HEALTH CENTER RELATED PROVISIONS IN HEALTH REFORM LEGISLATION

Provision	Health Care Reform Package (Senate Bill and Reconciliation Bill)[1]

Health Centers Program Funding	• Authorizes and appropriates $9.5 billion in the following annual amounts to a new Community Health Centers Trust Fund for the purpose of expanding Community Health Centers' operational capacity to serve nearly 20 million new patients and enhance their medical, oral, and behavioral health services:
	  • $1 billion for FY2011;
	  • $1.2 billion for FY2012;
	  • $1.5 billion for FY2013;
	  • $2.2 billion for FY2014;
	  • $3.6 billion for FY2015.
	
	• Within the Community Health Centers Trust Fund, also authorizes and appropriates $1.5 billion over five years to allow Community Health Centers' to meet their capital needs by expanding and improving existing facilities and constructing new sites.
	
	TOTAL = $11 billion over five years.

National Health Service Corps Program Funding & Program Changes	• Authorizes and appropriates the following annual amounts to a new National Health Service Corps Trust Fund:
	  • $290 million for FY 2011;
	  • $295 million for FY 2012;
	  • $300 million for FY 2013;
	  • $305 million for FY 2014;
	  • $310 million for FY 2015.
	
	TOTAL = $1.5 billion over five years.
	
	• Allows for teaching to count as clinical practice for up to 50% of obligated service.

[1] The Reconciliation Bill (HR 4872), which became law on 3/30/2010, made changes to the Senate Bill (HR 3590), which became law on 3/23/2010. Both bills are now law, and together we refer to them as the health care reform package.

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Medicaid Eligibility & Financing Changes	• Beginning January 1, 2014, expands Medicaid to all individuals under age 65 (including all children, pregnant women, parents, and adults with no restriction) with incomes up to 133% FPL based on modified adjusted gross income. As under current law and in the House and Senate-passed bills, undocumented immigrants are not eligible for Medicaid.
	• Guarantees that all newly eligible adults receive a benchmark benefit package that at least provides "Essential Health Benefits" as defined in the law.
	• Eliminates cost-sharing for preventive services in Medicaid and Medicare. For states that provide Medicaid coverage for and remove cost-sharing for preventive services recommended by a federal Preventive Services Task Force and recommended immunizations, provides a one percentage point increase in the FMAP for these services.
	• Beginning April 1, 2010, states have the option to expand Medicaid eligibility to childless adults, but will receive their regular (unenhanced) FMAP until 2014.
	• After 2014, to finance the coverage for the newly eligible (those who were not previously eligible for a full benchmark benefit package or who were eligible for a capped program but were not enrolled), all states except expansion states[2] will receive the following federal Medicaid matching rates (FMAP):
	  • 100% in 2014, 2015, and 2016;
	  • 95% in 2017;
	  • 94% in 2018;
	  • 93% in 2019;
	  • 90% in 2020 and thereafter.
	• Expansion states (states that have already expanded eligibility to adults with incomes up to 100% FPL) will receive a phased-in increase in the FMAP for non-pregnant childless adults so that by 2019 they receive the same federal financing as other states (93% in 2019 and 90% in 2020 and thereafter).
	• Increases Medicaid payments in fee-for-service and managed care for primary care services provided by primary care doctors (family medicine, general internal medicine, or pediatric medicine) to 100% of the Medicare payment rates for 2013 and 2014. States will receive 100% federal financing for the increased payment rates.

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Funding for the Territories	• Each territory (Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa) that elects to establish a Health Benefits Exchange, which must meet certain terms and conditions, will be entitled to payment from a $1 billion appropriation in the following allocation amounts in the period between 2014 and 2019:
	  ◦ $925 million for Puerto Rico
	  ◦ $75 million for the other territories
	• Raises the caps on federal Medicaid funding for each of the territories for the period July 1, 2011 to September 30, 2019 by an amount such that the total additional payments equal $6.3 billion.

