, local, or tribal health department; or
“(4) a consortium of 2 or more entities described in paragraphs (1) through (3).

“(c) USE OF FUNDS.—Amounts received under a grant or contract under this section shall be used to—

“(1) plan, develop (including the development of curricula), operate, or participate in an accredited residency or internship program in preventive medicine or public health;
“(2) defray the costs of practicum experiences, as required in such a program; and
“(3) establish, maintain, or improve—

“(A) academic administrative units (including departments, divisions, or other appropriate units) in preventive medicine and public health; or
“(B) programs that improve clinical teaching in preventive medicine and public health.

“(d) REPORT.—The Secretary shall submit to the Congress an annual report on the program carried out under this section.’

Subtitle D of title V of the ACA is amended by adding the following to the end of subtitle D, Title V:

SEC. 5316. DEMONSTRATION GRANTS FOR FAMILY NURSE PRACTITIONER TRAINING PROGRAMS.

“(a) ESTABLISHMENT OF PROGRAM.—The Secretary of Health and Human Services (referred to in this section as the ‘Secretary’) shall establish a training demonstration program for family nurse practitioners (referred to in this section as the ‘program’) to employ and provide 1-year training for nurse practitioners who have graduated from a nurse practitioner program for careers as primary care providers in Federally qualified health centers (referred to...
in this section as ‘FQHCs’) and nurse-managed health clinics (referred to in this section as ‘NMHCs’).

“(b) PURPOSE.—The purpose of the program is to enable each grant recipient to—

“(1) provide new nurse practitioners with clinical training to enable them to serve as primary care providers in FQHCs and NMHCs;

“(2) train new nurse practitioners to work under a model of primary care that is consistent with the principles set forth by the Institute of Medicine and the needs of vulnerable populations; and

“(3) create a model of FQHC and NMHC training for nurse practitioners that may be replicated nationwide.

“(c) GRANTS.—The Secretary shall award 3-year grants to eligible entities that meet the requirements established by the Secretary, for the purpose of operating the nurse practitioner primary care programs described in subsection (a) in such entities.

“(d) ELIGIBLE ENTITIES.—To be eligible to receive a grant under this section, an entity shall—

“(1)(A) be a FQHC as defined in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa)); or

“(B) be a nurse-managed health clinic, as defined in section 330A–1 of the Public Health Service Act (as added by section 5208 of this Act); and

“(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

“(e) PRIORITY IN AWARDING GRANTS.—In awarding grants under this section, the Secretary shall give priority to eligible entities that—

“(1) demonstrate sufficient infrastructure in size, scope, and capacity to undertake the requisite training of a minimum of 3 nurse practitioners per year, and to provide to each awardee 12 full months of full-time, paid employment and benefits consistent with the benefits offered to other full-time employees of such entity;

“(2) will assign not less than 1 staff nurse practitioner or physician to each of 4 precepted clinics;

“(3) will provide to each awardee specialty rotations, including specialty training in prenatal care and women’s health, adult and child psychiatry, orthopedics, geriatrics, and at least 3 other high-volume, high-burden specialty areas;

“(4) provide sessions on high-volume, high-risk health problems and have a record of training health care professionals in the care of children, older adults, and underserved populations; and

“(5) collaborate with other safety net providers, schools,
colleges, and universities that provide health professions training.

“(f) ELIGIBILITY OF NURSE PRACTITIONERS.—

“(1) IN GENERAL.—To be eligible for acceptance to a program funded through a grant awarded under this section, an individual shall—

“(A) be licensed or eligible for licensure in the State in which the program is located as an advanced practice registered nurse or advanced practice nurse and be eligible or board-certified as a family nurse practitioner; and

“(B) demonstrate commitment to a career as a primary care provider in a FQHC or in a NMHC.

“(2) PREFERENCE.—In selecting awardees under the program, each grant recipient shall give preference to bilingual candidates that meet the requirements described in paragraph (1).

“(3) DEFERRAL OF CERTAIN SERVICE.—The starting date of required service of individuals in the National Health Service Corps Service program under title II of the Public Health Service Act (42 U.S.C. 202 et seq.) who receive training under this section shall be deferred until the date that is 22 days after the date of completion of the program.

“(g) GRANT AMOUNT.—Each grant awarded under this section shall be in an amount not to exceed $600,000 per year. A grant recipient may carry over funds from 1 fiscal year to another without obtaining approval from the Secretary.

“(h) TECHNICAL ASSISTANCE GRANTS.—The Secretary may award technical assistance grants to 1 or more FQHCs or NMHCs that have demonstrated expertise in establishing a nurse practitioner residency training program. Such technical assistance grants shall be for the purpose of providing technical assistance to other recipients of grants under subsection (c).

“(i) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 through 2014.’

Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended, in part, by ACA sections 4105 and 10501 by adding the following new subsection at the end of Section 1395m:

“(o) DEVELOPMENT AND IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.—

“(1) DEVELOPMENT.—

“(A) IN GENERAL.—The Secretary shall develop a prospective payment system for payment for Federally qualified health center services furnished by Federally qualified health centers under this title. Such system shall include a process for appropriately describing the services furnished by Federally qualified health centers and shall establish payment rates for specific payment codes based
on such appropriate descriptions of services. Such system shall be established to take into account the type, intensity, and duration of services furnished by Federally qualified health centers. Such system may include adjustments, including geographic adjustments, determined appropriate by the Secretary.

“(B) COLLECTION OF DATA AND EVALUATION.—By not later than January 1, 2011, the Secretary shall require Federally qualified health centers to submit to the Secretary such information as the Secretary may require in order to develop and implement the prospective payment system under this subsection, including the reporting of services using HCPCS codes.

“(2) IMPLEMENTATION.—

“(A) IN GENERAL.—Notwithstanding section 1833(a)(3)(A), the Secretary shall provide, for cost reporting periods beginning on or after October 1, 2014, for payments of prospective payment rates for Federally qualified health center services furnished by Federally qualified health centers under this title in accordance with the prospective payment system developed by the Secretary under paragraph (1).

“(B) PAYMENTS.—

“(i) INITIAL PAYMENTS.—The Secretary shall implement such prospective payment system so that the estimated aggregate amount of prospective payment rates (determined prior to the application of section 1833(a)(1)(Z)) under this title for Federally qualified health center services in the first year that such system is implemented is equal to 100 percent of the estimated amount of reasonable costs (determined without the application of a per visit payment limit or productivity screen and prior to the application of section 1866(a)(2)(A)(ii)) that would have occurred for such services under this title in such year if the system had not been implemented.

“(ii) PAYMENTS IN SUBSEQUENT YEARS.—Payment rates in years after the year of implementation of such system shall be the payment rates in the previous year increased—

“(I) in the first year after implementation of such system, by the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year involved; and

“(II) in subsequent years, by the percentage increase in a market basket of Federally qualified health center goods and services as promulgated
through regulations, or if such an index is not available, by the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year involved.

