Rural Health Clinics in Iowa

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

Peter C. Damiano
Suzanne E. Bentler
Asthा Singhal
Peter Schumacher

The University of Iowa
Public Policy Center

Last Updated
September 27, 2013
Rural Health Clinics

Introduction
This is a report that inventories all the information we have collected on the finances, providers, and patients of Iowa’s Rural Health Clinics. 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 Rural Health Clinics.

A Rural Health Clinic (RHC) is a clinic certified by the federal government as a safety net provider and is allowed to receive special Medicare and Medicaid reimbursement. The purpose of the RHC program is to improve access to primary care in non-urbanized, medically underserved areas by using physician assistants and nurse practitioners to extend physician services and by providing a reimbursement framework to financially support these clinics. RHCs are required to use a team approach of physicians and midlevel practitioners such as nurse practitioners, physician assistants, and certified nurse midwives to provide services. RHCs are required to provide out-patient primary care services and basic laboratory services.

Eligibility Criteria for being certified as a RHC by the Centers for Medicare and Medicaid Services (CMS):

- Eligible clinics must be in a rural area designated or updated within the past three calendar years as having a shortage of primary care physicians. Qualifying designations include
  - Health Professional Shortage Area (HPSA);
  - Medically Underserved Area (MUA);
  - High Migrant Impact Area (HMIA); and
  - An area designated as medically underserved by the chief executive officer (Governor) of the state. (Iowa is one of 13 states that utilized the Governor’s RHC Designation process).
- The clinic must be staffed at least 50% of the time with a midlevel practitioner and meeting a set of minimum standards for physical plant and services provided.

As of January 2012, 142 CMS-certified Rural Health Clinics (RHC) operated in 58 Iowa counties. This number varies frequently as clinics decertify, change ownership, or apply and receive certification. The clinics often operate as rural community clinics in that they are located in small towns, the staff and providers usually reside in the communities, and the clinics bring economic benefits to their counties. RHCs are either provider-based (owned by hospital) or freestanding (provider owned). In Iowa, 76 percent of RHCs are provider-based owned by hospitals.

In a recent statewide health assessment, 92 of 99 counties identified access to health services as an issue. Inadequate transportation has long been identified as a major access issue in rural Iowa where 44 percent of Iowans live and 22 percent of rural Iowans are over the age of 65. A significant segment of the rural population depends on family members, public transit...
and/or volunteer efforts to access health care and the RHCs in Iowa increase access to primary care services for rural residents.

**Financing**

RHCs are not directly subsidized by any government programs but they do receive *cost-based reimbursement* for a defined set of core physician and certain non-physician outpatient services.\(^9\) Payment is based on an all-inclusive payment methodology, subject to a maximum payment per visit and annual reconciliation.\(^10\) The per-visit payment limit does not apply to RHCs that are an integral and subordinate part of a hospital with fewer than 50 beds.\(^11\) Laboratory tests are paid separately.\(^12\) The RHC *per-visit payment limit* ($79.48 per visit in 2012 for Medicare, clinic specific for Medicaid) is established by Congress and changes each year based on the percentage change in the Medicare Economic Index.\(^13\)

Table 1 indicates revenues, expenses and adjusted cost per visit for RHCs nationally in 2000.

<table>
<thead>
<tr>
<th>Total Revenues, Expenses, and Adjusted-Cost-Per-Visit</th>
<th>Total Revenues N</th>
<th>Total Expenses N</th>
<th>Adjusted Cost Per Visit N</th>
</tr>
</thead>
<tbody>
<tr>
<td>All RHCs</td>
<td>$641,683</td>
<td>229</td>
<td>$681,457</td>
</tr>
<tr>
<td>Independent RHCs</td>
<td>$690,669</td>
<td>148</td>
<td>$731,174</td>
</tr>
<tr>
<td>Provider-Based RHCs</td>
<td>$552,176</td>
<td>81</td>
<td>$590,617</td>
</tr>
</tbody>
</table>

Source: 2000 National Survey of Rural Health Clinics, Muskie School of Public Service, University of Southern Maine

Table 2 shows the proportion of revenues and patient visits of RHCs by payer nationally in 2000. Approximately 30 percent of patient revenue was from Medicare, 30 percent from private insurance, 25 percent from Medicaid/SCHIP, and 15 percent from the out-of-pocket payment.