Treatment of CHIP	• Require states to maintain current income eligibility levels for children in Medicaid and the Children's Health Insurance Program (CHIP) until 2019 and extend funding for CHIP through 2015. CHIP benefit package and cost sharing rules will continue as under current law. • Beginning in 2015, states will receive a 23 percentage point increase in the CHIP match rate up to a cap of 100%. • CHIP-eligible children who are unable to enroll in the program due to enrollment caps will be eligible for tax credits in the state Exchanges.
Medicare Reimbursement for FQHCs	• FQHC preventive services are updated to include an expanded list of preventives services covered under Medicare, effective for services provided on or after January 1, 2011. • FQHCs' Medicare reimbursement will be updated to a new PPS payment methodology effective on or after October 2014. At this time, both the Medicare cap and productivity screen are eliminated.
Prevention and Wellness Programs	• Establishes a Prevention and Public Health Fund and appropriates $7 billion in funding for fiscal years 2010 through 2015 and $2 billion for each fiscal year after 2015 for prevention, wellness, and public health activities, including prevention research and health screenings, the Education and Outreach Campaign for preventive benefits, and immunization programs. • Provides grants for up to five years to small employers that establish wellness programs. • Establishes a demonstration program for health centers to receive funding for drafting individualized patient wellness plans. • Directs the President to establish the *"National Prevention, Health Promotion and Public Health Council"* composed of the heads of

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	Federal departments and agencies (including HHS, DHS, Agriculture, Transportation, FTC, FCC, etc.), dedicated to promoting "healthy policies" at the federal level, as proposed in the HELP Committee bill. • Formally establishes and charges the Community Preventive Services Task Force to review effectiveness of clinical and community-based preventive services and make recommendations.

Individual Mandate	• Requires U.S. citizens and legal residents to have qualifying health coverage.
	• Those without coverage pay a tax penalty of the greater of $695 per year up to a maximum of three times that amount ($2,085) per family or 2.5% of household income.
	• The penalty will be phased in according to the following schedule:
	  • $95 in 2014 for the flat fee
	  • $325 in 2015 for the flat fee
	  • $695 in 2016 for the flat fee
	  OR
	  • 1.0% of taxable income in 2014
	  • 2.0% of taxable income in 2015
	  • 2.5% of taxable income in 2016
	• Beginning after 2016, the penalty will be increased annually by the cost-of-living adjustment.
	• Exemptions will be granted for various groups (i.e. financial hardship, religious objections, American Indians, and others).

Premium and Cost-Sharing Subsidies to Individuals	• Improves the financing for premiums and cost sharing for individuals with incomes up to 400% of the federal poverty level by improving tax credits to make premiums more affordable as a percent of income and improving support for cost sharing with a focus on those with incomes below 250% of the federal poverty level. • Limits availability of premium credits and cost-sharing subsidies through the Exchanges to U.S. citizens and legal immigrants who meet income limits. Employees who are offered coverage by an employer are not eligible for premium credits unless the employer plan does not have an actuarial value of at least 60% or if the employee-share of the premium exceeds 9.8% of income. Legal immigrants who are barred from enrolling in Medicaid during their first five years in the U.S. will be eligible for premium credits. • Provides refundable and advanceable premium credits to eligible individuals and families with incomes between 133-400% FPL to purchase insurance through the Exchanges on a sliding scale so that individual premium contributions are limited to the following

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	percentages of income: • Up to 133% FPL: 2% of income • 133-150% FPL: 3 – 4% of income • 150-200% FPL: 4 – 6.3% of income • 200-250% FPL: 6.3 – 8.05% of income • 250-300% FPL: 8.05 – 9.5% of income • 300-400% FPL: 9.5% of income
Employer Requirements	• Employers with 50 or fewer employees will be exempt from any penalties. • Assesses a fee of $2,000 per full-time employee on employers with more than 50 employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit, starting with a firm's 31st employee; excludes the first 30 employees from the assessment. • Starting January 1, 2014, employers with more than 50 employees that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of $3,000 for each employee receiving a premium credit or $2,000 for each full-time employee. • Starting January 1, 2014, requires employers that offer coverage to their employees to provide a free choice voucher to employees with incomes less than 400% FPL whose share of the premium exceeds 8% but is less than 9.8% of their income and who choose to enroll in a plan in the Exchange. The voucher amount is equal to what the employer would have paid to provide coverage to the employee under the employer's plan and will be used to offset the premium costs for the plan in which the employee is enrolled. Employers providing free choice vouchers will not be subject to penalties for employees that receive premium credits in Exchange.
Premium Subsidies to Employers	• Provide employers with no more than 25 employees and average annual wages of less than $50,000 that purchase health insurance for employees with a tax credit. • Phase I: For tax years 2010 through 2013, provide a tax credit of up to 35% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost or 50% of a benchmark premium. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $25,000. The credit phases-out as firm size and average wage increases. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 25% of the employer's contribution toward the employee's health insurance