“(C) PREPARATION FOR PPS IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may establish and implement by program instruction or otherwise the payment codes to be used under the prospective payment system under this section.”

Section 751 of the Public Health Service Act (42 U.S.C. 294a) is amended, in part, by ACA Section 5403 to read as follows:

“SEC. 751. AREA HEALTH EDUCATION CENTERS.
“(a) ESTABLISHMENT OF AWARDS.—The Secretary shall make the following 2 types of awards in accordance with this section:
“(1) INFRASTRUCTURE DEVELOPMENT AWARD.—The Secretary shall make awards to eligible entities to enable such entities to initiate health care workforce educational programs or to continue to carry out comparable programs that are operating at the time the award is made by planning, developing, operating, and evaluating an area health education center program.
“(2) POINT OF SERVICE MAINTENANCE AND ENHANCEMENT AWARD.—The Secretary shall make awards to eligible entities to maintain and improve the effectiveness and capabilities of an existing area health education center program, and make other modifications to the program that are appropriate due to changes in demographics, needs of the populations served, or other similar issues affecting the area health education center program. For the purposes of this section, the term ‘Program’ refers to the area health education center program.

“(b) ELIGIBLE ENTITIES; APPLICATION.—
“(1) ELIGIBLE ENTITIES.—
“(A) INFRASTRUCTURE DEVELOPMENT.—For purposes of subsection (a)(1), the term ‘eligible entity’ means a school of medicine or osteopathic medicine, an incorporated consortium of such schools, or the parent institutions of such a school. With respect to a State in which no area health education center program is in operation, the Secretary may award a grant or contract under subsection (a)(1) to a school of nursing.
“(B) POINT OF SERVICE MAINTENANCE AND ENHANCEMENT.—For purposes of subsection (a)(2), the term ‘eligible entity’ means an entity that has received funds under this section, is operating an area health education center program, including an area health education center or centers, and has a center or centers that are no longer eligible.
to receive financial assistance under subsection (a)(1).

“(2) APPLICATION.—An eligible entity desiring to receive
an award under this section shall submit to the Secretary
an application at such time, in such manner, and containing
such information as the Secretary may require.

“(c) USE OF FUNDS.—

“(1) REQUIRED ACTIVITIES.—An eligible entity shall use
amounts awarded under a grant under subsection (a)(1) or
(a)(2) to carry out the following activities:

“(A) Develop and implement strategies, in coordination
with the applicable one-stop delivery system under section
134(c) of the Workforce Investment Act of 1998, to recruit
individuals from underrepresented minority populations or
from disadvantaged or rural backgrounds into health
professions, and support such individuals in attaining such
careers.

“(B) Develop and implement strategies to foster and
provide community-based training and education to individuals
seeking careers in health professions within underserved
areas for the purpose of developing and maintaining
a diverse health care workforce that is prepared to deliver
high-quality care, with an emphasis on primary care, in
underserved areas or for health disparity populations, in
collaboration with other Federal and State health care
workforce development programs, the State workforce
agency, and local workforce investment boards, and in
health care safety net sites.

“(C) Prepare individuals to more effectively provide
health services to underserved areas and health disparity
populations through field placements or preceptorships in
conjunction with community-based organizations, accredited
primary care residency training programs, Federally
qualified health centers, rural health clinics, public health
departments, or other appropriate facilities.

“(D) Conduct and participate in interdisciplinary
training that involves physicians, physician assistants,
nurse practitioners, nurse midwives, dentists, psychologists,
pharmacists, optometrists, community health
workers, public and allied health professionals, or other
health professionals, as practicable.

“(E) Deliver or facilitate continuing education and
information dissemination programs for health care professionals,
with an emphasis on individuals providing care
in underserved areas and for health disparity populations.

“(F) Propose and implement effective program and outcomes
measurement and evaluation strategies.

recruit high school students into health careers, with
a focus on careers in public health.

“(2) INNOVATIVE OPPORTUNITIES.—An eligible entity may use amounts awarded under a grant under subsection (a)(1) or subsection (a)(2) to carry out any of the following activities:

“(A) Develop and implement innovative curricula in collaboration with community-based accredited primary care residency training programs, Federally qualified health centers, rural health clinics, behavioral and mental health facilities, public health departments, or other appropriate facilities, with the goal of increasing the number of primary care physicians and other primary care providers prepared to serve in underserved areas and health disparity populations.

“(B) Coordinate community-based participatory research with academic health centers, and facilitate rapid flow and dissemination of evidence-based health care information, research results, and best practices to improve quality, efficiency, and effectiveness of health care and health care systems within community settings.

“(C) Develop and implement other strategies to address identified workforce needs and increase and enhance the health care workforce in the area served by the area health education center program.

“(d) REQUIREMENTS.—

“(1) AREA HEALTH EDUCATION CENTER PROGRAM.—In carrying out this section, the Secretary shall ensure the following:

“(A) An entity that receives an award under this section shall conduct at least 10 percent of clinical education required for medical students in community settings that are removed from the primary teaching facility of the contracting institution for grantees that operate a school of medicine or osteopathic medicine. In States in which an entity that receives an award under this section is a nursing school or its parent institution, the Secretary shall alternatively ensure that—

“(i) the nursing school conducts at least 10 percent of clinical education required for nursing students in community settings that are remote from the primary teaching facility of the school; and

“(ii) the entity receiving the award maintains a written agreement with a school of medicine or osteopathic medicine to place students from that school in training sites in the area health education center program area.

“(B) An entity receiving funds under subsection (a)(2) does not distribute such funding to a center that is eligible to receive funding under subsection (a)(1).

“(2) AREA HEALTH EDUCATION CENTER.—The Secretary shall
ensure that each area health education center program includes at least 1 area health education center, and that each such center—

(A) is a public or private organization whose structure, governance, and operation is independent from the awardee and the parent institution of the awardee;

(B) is not a school of medicine or osteopathic medicine, the parent institution of such a school, or a branch campus or other subunit of a school of medicine or osteopathic medicine or its parent institution, or a consortium of such entities;

(C) designates an underserved area or population to be served by the center which is in a location removed from the main location of the teaching facilities of the schools participating in the program with such center and does not duplicate, in whole or in part, the geographic area or population served by any other center;

(D) fosters networking and collaboration among communities and between academic health centers and community-based centers;

(E) serves communities with a demonstrated need of health professionals in partnership with academic medical centers;

(F) addresses the health care workforce needs of the communities served in coordination with the public workforce investment system; and

(G) has a community-based governing or advisory board that reflects the diversity of the communities involved.