<table>
<thead>
<tr>
<th>Payer Type</th>
<th>Percent of Revenues</th>
<th>Percent of Patient Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>29.9%</td>
<td>30.8%</td>
</tr>
<tr>
<td>Medicaid/SCHIP</td>
<td>24.4%</td>
<td>25.0%</td>
</tr>
<tr>
<td>Uninsured/Private Pay/Free Cost Care</td>
<td>14.7%</td>
<td>14.6%</td>
</tr>
<tr>
<td>Commercial/Private Insurance</td>
<td>29.5%</td>
<td>28.4%</td>
</tr>
<tr>
<td>Other</td>
<td>4.2%</td>
<td>3.9%</td>
</tr>
</tbody>
</table>

Source: 2000 National Survey of Rural Health Clinics, Muskie School of Public Service, University of Southern Maine
In Iowa, total Medicaid payments to RHCs by during the 2008 fiscal year were $12.7 million and the total number of Medicaid beneficiaries that received services at RHCs was 34,342, which brings the cost per beneficiary to $369.91. For 2009, Medicaid paid $15.1 million to the RHCs for 36,179 beneficiaries receiving services at the RHCs.14

**RHC Provider Network**

There were 140 RHCs in Iowa as of June 2012 (Figure 1).15 Sixty-three of these clinics participated in the Iowa Collaborative Safety Net Network’s program during the 2011 state fiscal year and sixty-six are participating during state fiscal year 2012. For their participation during the 2011 state fiscal year, each clinic received $1,300 per year from the state to provide data about their services to the safety net network.16 For the 2012 state fiscal year, the award will be approximately $1,600.

**Figure 1: Map of location of RHCs in Iowa as of Jan. 2012**  
![Map of Iowa Rural Health Clinics](image.png)  
*Source: IDPH, 2012.*
Provider Full Time Equivalents (FTEs):
The US Department of Health and Human Services, Health Resources and Services Administration’s (HRSA) Rural Health Clinics Health site directory (POS) gives the provider FTEs at each of the 141 locations in Iowa in 2011, summarized as shown in Table 3.18

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>FTEs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>198.92</td>
</tr>
<tr>
<td>Physician Assistant</td>
<td>78.49</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>62.65</td>
</tr>
<tr>
<td>Other Personnel</td>
<td>523.12</td>
</tr>
</tbody>
</table>


The National Health Service Corps (NHSC), a program for placing clinicians in underserved areas, staff many RHCs.19

Services Provided
HRSA’s data also indicated the following services being available at RHCs and reimbursable by Medicare and Medicaid (Table 4).20 Service reimbursement shown in Table 4 is nationally applicable.

<table>
<thead>
<tr>
<th>Service</th>
<th>Medicare</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Services</td>
<td>Specified Medicare Covered Preventive Services Only</td>
<td>If covered in State Plan</td>
</tr>
<tr>
<td>Core Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Services</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>MLP Services</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Clinical Psychologist Services</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Clinical Social Worker Services</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Services and Supplies</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>“Incident to” Covered Services</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Visiting Nurse Home Health Services (in designated areas)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Other Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Care</td>
<td></td>
<td>If covered in State Plan</td>
</tr>
<tr>
<td>Nursing Home Care</td>
<td>✓</td>
<td>If covered in State Plan</td>
</tr>
<tr>
<td>Other Ambulatory Services Included in the State Medicaid Plan</td>
<td></td>
<td>If covered in State Plan</td>
</tr>
<tr>
<td>Diabetes Self-Management Training Services and Medical Nutrition Therapy Services</td>
<td></td>
<td>If covered in State Plan</td>
</tr>
<tr>
<td>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>
The top five medical illnesses reported as ICD-9 Codes seen at RHCs in CY 2012 were as follows:

- Hypertension
- Diabetes mellitus
- Acute sinusitis (unspecified)
- Acute upper respiratory infections
- Allergic rhinitis

**Population Served**

Based on a maximum of 72 clinics responding to the Iowa Collaborative Safety Net Provider Network survey, in CY 2011, rural health clinics in Iowa experienced:

- 126,353 total unduplicated patients (43 clinics);
- 557,960 total encounters (68 clinics);
- 12 percent of patients had income below 200 percent FPL (in 2010); and
- 50 percent of patients were privately insured, 27 percent received Medicare, 13 percent received Medicaid and 8 percent were uninsured.21

* We did not include race/ethnic patient characteristics due to low response rate from clinics (12 of 72 responded); among survey responses, the White/Caucasian (93%) and not Hispanic/Latino (64%) categories were the most common.

In CY 2012, fewer RHCs (57) reported data to the Iowa Collaborative Safety Net Provider Network survey, and served the following:

- 116,199 total unduplicated patients (52 clinics);
- 410,339 total encounters (56 clinics);
- 48% of patients were privately insured, 29% received Medicare, 12% received Medicaid and 8% were uninsured (34 clinics). 22

In 2012, the largest number of patients and the largest proportion of the encounters were for those ages 65 and older followed by patients between the ages of 6 and 17 (Figure 2). As earlier mentioned, RHCs care for a substantial number of patients with private insurance as well as a substantial number with public insurance (Figure 2).
Figure 2. The characteristics of populations served, by patient count in 2012*

Source: Calendar Year 2012 Data Report – Iowa Collaborative Safety Net Provider Network.