(e) MATCHING FUNDS.—With respect to the costs of operating a program through a grant under this section, to be eligible for financial assistance under this section, an entity shall make available (directly or through contributions from State, county or municipal governments, or the private sector) recurring non-Federal contributions in cash or in kind, toward such costs in an amount that is equal to not less than 50 percent of such costs. At least 25 percent of the total required non-Federal contributions shall be in cash. An entity may apply to the Secretary for a waiver of not more than 75 percent of the matching fund amount required by the entity for each of the first 3 years the entity is funded through a grant under subsection (a)(1).

(f) LIMITATION.—Not less than 75 percent of the total amount provided to an area health education center program under subsection (a)(1) or (a)(2) shall be allocated to the area health education centers participating in the program under this section. To provide needed flexibility to newly funded area health education center programs, the Secretary may waive the requirement in the sentence
for the first 2 years of a new area health education center program funded under subsection (a)(1).

“(g) AWARD.—An award to an entity under this section shall be not less than $250,000 annually per area health education center included in the program involved. If amounts appropriated to carry out this section are not sufficient to comply with the preceding sentence, the Secretary may reduce the per center amount provided for in such sentence as necessary, provided the distribution established in subsection (j)(2) is maintained.

“(h) PROJECT TERMS.—

“(1) IN GENERAL.—Except as provided in paragraph (2), the period during which payments may be made under an award under subsection (a)(1) may not exceed—

“(A) in the case of a program, 12 years; or

“(B) in the case of a center within a program, 6 years.

“(2) EXCEPTION.—The periods described in paragraph (1) shall not apply to programs receiving point of service maintenance and enhancement awards under subsection (a)(2) to maintain existing centers and activities.

“(i) INAPPLICABILITY OF PROVISION.—Notwithstanding any other provision of this title, section 791(a) shall not apply to an area health education center funded under this section.

“(j) AUTHORIZATION OF APPROPRIATIONS.—

“(1) IN GENERAL.—There is authorized to be appropriated to carry out this section $125,000,000 for each of the fiscal years 2010 through 2014.

“(2) REQUIREMENTS.—Of the amounts appropriated for a fiscal year under paragraph (1)—

“(A) not more than 35 percent shall be used for awards under subsection (a)(1);

“(B) not less than 60 percent shall be used for awards under subsection (a)(2);

“(C) not more than 1 percent shall be used for grants and contracts to implement outcomes evaluation for the area health education centers; and

“(D) not more than 4 percent shall be used for grants and contracts to provide technical assistance to entities receiving awards under this section.

“(3) CARRYOVER FUNDS.—An entity that receives an award under this section may carry over funds from 1 fiscal year to another without obtaining approval from the Secretary. In no case may any funds be carried over pursuant to the preceding sentence for more than 3 years.

“(k) SENSE OF CONGRESS.—It is the sense of the Congress that every State have an area health education center program in effect under this section.”
Part D of title VII of the Public Health Service Act (42 U.S.C. 294 et seq.) is amended, in part, by ACA Section 5403 to read:

“SEC. 752. CONTINUING EDUCATIONAL SUPPORT FOR HEALTH PROFESSIONALS SERVING IN UNDERSERVED COMMUNITIES.

“(a) IN GENERAL.—The Secretary shall make grants to, and enter into contracts with, eligible entities to improve health care, increase retention, increase representation of minority faculty members, enhance the practice environment, and provide information dissemination and educational support to reduce professional isolation through the timely dissemination of research findings using relevant resources.

“(b) ELIGIBLE ENTITIES.—For purposes of this section, the term ‘eligible entity’ means an entity described in section 799(b).

“(c) APPLICATION.—An eligible entity desiring to receive an award under this section shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

“(d) USE OF FUNDS.—An eligible entity shall use amounts awarded under a grant or contract under this section to provide innovative supportive activities to enhance education through distance learning, continuing educational activities, collaborative conferences, and electronic and telelearning activities, with priority for primary care.

“(e) AUTHORIZATION.—There is authorized to be appropriated to carry out this section $5,000,000 for each of the fiscal years 2010 through 2014, and such sums as may be necessary for each subsequent fiscal year.”

Part C of title VII (42 U.S.C. 293k et seq.) is amended, in part, by ACA Section 5301 to read as follows:

“SEC. 747. PRIMARY CARE TRAINING AND ENHANCEMENT.

“(a) SUPPORT AND DEVELOPMENT OF PRIMARY CARE TRAINING PROGRAMS.—

“(1) IN GENERAL.—The Secretary may make grants to, or enter into contracts with, an accredited public or nonprofit private hospital, school of medicine or osteopathic medicine, academically affiliated physician assistant training program, or a public or private nonprofit entity which the Secretary has determined is capable of carrying out such grant or contract—

“(A) to plan, develop, operate, or participate in an accredited professional training program, including an accredited residency or internship program in the field of family medicine, general internal medicine, or general pediatrics for medical students, interns, residents, or practicing physicians as defined by the Secretary;

“(B) to provide need-based financial assistance in the
form of traineeships and fellowships to medical students, interns, residents, practicing physicians, or other medical personnel, who are participants in any such program, and who plan to specialize or work in the practice of the fields defined in subparagraph (A);
“(C) to plan, develop, and operate a program for the training of physicians who plan to teach in family medicine, general internal medicine, or general pediatrics training programs;
“(D) to plan, develop, and operate a program for the training of physicians teaching in community-based settings;
“(E) to provide financial assistance in the form of traineeships and fellowships to physicians who are participants in any such programs and who plan to teach or conduct research in a family medicine, general internal medicine, or general pediatrics training program;
“(F) to plan, develop, and operate a physician assistant education program, and for the training of individuals who will teach in programs to provide such training;
“(G) to plan, develop, and operate a demonstration program that provides training in new competencies, as recommended by the Advisory Committee on Training in Primary Care Medicine and Dentistry and the National Health Care Workforce Commission established in section 5101 of the Patient Protection and Affordable Care Act, which may include—
“(i) providing training to primary care physicians relevant to providing care through patient-centered medical homes (as defined by the Secretary for purposes of this section);
“(ii) developing tools and curricula relevant to patient-centered medical homes; and
“(iii) providing continuing education to primary care physicians relevant to patient-centered medical homes; and
“(H) to plan, develop, and operate joint degree programs to provide interdisciplinary and interprofessional graduate training in public health and other health professions to provide training in environmental health, infectious disease control, disease prevention and health promotion, epidemiological studies and injury control.
“(2) DURATION OF AWARDS.—The period during which payments are made to an entity from an award of a grant or contract under this subsection shall be 5 years.
“(b) CAPACITY BUILDING IN PRIMARY CARE.—
“(1) IN GENERAL.—The Secretary may make grants to or enter into contracts with accredited schools of medicine or
osteopathic medicine to establish, maintain, or improve—
“(A) academic units or programs that improve clinical
teaching and research in fields defined in subsection
(a)(1)(A); or
“(B) programs that integrate academic administrative
units in fields defined in subsection (a)(1)(A) to enhance
interdisciplinary recruitment, training, and faculty development.
“(2) PREFERENCE IN MAKING AWARDS UNDER THIS SUBSECTION.—In making awards of grants and contracts under
paragraph (1), the Secretary shall give preference to any qualified
applicant for such an award that agrees to expend the
award for the purpose of—
“(A) establishing academic units or programs in fields
defined in subsection (a)(1)(A); or
“(B) substantially expanding such units or programs.
“(3) PRIORITIES IN MAKING AWARDS.—In awarding grants
or contracts under paragraph (1), the Secretary shall give priority
to qualified applicants that—
“(A) proposes a collaborative project between academic
administrative units of primary care;
“(B) proposes innovative approaches to clinical teaching
using models of primary care, such as the patient centered
medical home, team management of chronic disease, and
interprofessional integrated models of health care that
incorporate transitions in health care settings and integration
physical and mental health provision;
“(C) have a record of training the greatest percentage
of providers, or that have demonstrated significant
improvements in the percentage of providers trained, who
enter and remain in primary care practice;
“(D) have a record of training individuals who are
from underrepresented minority groups or from a rural
or disadvantaged background;
“(E) provide training in the care of vulnerable populations
such as children, older adults, homeless individuals,
victims of abuse or trauma, individuals with mental health
or substance-related disorders, individuals with HIV/AIDS,
and individuals with disabilities;
“(F) establish formal relationships and submit joint
applications with federally qualified health centers, rural
health clinics, area health education centers, or clinics
located in underserved areas or that serve underserved
populations;
“(G) teach trainees the skills to provide interprofessional,
integrated care through collaboration among health
professionals;
“(H) provide training in enhanced communication with
patients, evidence-based practice, chronic disease management, preventive care, health information technology, or other competencies as recommended by the Advisory Committee on Training in Primary Care Medicine and Dentistry and the National Health Care Workforce Commission established in section 5101 of the Patient Protection and Affordable Care Act; or "(I) provide training in cultural competency and health literacy.