For the legal analysis of the ACA’s impact on rural health clinics and the full ACA text of the provisions affecting rural health clinics see Appendix A.
References

20 Comparison of the Rural Health Clinic and Federally Qualified Health Center Programs.  
21 Calendar Year 2011 Data Report – Iowa Collaborative Safety Net Provider Network.
22 Calendar Year 2012 Data Report – Iowa Collaborative Safety Net Provider Network.
Appendix A

The Legal Review of the Affordable Care Act’s Impact on Rural Health Clinics

The ACA utilizes the definition for a rural health clinic from the Social Security Act, which defines a rural health clinic as either a physician-directed clinic or not physician-directed clinic located in an unurbanized area (as defined by the Bureau of the Census) that contains an insufficient number of health care professionals; an area that has been officially deemed as an area with either a shortage of personal health services or health professionals. The federal definition for a rural health clinic explicitly excludes any rehabilitative centers or any facility primarily for the care and treatment of mental diseases.

The ACA expands the number of counties that are eligible to participate in the demonstration program for community health integration models in addition to eliminating one of the eligibility criteria that critical access hospitals can provide rural health clinic services. As part of the ACA’s provision of grants for programs providing public health community interventions, screenings, and clinical referrals for individuals between 55 and 64 years old, the ACA requires eligible entities (i.e., local public health departments, State health departments, or Indian tribes) to enter into contracts with community health centers, rural health clinics, or mental health and substance use disorder service providers for referral, treatment, or both.

Finally, the ACA establishes a grant for developing teaching health centers in order to prepare primary care residents. A rural health clinic is explicitly defined by the ACA as a teaching health center. Grants under this section are limited to three years and a total award of $500,000. 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. 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.

As part of the ACA’s funding of FQHCs, the ACA specifically allows community health centers to contract with federally certified rural health clinics for providing primary health care services to individuals eligible for receiving free, or reduced-cost, services at a community health center. The ACA establishes an option for states to provide health homes for individuals with chronic conditions. A rural health clinic is explicitly defined by the ACA as a designated provider capable of delivering health home care services.
services, which include: comprehensive care management, comprehensive transitional care, patient and family support, and referral to community and social support services.  

The ACA amends the Public Health Service Act in order to provide grants for area health education centers. Grants are for no less than $250,000 per year per health education center and for a maximum of 12 years. The grant awards require a range of activities including: minority recruitment into the health professions and preparation of individuals for placement in underserved areas. Additionally, a grant awardee may use funding to develop, in collaboration with rural health clinics, curricula for preparing primary care providers to serve in underserved areas.

In another effort to increase the supply of primary care providers, the ACA prioritizes grants to eligible entities having a formal agreement, or joint application, with rural health clinics for developing and providing training in primary care. Included in the funded activities are: professional training programs, need-based financial assistance, community-based training, and primary care capacity building programs. The ACA emphasizes primary care training in community-based settings. Maximum length of time for a grant is 5 years per entity.

The ACA expands the authority for MACPAC (Medicaid and CHIP Payment and Access Commission) to review and assess payment policies for rural health clinics. MACPAC’s reporting requirements are also increased by adding required reports to Congress.

In another training program established by the ACA, graduate nurse demonstration project funding is authorized for a maximum of 5 hospitals having written agreements with at least one school of nursing and at least two non-hospital, community-based care settings, which includes rural health clinics. Participating rural health clinics are reimbursed according to the ACA for reasonable costs associated with providing training to the graduate nurses.

The ACA also attempts to encourage training of oral health professionals in general, pediatric, and public health dentistry by providing grants to either eligible entities that can provide a general, pediatric, or public health dentistry training program or programs for training health care providers who plan to teach general, pediatric, and public health dentistry. Additionally, grants are provided for: need-based financial assistance for students planning to practice in general, pediatric, and public health dentistry; faculty development programs in primary care; or faculty loan repayment programs. Priority is given to grant applicants who have a formal agreement with a rural health center.

**Full Text for ACA Provisions Affecting Rural Health Clinics**

42 USCS Section 1395i-4 as amended by ACA Section 3126


"(a) In general. The Secretary shall establish a demonstration project to allow eligible entities to develop and test new models for the delivery of health care services in eligible counties for the purpose
of improving access to, and better integrating the delivery of, acute care, extended care, and other 
esential health care services to Medicare beneficiaries.

"(b) Purpose. The purpose of the demonstration project under this section is to--

"(1) explore ways to increase access to, and improve the adequacy of, payments for acute care, 
extended care, and other essential health care services provided under the Medicare and Medicaid 
programs in eligible counties; and

"(2) evaluate regulatory challenges facing such providers and the communities they serve.
"(c) Requirements. The following requirements shall apply under the demonstration project:

"(1) Health care providers in eligible counties selected to participate in the demonstration project 
under subsection (d)(3) shall (when determined appropriate by the Secretary), instead of the payment 
rates otherwise applicable under the Medicare program, be reimbursed at a rate that covers at least the 
reasonable costs of the provider in furnishing acute care, extended care, and other essential health care 
services to Medicare beneficiaries.

"(2) Methods to coordinate the survey and certification process under the Medicare program and the 
Medicaid program across all health service categories included in the demonstration project shall be 
tested with the goal of assuring quality and safety while reducing administrative burdens, as 
appropriate, related to completing such survey and certification process.

"(3) Health care providers in eligible counties selected to participate in the demonstration project 
under subsection (d)(3) and the Secretary shall work with the State to explore ways to revise 
reimbursement policies under the Medicaid program to improve access to the range of health care 
services available in such eligible counties.

"(4) The Secretary shall identify regulatory requirements that may be revised appropriately to 
 improve access to care in eligible counties.

"(5) Other essential health care services necessary to ensure access to the range of health care 
services in eligible counties selected to participate in the demonstration project under subsection (d)(3) 
shall be identified. Ways to ensure adequate funding for such services shall also be explored.

"(d) Application process.

(1) Eligibility.

(A) In general. Eligibility to participate in the demonstration project under this section shall be 
limited to eligible entities.

"(B) Eligible entity defined. In this section, the term 'eligible entity' means an entity that--

"(i) is a Rural Hospital Flexibility Program grantee under section 1820(g) of the Social Security Act 
(42 U.S.C. 1395i-4(g)); and

"(ii) is located in a State in which at least 65 percent of the counties in the State are counties that 
have 6 or less residents per square mile.

"(2) Application.

(A) In general. An eligible entity seeking to participate in the demonstration project 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.

"(B) Limitation. The Secretary shall select eligible entities located in not more than 4 States to 
participate in the demonstration project under this section.

"(3) Selection of eligible counties. An eligible entity selected by the Secretary to participate in the
demonstration project under this section shall select eligible counties in the State in which the entity is located in which to conduct the demonstration project.

"(4) Eligible county defined. In this section, the term 'eligible county' means a county that meets the following requirements:

"(A) The county has 6 or less residents per square mile.

"(B) As of the date of the enactment of this Act, a facility designated as a critical access hospital which meets the following requirements was located in the county:

"(i) As of the date of the enactment of this Act, the critical access hospital furnished 1 or more of the following:

"(I) Home health services.

"(II) Hospice care.

"(ii) As of the date of the enactment of this Act, the critical access hospital has an average daily inpatient census of 5 or less.

"(C) As of the date of the enactment of this Act, skilled nursing facility services were available in the county in--

"(i) a critical access hospital using swing beds; or

"(ii) a local nursing home.

"(e) Administration.

(1) In general. The demonstration project under this section shall be administered jointly by the Administrator of the Office of Rural Health Policy of the Health Resources and Services Administration and the Administrator of the Centers for Medicare & Medicaid Services, in accordance with paragraphs (2) and (3).

"(2) HRSA duties. In administering the demonstration project under this section, the Administrator of the Office of Rural Health Policy of the Health Resources and Services Administration shall--

"(A) award grants to the eligible entities selected to participate in the demonstration project; and

"(B) work with such entities to provide technical assistance related to the requirements under the project.

"(3) CMS duties. In administering the demonstration project under this section, the Administrator of the Centers for Medicare & Medicaid Services shall determine which provisions of titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 et seq.; 1396 et seq.) the Secretary should waive under the waiver authority under subsection (i) that are relevant to the development of alternative reimbursement methodologies, which may include, as appropriate, covering at least the reasonable costs of the provider in furnishing acute care, extended care, and other essential health care services to Medicare beneficiaries and coordinating the survey and certification process under the Medicare and Medicaid programs, as appropriate, across all service categories included in the demonstration project.

"(f) Duration.

(1) In general. The demonstration project under this section shall be conducted for a 3-year period beginning on October 1, 2009.

"(2) Beginning date of demonstration project. The demonstration project under this section shall be considered to have begun in a State on the date on which the eligible counties selected to participate in the demonstration project under subsection (d)(3) begin operations in accordance with the requirements under the demonstration project.
"(g) Funding.
(1) CMS.
   (A) In general. The Secretary shall provide for the transfer, in appropriate part from the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), of such sums as are necessary for the costs to the Centers for Medicare & Medicaid Services of carrying out its duties under the demonstration project under this section.
   (B) Budget neutrality. In conducting the demonstration project under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary estimates would have been paid if the demonstration project under this section was not implemented.
   (2) HRSA. There are authorized to be appropriated to the Office of Rural Health Policy of the Health Resources and Services Administration $800,000 for each of fiscal years 2010, 2011, and 2012 for the purpose of carrying out the duties of such Office under the demonstration project under this section, to remain available for the duration of the demonstration project.