"(4) DURATION OF AWARDS.—The period during which payments are made to an entity from an award of a grant or contract under this subsection shall be 5 years.

"(c) AUTHORIZATION OF APPROPRIATIONS.—

"(1) IN GENERAL.—For purposes of carrying out this section (other than subsection (b)(1)(B)), there are authorized to be appropriated $125,000,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2014.

"(2) TRAINING PROGRAMS.—Fifteen percent of the amount appropriated pursuant to paragraph (1) in each such fiscal year shall be allocated to the physician assistant training programs described in subsection (a)(1)(F), which prepare students for practice in primary care.

"(3) INTEGRATING ACADEMIC ADMINISTRATIVE UNITS.—For purposes of carrying out subsection (b)(1)(B), there are authorized to be appropriated $750,000 for each of fiscal years 2010 through 2014.’

Section 330(r) of the Public Health Service Act (42 U.S.C. 254b(r)) is amended, in part, by ACA Section 5601 to read as follows:

"(1) GENERAL AMOUNTS FOR GRANTS.—For the purpose of carrying out this section, in addition to the amounts authorized to be appropriated under subsection (d), there is authorized to be appropriated the following:

"(A) For fiscal year 2010, $2,988,821,592.

"(B) For fiscal year 2011, $3,862,107,440.

"(C) For fiscal year 2012, $4,990,553,440.

"(D) For fiscal year 2013, $6,448,713,307.

"(E) For fiscal year 2014, $7,332,924,155.

"(F) For fiscal year 2015, $8,332,924,155.

"(G) For fiscal year 2016, and each subsequent fiscal year, the amount appropriated for the preceding fiscal year adjusted by the product of—

"(i) one plus the average percentage increase in costs incurred per patient served; and

"(ii) one plus the average percentage increase in the total number of patients served.’"
Section 330(r) of the Public Health Service Act (42 U.S.C. 254b(r)) is amended, in part, by ACA Section 5601 to read as follows:

“(4) RULE OF CONSTRUCTION WITH RESPECT TO RURAL HEALTH CLINICS.—

“(A) IN GENERAL.—Nothing in this section shall be construed to prevent a community health center from contracting with a Federally certified rural health clinic (as defined in section 1861(aa)(2) of the Social Security Act), a low-volume hospital (as defined for purposes of section 1886 of such Act), a critical access hospital, a sole community hospital (as defined for purposes of section 1886(d)(5)(D)(iii) of such Act), or a medicare-dependent share hospital (as defined for purposes of section 1886(d)(5)(G)(iv) of such Act) for the delivery of primary health care services that are available at the clinic or hospital to individuals who would otherwise be eligible for free or reduced cost care if that individual were able to obtain that care at the community health center. Such services may be limited in scope to those primary health care services available in that clinic or hospitals.

“(B) ASSURANCES.—In order for a clinic or hospital to receive funds under this section through a contract with a community health center under subparagraph (A), such clinic or hospital shall establish policies to ensure—

“(i) nondiscrimination based on the ability of a patient to pay; and

“(ii) the establishment of a sliding fee scale for low-income patients.”

Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by ACA Section 1033, which adds at the end of Part D the following new subpart:

“Subpart XI—Community-Based Collaborative Care Network Program

“SEC. 340H. COMMUNITY-BASED COLLABORATIVE CARE NETWORK PROGRAM.

“(a) IN GENERAL.—The Secretary may award grants to eligible entities to support community-based collaborative care networks that meet the requirements of subsection (b).

“(b) COMMUNITY-BASED COLLABORATIVE CARE NETWORKS.—

“(1) DESCRIPTION.—A community-based collaborative care network (referred to in this section as a ‘network’) shall be a consortium of health care providers with a joint governance structure (including providers within a single entity) that provides comprehensive coordinated and integrated health care services (as defined by the Secretary) for low-income populations.

“(2) REQUIRED INCLUSION.—A network shall include the following providers (unless such provider does not exist within...
the community, declines or refuses to participate, or places unreasonable conditions on their participation):

“(A) A hospital that meets the criteria in section 1923(b)(1) of the Social Security Act; and
“(B) All Federally qualified health centers (as defined in section 1861(aa) of the Social Security Act located in the community.

“(3) PRIORITY.—In awarding grants, the Secretary shall give priority to networks that include—
“(A) the capability to provide the broadest range of services to low-income individuals;
“(B) the broadest range of providers that currently serve a high volume of low-income individuals; and
“(C) a county or municipal department of health.

“(c) APPLICATION.—
“(1) APPLICATION.—A network described in subsection (b) shall submit an application to the Secretary.
“(2) RENEWAL.—In subsequent years, based on the performance of grantees, the Secretary may provide renewal grants to prior year grant recipients.