(h) Report.
(1) Interim report. Not later than the date that is 2 years after the date on which the demonstration project under this section is implemented, the Administrator of the Office of Rural Health Policy of the Health Resources and Services Administration, in coordination with the Administrator of the Centers for Medicare & Medicaid Services, shall submit a report to Congress on the status of the demonstration project that includes initial recommendations on ways to improve access to, and the availability of, health care services in eligible counties based on the findings of the demonstration project.
(2) Final report. Not later than 1 year after the completion of the demonstration project, the Administrator of the Office of Rural Health Policy of the Health Resources and Services Administration, in coordination with the Administrator of the Centers for Medicare & Medicaid Services, shall submit a report to Congress on such project, together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(i) Waiver authority. The Secretary may waive such requirements of titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 et seq.; 1396 et seq.) as may be necessary and appropriate for the purpose of carrying out the demonstration project under this section.

(j) Definitions. In this section:
   (1) Extended care services. The term 'extended care services' means the following:
      (A) Home health services.
      (B) Covered skilled nursing facility services.
      (C) Hospice care.
   (2) Covered skilled nursing facility services. The term 'covered skilled nursing facility services' has the meaning given such term in section 1888(e)(2)(A) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(A)).
   (3) Critical access hospital. The term 'critical access hospital' means a facility designated as a critical access hospital under section 1820(c) of such Act (42 U.S.C. 1395i-4(c)).
   (4) Home health services. The term 'home health services' has the meaning given such term in section 1861(m) of such Act (42 U.S.C. 1395x(m)).
"(5) Hospice care. The term 'hospice care' has the meaning given such term in section 1861(dd) of such Act (42 U.S.C. 1395x(dd)).

"(6) Medicaid program. The term 'Medicaid program' means the program under title XIX of such Act (42 U.S.C. 1396 et seq.).

"(7) Medicare program. The term 'Medicare program' means the program under title XVIII of such Act (42 U.S.C. 1395 et seq.).

"(8) Other essential health care services. The term 'other essential health care services' means the following:

"(A) Ambulance services (as described in section 1861(s)(7) of the Social Security Act (42 U.S.C. 1395x(s)(7))).

"(B) Physicians' services (as defined in section 1861(q) of the Social Security Act (42 U.S.C. 1395x(q))).

"(C) Public health services (as defined by the Secretary).

"(D) Other health care services determined appropriate by the Secretary.

"(9) Secretary. The term 'Secretary' means the Secretary of Health and Human Services."

Establishment of Pilot Program for healthy aging, living well from ACA Section 4202

(a) HEALTHY AGING, LIVING WELL.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the “Secretary”), acting through the Director of the Centers for Disease Control and Prevention, shall award grants to State or local health departments and Indian tribes to carry out 5-year pilot programs to provide public health community interventions, screenings, and where necessary, clinical referrals for individuals who are between 55 and 64 years of age.

(2) ELIGIBILITY.—To be eligible to receive a grant under paragraph (1), an entity shall—

(A) be—

(i) a State health department;

(ii) a local health department; or

(iii) an Indian tribe;

(B) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require including a description of the program to be carried out under the grant;

(C) design a strategy for improving the health of the 55-to-64 year-old population through community-based public health interventions; and

(D) demonstrate the capacity, if funded, to develop the relationships necessary with relevant health agencies, health care providers, community-based organizations, and
insurers to carry out the activities described in paragraph (3), such relationships to include the identification of a community-based clinical partner, such as a community health center or rural health clinic.

(3) USE OF FUNDS.—
(A) IN GENERAL.—A State or local health department shall use amounts received under a grant under this subsection to carry out a program to provide the services described in this paragraph to individuals who are between 55 and 64 years of age.

(B) PUBLIC HEALTH INTERVENTIONS.—
(i) IN GENERAL.—In developing and implementing such activities, a grantee shall collaborate with the Centers for Disease Control and Prevention and the Administration on Aging, and relevant local agencies and organizations.
(ii) TYPES OF INTERVENTION ACTIVITIES.—Intervention activities conducted under this subparagraph may include efforts to improve nutrition, increase physical activity, reduce tobacco use and substance abuse, improve mental health, and promote healthy lifestyles among the target population.

(C) COMMUNITY PREVENTIVE SCREENINGS.—
(i) IN GENERAL.—In addition to community-wide public health interventions, a State or local health department shall use amounts received under a grant under this subsection to conduct ongoing health screening to identify risk factors for cardiovascular disease, cancer, stroke, and diabetes among individuals in both urban and rural areas who are between 55 and 64 years of age.
(ii) TYPES OF SCREENING ACTIVITIES.—Screening activities conducted under this subparagraph may include—
(I) mental health/behavioral health and substance use disorders;
(II) physical activity, smoking, and nutrition; and
(III) any other measures deemed appropriate by the Secretary.
(iii) MONITORING.—Grantees under this section shall maintain records of screening results under this subparagraph to establish the baseline data for monitoring the targeted population.

(D) CLINICAL REFERRAL/TREATMENT FOR CHRONIC DISEASES.—
(i) IN GENERAL.—A State or local health department shall use amounts received under a grant under
this subsection to ensure that individuals between 55 and 64 years of age who are found to have chronic disease risk factors through the screening activities described in subparagraph (C)(ii), receive clinical referral/treatment for follow-up services to reduce such risk.

(ii) MECHANISM.—

(I) IDENTIFICATION AND DETERMINATION OF STATUS.—With respect to each individual with risk factors for or having heart disease, stroke, diabetes, or any other condition for which such individual was screened under subparagraph (C), a grantee under this section shall determine whether or not such individual is covered under any public or private health insurance program.

(II) INSURED INDIVIDUALS.—An individual determined to be covered under a health insurance program under subclause (I) shall be referred by the grantee to the existing providers under such program or, if such individual does not have a current provider, to a provider who is in-network with respect to the program involved.

(III) UNINSURED INDIVIDUALS.—With respect to an individual determined to be uninsured under subclause (I), the grantee’s community-based clinical partner described in paragraph (4)(D) shall assist the individual in determining eligibility for available public coverage options and identify other appropriate community health care resources and assistance programs.

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

(E) GRANTEE EVALUATION.—An eligible entity shall use amounts provided under a grant under this subsection to conduct activities to measure changes in the prevalence of chronic disease risk factors among participants.

(4) PILOT PROGRAM EVALUATION.—The Secretary shall conduct an annual evaluation of the effectiveness of the pilot program under this subsection. In determining such effectiveness, the Secretary shall consider changes in the prevalence of uncontrolled chronic disease risk factors among new Medicare
enrollees (or individuals nearing enrollment, including those who are 63 and 64 years of age) who reside in States or localities receiving grants under this section as compared with national and historical data for those States and localities for the same population.

42 USC Section 293k et seq. as amended by ACA Sections 5303 and 5508

"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).

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.”

42 USC Section 254b et seq. as amended by ACA Section 5508(c)

“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); and

“(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 (2) 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.”

42 USC Section 254b(r) as amended by ACA Section 5601(b)

“(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.”

42 USC Section 1396a et seq. as amended by ACA Sections 2201, 2305, and 2703

(a) STATE PLAN AMENDMENT.—Title XIX of the Social Security
Act (42 U.S.C. 1396a et seq.), as amended by sections 2201 and
2305, is amended by adding at the end the following new section:
“SEC. 1945. STATE OPTION TO PROVIDE COORDINATED CARE
THROUGH A HEALTH HOME FOR INDIVIDUALS WITH CHRONIC CONDITIONS.—
“(a) IN GENERAL.—Notwithstanding section 1902(a)(1) (relating to statewideness), section 1902(a)(10)(B) (relating to comparability), and any other provision of this title for which the Secretary determines it is necessary to waive in order to implement this section, beginning January 1, 2011, a State, at its option as a State plan amendment, may provide for medical assistance under this title to eligible individuals with chronic conditions who select a designated provider (as described under subsection (h)(5)), a team of health care professionals (as described under subsection (h)(6)) operating with such a provider, or a health team (as described under subsection (h)(7)) as the individual’s health home for purposes of providing the individual with health home services.

“(b) HEALTH HOME QUALIFICATION STANDARDS.—The Secretary shall establish standards for qualification as a designated provider for the purpose of being eligible to be a health home for purposes of this section.

“(c) PAYMENTS.—

“(1) IN GENERAL.—A State shall provide a designated provider, a team of health care professionals operating with such a provider, or a health team with payments for the provision of health home services to each eligible individual with chronic conditions that selects such provider, team of health care professionals, or health team as the individual’s health home. Payments made to a designated provider, a team of health care professionals operating with such a provider, or a health team for such services shall be treated as medical assistance for purposes of section 1903(a), except that, during the first 8 fiscal year quarters that the State plan amendment is in effect, the Federal medical assistance percentage applicable to such payments shall be equal to 90 percent.

“(2) METHODOLOGY.—

“(A) IN GENERAL.—The State shall specify in the State plan amendment the methodology the State will use for determining payment for the provision of health home services. Such methodology for determining payment—

eligible individual with chronic conditions provided such services by a designated provider, a team of health care professionals operating with such a provider, or a health team, as well as the severity or number of each such individual’s chronic conditions or the specific capabilities of the provider, team of health care professionals, or health team; and

“(ii) shall be established consistent with section 1902(a)(30)(A).

“(B) ALTERNATE MODELS OF PAYMENT.—The methodology for determining payment for provision of health home services under this section shall not be limited to a permember
per-month basis and may provide (as proposed by the State and subject to approval by the Secretary) for alternate models of payment.

“(3) PLANNING GRANTS.—

“(A) IN GENERAL.—Beginning January 1, 2011, the Secretary may award planning grants to States for purposes of developing a State plan amendment under this section. A planning grant awarded to a State under this paragraph shall remain available until expended.

“(B) STATE CONTRIBUTION.—A State awarded a planning grant shall contribute an amount equal to the State percentage determined under section 1905(b) (without regard to section 5001 of Public Law 111–5) for each fiscal year for which the grant is awarded.

“(C) LIMITATION.—The total amount of payments made to States under this paragraph shall not exceed $25,000,000.