“(d) USE OF FUNDS.—
“(1) USE BY GRANTEES.—Grant funds may be used for the following activities:
“(A) Assist low-income individuals to—
“(i) access and appropriately use health services;
“(ii) enroll in health coverage programs; and
“(iii) obtain a regular primary care provider or a medical home.
“(B) Provide case management and care management.

Part C of Title VII of the Public Health Service Act (42 U.S.C. 293k et seq.) is amended, in part, by ACA Section 5303 to read as follows:

“SEC. 748. TRAINING IN GENERAL, PEDIATRIC, AND PUBLIC HEALTH DENTISTRY.
“(a) SUPPORT AND DEVELOPMENT OF DENTAL TRAINING PROGRAMS.—
“(1) IN GENERAL.—The Secretary may make grants to, or enter into contracts with, a school of dentistry, public or nonprofit private hospital, or a public or private nonprofit entity which the Secretary has determined is capable of carrying out such grant or contract—
“(A) to plan, develop, and operate, or participate in, an approved professional training program in the field of general dentistry, pediatric dentistry, or public health dentistry for dental students, residents, practicing dentists, dental hygienists, or other approved primary care dental trainees, that emphasizes training for general, pediatric,
or public health dentistry;
“(B) to provide financial assistance to dental students, residents, practicing dentists, and dental hygiene students who are in need thereof, who are participants in any such program, and who plan to work in the practice of general, pediatric, public health dentistry, or dental hygiene;
“(C) to plan, develop, and operate a program for the training of oral health care providers who plan to teach in general, pediatric, public health dentistry, or dental hygiene;
“(D) to provide financial assistance in the form of traineeships and fellowships to dentists who plan to teach or are teaching in general, pediatric, or public health dentistry;
“(E) to meet the costs of projects to establish, maintain, or improve dental faculty development programs in primary care (which may be departments, divisions or other units);
“(F) to meet the costs of projects to establish, maintain, or improve predoctoral and postdoctoral training in primary care programs;
“(G) to create a loan repayment program for faculty in dental programs; and
“(H) to provide technical assistance to pediatric training programs in developing and implementing instruction regarding the oral health status, dental care needs, and risk-based clinical disease management of all pediatric populations with an emphasis on underserved children.
“(2) FACULTY LOAN REPAYMENT.—
“(A) IN GENERAL.—A grant or contract under subsection (a)(1)(G) may be awarded to a program of general, pediatric, or public health dentistry described in such subsection to plan, develop, and operate a loan repayment program under which—
“(i) individuals agree to serve full-time as faculty members; and
“(ii) the program of general, pediatric or public health dentistry agrees to pay the principal and interest on the outstanding student loans of the individuals.
“(B) MANNER OF PAYMENTS.—With respect to the payments described in subparagraph (A)(ii), upon completion by an individual of each of the first, second, third, fourth, and fifth years of service, the program shall pay an amount equal to 10, 15, 20, 25, and 30 percent, respectively, of the individual’s student loan balance as calculated based on principal and interest owed at the initiation of the agreement.
“(b) ELIGIBLE ENTITY.—For purposes of this subsection, entities eligible for such grants or contracts in general, pediatric, or public
health dentistry shall include entities that have programs in dental or dental hygiene schools, or approved residency or advanced education programs in the practice of general, pediatric, or public health dentistry. Eligible entities may partner with schools of public health to permit the education of dental students, residents, and dental hygiene students for a master’s year in public health at a school of public health.

“(c) PRIORITIES IN MAKING AWARDS.—With respect to training provided for under this section, the Secretary shall give priority in awarding grants or contracts to the following:

“(1) Qualified applicants that propose collaborative projects between departments of primary care medicine and departments of general, pediatric, or public health dentistry.

“(2) Qualified applicants that have a record of training the greatest percentage of providers, or that have demonstrated significant improvements in the percentage of providers, who enter and remain in general, pediatric, or public health dentistry.

“(3) Qualified applicants that have a record of training individuals who are from a rural or disadvantaged background, or from underrepresented minorities.

“(4) Qualified applicants that establish formal relationships with Federally qualified health centers, rural health centers, or accredited teaching facilities and that conduct training of students, residents, fellows, or faculty at the center or facility.

“(5) Qualified applicants that conduct teaching programs targeting vulnerable populations such as older adults, homeless individuals, victims of abuse or trauma, individuals with mental health or substance-related disorders, individuals with disabilities, and individuals with HIV/AIDS, and in the risk-based clinical disease management of all populations.

“(6) Qualified applicants that include educational activities in cultural competency and health literacy.

“(7) Qualified applicants that have a high rate for placing graduates in practice settings that serve underserved areas or health disparity populations, or who achieve a significant increase in the rate of placing graduates in such settings.

“(8) Qualified applicants that intend to establish a special populations oral health care education center or training program for the didactic and clinical education of dentists, dental health professionals, and dental hygienists who plan to teach oral health care for people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and vulnerable elderly.

“(d) APPLICATION.—An eligible entity desiring a grant under this section shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.
“(e) DURATION OF AWARD.—The period during which payments are made to an entity from an award of a grant or contract under subsection (a) shall be 5 years. The provision of such payments shall be subject to annual approval by the Secretary and subject to the availability of appropriations for the fiscal year involved to make the payments.

“(f) AUTHORIZATIONS OF APPROPRIATIONS.—For the purpose of carrying out subsections (a) and (b), there is authorized to be appropriated $30,000,000 for fiscal year 2010 and such sums as may be necessary for each of fiscal years 2011 through 2015.

“(g) CARRYOVER FUNDS.—An entity that receives an award under this section may carry over funds from 1 fiscal year to another without obtaining approval from the Secretary. In no case may any funds be carried over pursuant to the preceding sentence for more than 3 years.’

Subpart X, Part D, Title III of the Public Health Service Act (42 U.S.C. 256f et seq.) is amended, in part, by ACA Section 5304 to read as follows:

“SEC. 340G–1. DEMONSTRATION PROGRAM.

“(a) IN GENERAL.—

“(1) AUTHORIZATION.—The Secretary is authorized to award grants to 15 eligible entities to enable such entities to establish a demonstration program to establish training programs to train, or to employ, alternative dental health care providers in order to increase access to dental health care services in rural and other underserved communities.

“(2) DEFINITION.—The term ‘alternative dental health care providers’ includes community dental health coordinators, advance practice dental hygienists, independent dental hygienists, supervised dental hygienists, primary care physicians, dental therapists, dental health aides, and any other health professional that the Secretary determines appropriate.

“(b) TIMEFRAME.—The demonstration projects funded under this section shall begin not later than 2 years after the date of enactment of this section, and shall conclude not later than 7 years after such date of enactment.

“(c) ELIGIBLE ENTITIES.—To be eligible to receive a grant under subsection (a), an entity shall—

“(1) be—

“(A) an institution of higher education, including a community college;

“(B) a public-private partnership;

“(C) a federally qualified health center;

“(D) an Indian Health Service facility or a tribe or tribal organization (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act);
“(E) a State or county public health clinic, a health facility operated by an Indian tribe or tribal organization, or urban Indian organization providing dental services; or
“(F) a public hospital or health system;
“(2) be within a program accredited by the Commission on Dental Accreditation or within a dental education program in an accredited institution; and
“(3) shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.
“(d) ADMINISTRATIVE PROVISIONS.—
“(1) AMOUNT OF GRANT.—Each grant under this section shall be in an amount that is not less than $4,000,000 for the 5-year period during which the demonstration project being conducted.
“(2) DISBURSEMENT OF FUNDS.—
“(A) PRELIMINARY DISBURSEMENTS.—Beginning 1 year after the enactment of this section, the Secretary may disperse to any entity receiving a grant under this section not more than 20 percent of the total funding awarded to such entity under such grant, for the purpose of enabling the entity to plan the demonstration project to be conducted under such grant.
“(B) SUBSEQUENT DISBURSEMENTS.—The remaining amount of grant funds not dispersed under subparagraph (A) shall be dispersed such that not less than 15 percent of such remaining amount is dispersed each subsequent year.
“(e) COMPLIANCE WITH STATE REQUIREMENTS.—Each entity receiving a grant under this section shall certify that it is in compliance with all applicable State licensing requirements.
“(f) EVALUATION.—The Secretary shall contract with the Director of the Institute of Medicine to conduct a study of the demonstration programs conducted under this section that shall provide analysis, based upon quantitative and qualitative data, regarding access to dental health care in the United States.
“(g) CLARIFICATION REGARDING DENTAL HEALTH AIDE PROGRAM.—Nothing in this section shall prohibit a dental health aide training program approved by the Indian Health Service from being eligible for a grant under this section.
“(h) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to carry out this section.”

ACA Section 5509 establishes a graduate nurse education demonstration program under Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as follows:
(a) IN GENERAL.—
(1) ESTABLISHMENT.—
(A) IN GENERAL.—The Secretary shall establish a graduate nurse education demonstration under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) under which an eligible hospital may receive payment for the hospital’s reasonable costs (described in paragraph (2)) for the provision of qualified clinical training to advance practice nurses.
(B) NUMBER.—The demonstration shall include up to 5 eligible hospitals.
(C) WRITTEN AGREEMENTS.—Eligible hospitals selected to participate in the demonstration shall enter into written agreements pursuant to subsection (b) in order to reimburse the eligible partners of the hospital the share of the costs attributable to each partner.

(2) COSTS DESCRIBED.—
(A) IN GENERAL.—Subject to subparagraph (B) and subsection (d), the costs described in this paragraph are the reasonable costs (as described in section 1861(v) of the Social Security Act (42 U.S.C. 1395x(v))) of each eligible hospital for the clinical training costs (as determined by the Secretary) that are attributable to providing advanced practice registered nurses with qualified training.
(B) LIMITATION.—With respect to a year, the amount reimbursed under subparagraph (A) may not exceed the amount of costs described in subparagraph (A) that are attributable to an increase in the number of advanced practice registered nurses enrolled in a program that provides qualified training during the year and for which the hospital is being reimbursed under the demonstration, as compared to the average number of advanced practice registered nurses who graduated in each year during the period beginning on January 1, 2006, and ending on December 31, 2010 (as determined by the Secretary) from the graduate nursing education program operated by the applicable school of nursing that is an eligible partner of the hospital for purposes of the demonstration.

(3) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be necessary to carry out the demonstration.

(4) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the implementation of this section.

(b) WRITTEN AGREEMENTS WITH ELIGIBLE PARTNERS.—No payment shall be made under this section to an eligible hospital unless such hospital has in effect a written agreement with the eligible partners of the hospital. Such written agreement shall describe,
at a minimum—
(1) the obligations of the eligible partners with respect
to the provision of qualified training; and
(2) the obligation of the eligible hospital to reimburse such
eligible partners applicable (in a timely manner) for the costs
of such qualified training attributable to partner.
(c) EVALUATION.—Not later than October 17, 2017, the Secretary
shall submit to Congress a report on the demonstration.
Such report shall include an analysis of the following:
(1) The growth in the number of advanced practice registered
nurses with respect to a specific base year as a result
of the demonstration.
(2) The growth for each of the specialties described in
subparagraphs (A) through (D) of subsection (e)(1).
(3) The costs to the Medicare program under title XVIII
of the Social Security Act as a result of the demonstration.
(4) Other items the Secretary determines appropriate and
relevant.
(d) FUNDING.—
(1) IN GENERAL.—There is hereby appropriated to the Secretary,
out of any funds in the Treasury not otherwise appropriated,
$50,000,000 for each of fiscal years 2012 through 2015
to carry out this section, including the design, implementation,
monitoring, and evaluation of the demonstration.
(2) PRORATION.—If the aggregate payments to eligible hospitals
under the demonstration exceed $50,000,000 for a fiscal
year described in paragraph (1), the Secretary shall prorate
the payment amounts to each eligible hospital in order to
ensure that the aggregate payments do not exceed such amount.
(3) WITHOUT FISCAL YEAR LIMITATION.—Amounts appropriated
under this subsection shall remain available without
fiscal year limitation.
(e) DEFINITIONS.—In this section:
(1) ADVANCED PRACTICE REGISTERED NURSE.—The term
“advanced practice registered nurse” includes the following:
(A) A clinical nurse specialist (as defined in subsection
(aa)(5) of section 1861 of the Social Security Act (42 U.S.C.
1395x)).
(B) A nurse practitioner (as defined in such subsection).
(C) A certified registered nurse anesthetist (as defined
in subsection (bb)(2) of such section).
(D) A certified nurse-midwife (as defined in subsection
(gg)(2) of such section).
(2) APPLICABLE NON-HOSPITAL COMMUNITY-BASED CARE SETTING.—
The term “applicable non-hospital community-based care
setting” means a non-hospital community-based care setting
which has entered into a written agreement (as described in
subsection (b)) with the eligible hospital participating in the
demonstration. Such settings include Federally qualified health centers, rural health clinics, and other non-hospital settings as determined appropriate by the Secretary.

(3) APPLICABLE SCHOOL OF NURSING.—The term “applicable school of nursing” means an accredited school of nursing (as defined in section 801 of the Public Health Service Act) which has entered into a written agreement (as described in subsection (b)) with the eligible hospital participating in the demonstration.

(4) DEMONSTRATION.—The term “demonstration” means the graduate nurse education demonstration established under subsection (a).

(5) ELIGIBLE HOSPITAL.—The term “eligible hospital” means a hospital (as defined in subsection (e) of section 1861 of the Social Security Act (42 U.S.C. 1395x)) or a critical access hospital (as defined in subsection (mm)(1) of such section) that has a written agreement in place with—

(A) 1 or more applicable schools of nursing; and

(B) 2 or more applicable non-hospital community-based care settings.