“(d) HOSPITAL REFERRALS.—A State shall include in the State plan amendment a requirement for hospitals that are participating providers under the State plan or a waiver of such plan to establish procedures for referring any eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated providers.

“(e) COORDINATION.—A State shall consult and coordinate, as appropriate, with the Substance Abuse and Mental Health Services Administration in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

“(f) MONITORING.—A State shall include in the State plan amendment—

“(1) a methodology for tracking avoidable hospital readmissions and calculating savings that result from improved chronic care coordination and management under this section; and

“(2) a proposal for use of health information technology in providing health home services under this section and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

“(g) REPORT ON QUALITY MEASURES.—As a condition for receiving payment for health home services provided to an eligible individual with chronic conditions, a designated provider shall report to the State, in accordance with such requirements as the Secretary shall specify, on all applicable measures for determining the quality of such services. When appropriate and feasible, a designated provider shall use health information technology in providing the State with such information.
“(h) DEFINITIONS.—In this section:

“(1) ELIGIBLE INDIVIDUAL WITH CHRONIC CONDITIONS.—

“(A) IN GENERAL.—Subject to subparagraph (B), the term ‘eligible individual with chronic conditions’ means an individual who—

“(i) is eligible for medical assistance under the State plan or under a waiver of such plan; and

“(ii) has at least—

“(I) 2 chronic conditions;

“(II) 1 chronic condition and is at risk of having a second chronic condition; or

“(III) 1 serious and persistent mental health condition.

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

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

“(A) A mental health condition.

“(B) Substance use disorder.

“(C) Asthma.

“(D) Diabetes.

“(E) Heart disease.

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

“(3) HEALTH HOME.—The term ‘health home’ means a designated provider (including a provider that operates in coordination with a team of health care professionals) or a health team selected by an eligible individual with chronic conditions to provide health home services.

“(4) HEALTH HOME SERVICES.—

“(A) IN GENERAL.—The term ‘health home services’ means comprehensive and timely high-quality services described in subparagraph (B) that are provided by a designated provider, a team of health care professionals operating with such a provider, or a health team.

“(B) SERVICES DESCRIBED.—The services described in this subparagraph are—

“(i) comprehensive care management;

“(ii) care coordination and health promotion;

“(iii) comprehensive transitional care, including appropriate follow-up, from inpatient to other settings;

“(iv) patient and family support (including authorized representatives);

“(v) referral to community and social support services,
if relevant; and "(vi) use of health information technology to link services, as feasible and appropriate."

"(5) DESIGNATED PROVIDER.—The term ‘designated provider’ means a physician, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, home health agency, or any other entity or provider (including pediatricians, gynecologists, and obstetricians) that is determined by the State and approved by the Secretary to be qualified to be a health home for eligible individuals with chronic conditions on the basis of documentation evidencing that the physician, practice, or clinic—

"(A) has the systems and infrastructure in place to provide health home services; and

"(B) satisfies the qualification standards established by the Secretary under subsection (b).

"(6) TEAM OF HEALTH CARE PROFESSIONALS.—The term ‘team of health care professionals’ means a team of health professionals (as described in the State plan amendment) that may—

"(A) include physicians and other professionals, such as a nurse care coordinator, nutritionist, social worker, behavioral health professional, or any professionals deemed appropriate by the State; and

"(B) be free standing, virtual, or based at a hospital, community health center, community mental health center, rural clinic, clinical practice or clinical group practice, academic health center, or any entity deemed appropriate by the State and approved by the Secretary.

42 USC Section 294a as amended by ACA Section 5403

"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.

“(G) Establish a youth public health program to expose and 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.’’

42 USC Section 294 et seq. as amended by ACA Section 5403(b)

‘‘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.”

42 USC Section 293k et seq. as amended by ACA Section 5301

“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.”
42 USC Section 1396 as amended by ACA Section 2801

(a) Establishment. There is hereby established the Medicaid and CHIP Payment and Access Commission (in this section referred to as "MACPAC").

(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 [42 USCS §§ 1396 et seq.] (in this section referred to as "Medicaid") and the State Children's Health Insurance Program established under title XXI [42 USCS §§ 1397aa et seq.] (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) Specific topics to be reviewed. Specifically, MACPAC shall review and assess the following:

(A) Medicaid and CHIP payment policies. Payment policies under Medicaid and CHIP, including--

(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;

(ii) payment methodologies; and

(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 [42 USCS §§ 1396 et seq. or 1397aa et seq.] 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 [42 USCS §§ 1395 et seq.], 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 [42 USCS §§ 1396 et seq. or 1397aa et seq.] 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 [42 USCS § 1395b-6] 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 [42 USCS §§ 1395 et seq.], 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 2081 [2602] of the Patient Protection and Affordable Care Act [42 USCS § 1315b] 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) Membership.

(1) Number and appointment. MACPAC shall be composed of 17 members appointed by the Comptroller General of the United States.

(2) Qualifications.