(6) ELIGIBLE PARTNERS.—The term “eligible partners” includes the following:

(A) An applicable non-hospital community-based care setting.

(B) An applicable school of nursing.

(7) QUALIFIED TRAINING.—

(A) IN GENERAL.—The term “qualified training” means training—

(i) that provides an advanced practice registered nurse with the clinical skills necessary to provide primary care, preventive care, transitional care, chronic care management, and other services appropriate for individuals entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act, or enrolled under part B of such title; and

(ii) subject to subparagraph (B), at least half of which is provided in a non-hospital community-based care setting.

(B) WAIVER OF REQUIREMENT HALF OF TRAINING BE PROVIDED IN NON-HOSPITAL COMMUNITY-BASED CARE SETTING IN CERTAIN AREAS.—The Secretary may waive the requirement under subparagraph (A)(ii) with respect to eligible hospitals located in rural or medically underserved areas.

(8) SECRETARY.—The term “Secretary” means the Secretary of Health and Human Services.

Part C of title VII of the Public Health Service Act (42 U.S.C. 293k et. seq.), is amended, in part, by ACA sections 5303 and 5508 to read as follows:
“SEC. 749A. TEACHING HEALTH CENTERS DEVELOPMENT GRANTS.
“(a) PROGRAM AUTHORIZED.—The Secretary may award grants under this section to teaching health centers for the purpose of establishing new accredited or expanded primary care residency programs.

“(b) AMOUNT AND DURATION.—Grants awarded under this section shall be for a term of not more than 3 years and the maximum award may not be more than $500,000.

“(c) USE OF FUNDS.—Amounts provided under a grant under this section shall be used to cover the costs of—

“(1) establishing or expanding a primary care residency training program described in subsection (a), including costs associated with—

“(A) curriculum development;
“(B) recruitment, training and retention of residents and faculty:
“(C) accreditation by the Accreditation Council for Graduate Medical Education (ACGME), the American Dental Association (ADA), or the American Osteopathic Association (AOA); and
“(D) faculty salaries during the development phase; and
“(2) technical assistance provided by an eligible entity.

“(d) APPLICATION.—A teaching health center seeking a grant under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

“(e) PREFERENCE FOR CERTAIN APPLICATIONS.—In selecting recipients for grants under this section, the Secretary shall give preference to any such application that documents an existing affiliation agreement with an area health education center program as defined in sections 751 and 799B.

“(f) DEFINITIONS.—In this section:

“(1) ELIGIBLE ENTITY.—The term ‘eligible entity’ means an organization capable of providing technical assistance including an area health education center program as defined in sections 751 and 799B.

“(2) PRIMARY CARE RESIDENCY PROGRAM.—The term ‘primary care residency program’ means an approved graduate medical residency training program (as defined in section 340H) in family medicine, internal medicine, pediatrics, internal medicine-pediatrics, obstetrics and gynecology, psychiatry, general dentistry, pediatric dentistry, and geriatrics.

“(3) TEACHING HEALTH CENTER.—
“(A) IN GENERAL.—The term ‘teaching health center’ means an entity that—
“(i) is a community based, ambulatory patient care
center; and
“(ii) operates a primary care residency program.
“(B) INCLUSION OF CERTAIN ENTITIES.—Such term includes the following:
“(i) A Federally qualified health center (as defined in section 1905(l)(2)(B), of the Social Security Act).
“(ii) A community mental health center (as defined in section 1861(ff)(3)(B) of the Social Security Act).
“(iii) A rural health clinic, as defined in section 1861(aa) of the Social Security Act.
“(iv) A health center operated by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act).
“(v) An entity receiving funds under title X of the Public Health Service Act.
“(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated, $25,000,000 for fiscal year 2010, $50,000,000 for fiscal year 2011, $50,000,000 for fiscal year 2012, and such sums as may be necessary for each fiscal year thereafter to carry out this section. Not to exceed $5,000,000 annually may be used for technical assistance program grants.”

Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended, in part, by ACA Section 5508 to read as follows:
“Subpart XI—Support of Graduate Medical Education in Qualified Teaching Health Centers
“SEC. 340H. PROGRAM OF PAYMENTS TO TEACHING HEALTH CENTERS THAT OPERATE GRADUATE MEDICAL EDUCATION PROGRAMS.
“(a) PAYMENTS.—Subject to subsection (h)(2), the Secretary shall make payments under this section for direct expenses and for indirect expenses to qualified teaching health centers that are listed as sponsoring institutions by the relevant accrediting body for expansion of existing or establishment of new approved graduate medical residency training programs.
“(b) AMOUNT OF PAYMENTS.—
“(1) IN GENERAL.—Subject to paragraph (2), the amounts payable under this section to qualified teaching health centers for an approved graduate medical residency training program for a fiscal year are each of the following amounts:
“(A) DIRECT EXPENSE AMOUNT.—The amount determined under subsection (c) for direct expenses associated with sponsoring approved graduate medical residency training programs.
“(B) INDIRECT EXPENSE AMOUNT.—The amount determined under subsection (d) for indirect expenses associated with the additional costs relating to teaching residents
in such programs.

“(2) CAPPED AMOUNT.—

“(A) IN GENERAL.—The total of the payments made
to qualified teaching health centers under paragraph (1)(A)
or paragraph (1)(B) in a fiscal year shall not exceed the
amount of funds appropriated under subsection (g) for such
payments for that fiscal year.

“(B) LIMITATION.—The Secretary shall limit the
funding of full-time equivalent residents in order to ensure
the direct and indirect payments as determined under subsection
(c) and (d) do not exceed the total amount of funds
appropriated in a fiscal year under subsection (g).

“(c) AMOUNT OF PAYMENT FOR DIRECT GRADUATE MEDICAL EDUCATION.—

“(1) IN GENERAL.—The amount determined under this subsection
for payments to qualified teaching health centers for
direct graduate expenses relating to approved graduate medical
residency training programs for a fiscal year is equal to the
product of—

“(A) the updated national per resident amount for
direct graduate medical education, as determined under
paragraph (2); and

“(B) the average number of full-time equivalent residents
in the teaching health center’s graduate approved
medical residency training programs as determined under
section 1886(h)(4) of the Social Security Act (without regard
to the limitation under subparagraph (F) of such section)
during the fiscal year.