(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.

(C) Majority nonproviders. Individuals who are directly involved in the provision, or management of
the delivery, of items and services covered under Medicaid or CHIP shall not constitute a majority of the
membership of MACPAC.

(D) Ethical disclosure. The Comptroller General of the United States shall establish a system for public
disclosure by members of MACPAC of financial and other potential conflicts of interest relating to such
members. Members of MACPAC shall be treated as employees of Congress for purposes of applying title

(3) Terms.

(A) In general. The terms of members of MACPAC shall be for 3 years except that the Comptroller
General of the United States shall designate staggered terms for the members first appointed.

(B) Vacancies. Any member appointed to fill a vacancy occurring before the expiration of the term for
which the member’s predecessor was appointed shall be appointed only for the remainder of that term.
A member may serve after the expiration of that member’s term until a successor has taken office. A
vacancy in MACPAC shall be filled in the manner in which the original appointment was made.

(4) Compensation. While serving on the business of MACPAC (including travel time), a member of
MACPAC shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of
the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away
from home and the member’s regular place of business, a member may be allowed travel expenses, as
authorized by the Chairman of MACPAC. Physicians serving as personnel of MACPAC may be provided a
physician comparability allowance by MACPAC in the same manner as Government physicians may be
provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such
purpose subsection (i) of such section shall apply to MACPAC in the same manner as it applies to the
Tennessee Valley Authority. For purposes of pay (other than pay of members of MACPAC) and
employment benefits, rights, and privileges, all personnel of MACPAC shall be treated as if they were
employees of the United States Senate.

(5) Chairman; Vice Chairman. The Comptroller General of the United States shall designate a member
of MACPAC, at the time of appointment of the member as Chairman and a member as Vice Chairman for
that term of appointment, except that in the case of vacancy of the Chairmanship or Vice Chairmanship,
the Comptroller General of the United States may designate another member for the remainder of that
member’s term.

(6) Meetings. MACPAC shall meet at the call of the Chairman.

(d) Director and staff; experts and consultants. Subject to such review as the Comptroller General of the
United States deems necessary to assure the efficient administration of MACPAC, MACPAC may--

(1) employ and fix the compensation of an Executive Director (subject to the approval of the
Comptroller General of the United States) and such other personnel as may be necessary to carry out its
duties (without regard to the provisions of title 5, United States Code, governing appointments in the
competitive service);
(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal and State departments and agencies;
(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of MACPAC (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5)) [41 USCS § 6101];
(4) make advance, progress, and other payments which relate to the work of MACPAC;
(5) provide transportation and subsistence for persons serving without compensation; and
(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of MACPAC.

(e) Powers.
(1) Obtaining official data. 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) [42 USCS §§ 1396b(a) and 1397ee(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.
(2) Data collection. In order to carry out its functions, MACPAC shall--
(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section;
(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and
(C) adopt procedures allowing any interested party to submit information for MACPAC's use in making reports and recommendations.
(3) Access of GAO to information. The Comptroller General of the United States shall have unrestricted access to all deliberations, records, and nonproprietary data of MACPAC, immediately upon request.
(4) Periodic audit. MACPAC shall be subject to periodic audit by the Comptroller General of the United States.

(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) [42 USCS § 1397dd(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.

42 USC Section 1395ww by ACA Section 5509

"(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 [42 USCS §§ 1301 et seq. and 1395 et seq.] as may be necessary to carry out the demonstration.
   (4) Administration. Chapter 35 of title 44, United States Code [44 USCS §§ 3501 et seq.], 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 [42 USCS § 256]) 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 [42 USCS §§ 1395c et seq.], or enrolled under part B of such title [42 USCS §§ 1395j
   et seq.]; 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."

42 USC Section 293k-2 as amended by ACA Section 5303

§ 293k-2. 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 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.

23 ACA Section 5002(b)(1)(26) referencing 42 USC Section 1395x(aa).
24 42 USC Section 1395x(aa)(2)(K)(iv).
25 ACA Section 3126(b).
26 ACA Section 4202(a)(3)(D)(iii).
27 ACA Section 5508(a).
28 ACA Section 5508(a).
29 ACA Section 5508(a).
30 ACA Section 5508(c).
31 ACA Section 5508(c).
32 ACA Section 5508(c).
33 ACA Section 5601(b).
34 ACA Section 2703(a).
35 ACA Section 2703(a).
36 ACA Section 5403(a).
37 ACA Section 5403(a).
38 ACA Section 5403(a).
39 ACA Section 5403(a).
40 ACA Section 5301.
41 ACA Section 5301.
42 ACA Section 5301.
43 ACA Section 2801(a)(B)(ii)(II)(bb).
44 ACA Section 2801(a)(F)(ii).
45 ACA Sections 5509(a)(1)(A), (e)(5).
46 ACA Section 5509(a)(2)(A).
47 ACA Section 5303(2).
48 ACA Section 5303(2).
49 ACA Section 5303(2).