“(2) UPDATED NATIONAL PER RESIDENT AMOUNT FOR DIRECT
GRADUATE MEDICAL EDUCATION.—The updated per resident
amount for direct graduate medical education for a qualified
teaching health center for a fiscal year is an amount determined
as follows:

“(A) DETERMINATION OF QUALIFIED TEACHING HEALTH
CENTER PER RESIDENT AMOUNT.—The Secretary shall compute
for each individual qualified teaching health center
a per resident amount—

“(i) by dividing the national average per resident
amount computed under section 340E(c)(2)(D) into a
wage-related portion and a non-wage related portion
by applying the proportion determined under subparagraph
(B);

“(ii) by multiplying the wage-related portion by
the factor applied under section 1886(d)(3)(E) of the
Social Security Act (but without application of section
4410 of the Balanced Budget Act of 1997 (42 U.S.C.
1395ww note)) during the preceding fiscal year for
the teaching health center’s area; and
“(iii) by adding the non-wage-related portion to
the amount computed under clause (ii).

“(B) UPDATING RATE.—The Secretary shall update such
per resident amount for each such qualified teaching health
center as determined appropriate by the Secretary.

“(d) AMOUNT OF PAYMENT FOR INDIRECT MEDICAL EDUCATION.—
“(1) IN GENERAL.—The amount determined under this subsection
for payments to qualified teaching health centers for
indirect expenses associated with the additional costs of
teaching residents for a fiscal year is equal to an amount
determined appropriate by the Secretary.

“(2) FACTORS.—In determining the amount under paragraph
(1), the Secretary shall—
“(A) evaluate indirect training costs relative to supporting
a primary care residency program in qualified
teaching health centers; and
“(B) based on this evaluation, assure that the aggregate
of the payments for indirect expenses under this section

and the payments for direct graduate medical education
as determined under subsection (c) in a fiscal year do
not exceed the amount appropriated for such expenses as
determined in subsection (g).

“(3) INTERIM PAYMENT.—Before the Secretary makes a payment
under this subsection pursuant to a determination of
indirect expenses under paragraph (1), the Secretary may provide
to qualified teaching health centers a payment, in addition
to any payment made under subsection (c), for expected indirect
expenses associated with the additional costs of teaching residents
for a fiscal year, based on an estimate by the Secretary.

“(e) CLARIFICATION REGARDING RELATIONSHIP TO OTHER PAYMENTS
FOR GRADUATE MEDICAL EDUCATION.—Payments under this
section—
“(1) shall be in addition to any payments—
“(A) for the indirect costs of medical education under
section 1886(d)(5)(B) of the Social Security Act;
“(B) for direct graduate medical education costs under
section 1886(h) of such Act; and
“(C) for direct costs of medical education under section
1886(k) of such Act;
“(2) shall not be taken into account in applying the limitation
on the number of total full-time equivalent residents under
subparagraphs (F) and (G) of section 1886(h)(4) of such Act
and clauses (v), (vi)(I), and (vi)(II) of section 1886(d)(5)(B) of
such Act for the portion of time that a resident rotates to
a hospital; and
“(3) shall not include the time in which a resident is
counted toward full-time equivalency by a hospital under paragraph
or under section 1886(d)(5)(B)(iv) of the Social Security Act, section 1886(h)(4)(E) of such Act, or section 340E of this Act.

“(f) RECONCILIATION.—The Secretary shall determine any changes to the number of residents reported by a hospital in the application of the hospital for the current fiscal year to determine the final amount payable to the hospital for the current fiscal year for both direct expense and indirect expense amounts. Based on such determination, the Secretary shall recoup any overpayments made to pay any balance due to the extent possible. The final amount so determined shall be considered a final intermediary determination for the purposes of section 1878 of the Social Security Act and shall be subject to administrative and judicial review under that section in the same manner as the amount of payment under section 1186(d) of such Act is subject to review under such section.

“(g) FUNDING.—To carry out this section, there are appropriated such sums as may be necessary, not to exceed $230,000,000, for the period of fiscal years 2011 through 2015.

“(h) ANNUAL REPORTING REQUIRED.—

“(1) ANNUAL REPORT.—The report required under this paragraph for a qualified teaching health center for a fiscal year is a report that includes (in a form and manner specified by the Secretary) the following information for the residency academic year completed immediately prior to such fiscal year:

“(A) The types of primary care resident approved training programs that the qualified teaching health center provided for residents.

“(B) The number of approved training positions for residents described in paragraph (4).

“(C) The number of residents described in paragraph (4) who completed their residency training at the end of such residency academic year and care for vulnerable populations living in underserved areas.

“(D) Other information as deemed appropriate by the Secretary.

“(2) AUDIT AUTHORITY; LIMITATION ON PAYMENT.—

“(A) AUDIT AUTHORITY.—The Secretary may audit a qualified teaching health center to ensure the accuracy and completeness of the information submitted in a report under paragraph (1).

“(B) LIMITATION ON PAYMENT.—A teaching health center may only receive payment in a cost reporting period for a number of such resident positions that is greater than the base level of primary care resident positions, as determined by the Secretary. For purposes of this subparagraph, the ‘base level of primary care residents’ for a teaching health center is the level of such residents
as of a base period.

“(3) REDUCTION IN PAYMENT FOR FAILURE TO REPORT.—

“(A) IN GENERAL.—The amount payable under this section to a qualified teaching health center for a fiscal year shall be reduced by at least 25 percent if the Secretary determines that—

“(i) the qualified teaching health center has failed to provide the Secretary, as an addendum to the qualified teaching health center’s application under this section for such fiscal year, the report required under paragraph (1) for the previous fiscal year; or

“(ii) such report fails to provide complete and accurate information required under any subparagraph of such paragraph.

“(B) NOTICE AND OPPORTUNITY TO PROVIDE ACCURATE AND MISSING INFORMATION.—Before imposing a reduction under subparagraph (A) on the basis of a qualified teaching health center’s failure to provide complete and accurate information described in subparagraph (A)(ii), the Secretary shall provide notice to the teaching health center of such failure and the Secretary’s intention to impose such reduction and shall provide the teaching health center with the opportunity to provide the required information within the period of 30 days beginning on the date of such notice. If the teaching health center provides such information within such period, no reduction shall be made under subparagraph (A) on the basis of the previous failure to provide such information.

“(4) RESIDENTS.—The residents described in this paragraph are those who are in part-time or full-time equivalent resident training positions at a qualified teaching health center in any approved graduate medical residency training program.

“(i) REGULATIONS.—The Secretary shall promulgate regulations to carry out this section.

“(j) DEFINITIONS.—In this section:

“(1) APPROVED GRADUATE MEDICAL RESIDENCY TRAINING PROGRAM.—The term ‘approved graduate medical residency medical training program—

“(A) participation in which may be counted toward certification in a specialty or subspecialty and includes formal postgraduate training programs in geriatric medicine approved by the Secretary; and

“(B) that meets criteria for accreditation (as established by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, or the American Dental Association).

“(2) PRIMARY CARE RESIDENCY PROGRAM.—The term ‘primary
care residency program’ has the meaning given that term in section 749A.
“(3) QUALIFIED TEACHING HEALTH CENTER.—The term ‘qualified teaching health center’ has the meaning given the term ‘teaching health center’ in section 749A.”