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	premium. • Phase II: For tax years 2014 and later, for eligible small businesses that purchase coverage through the state Exchange, provide a tax credit of up to 50% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost. The credit will be available for two years. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $25,000. The credit phases-out as firm size and average wage increases. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 35% of the employer's contribution toward the employee's health insurance premium.
Health Insurance Exchange	• Creates state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a government or non-profit entity, through which individuals and small businesses with up to 100 employees can purchase qualified coverage. Funding available to states to establish Exchanges within one year of enactment and until January 1, 2015. • Permits states to allow businesses with more than 100 employees to purchase coverage in the SHOP Exchange beginning in 2017. • Requires the Office of Personnel Management to contract with insurers to offer at least two multi-state plans in each Exchange. At least one plan must be offered by a non-profit entity and at least one plan must not provide coverage for abortions beyond those permitted by federal law. Each multi-state plan must be licensed in each state and must meet the qualifications of a qualified health plan. If a state has lower age rating requirements than 3:1, the state may require multi-state plans to meet the more protective age rating rules. These multi-state plans will be offered separately from the Federal Employees Health Benefit Program and will have a separate risk pool. • Authorizes a Consumer Operated and Oriented Plan (CO-OP) program of $6 billion to promote the creation of non-profit, member-run health insurance companies in all 50 states and the District of Columbia. • Permits states option to create a Basic Health Plan for uninsured individuals between 133-200% FPL. States would leverage federal subsidies to negotiate with plans, providers, companies, etc to purchase health care at a better value for families. • **Requires all plans operating in the Exchanges to pay FQHCs a rate that is no less than their Medicaid PPS rates.**
Network Adequacy Standards for Exchange Plans	• Basic exchange plans must contract with 'essential community providers,' defined as safety net providers including 340B eligible entities, which includes all FQHCs. • Private insurers would be required to develop and implement reimbursement structures to provide incentives for high quality care

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	to address: care coordination; hospital readmissions; use of best clinical practices, evidence-based medicine and HIT; wellness; and other measures.

Required Benefits in Exchange Plans	• Qualified health insurance plans would be required to offer at least "essential benefits" and would need to meet additional criteria to receive required certification by a Gateway.
	• Essential Health Benefits must include: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; medical and surgical care; mental health and substance abuse; prescription drugs; rehabilitative, habilitative, and laboratory services; preventative and wellness services; pediatric services (including oral and vision).
	• Creates 4 benefit categories to be offered through individual and small business exchange plans with out of pocket limits at current law HSA levels:
	  • *Bronze* plan includes essential benefits and covers 60% of the cost of the plan;
	  • *Silver* plan includes essential benefits and covers 70% of the cost of the plan;
	  • *Gold* plan includes essential benefits, and covers 80% of the cost of the plan;
	  • *Platinum* plan includes essential benefits and covers 90% of the cost of the plan; and
	  • *Catastrophic* plan to those under 30 or exempt from the mandate and provides catastrophic coverage at current law HSA levels.
	• The community health insurance option is considered a qualified insurance plan and must offer coverage and benefits according to the standards of other qualified plans.

Medicaid Interaction with the Exchange	• CHIP would be maintained at current eligibility and benefits levels with cost-sharing under current law until 2015; after 2014, CHIP-eligible children who are not able enroll in CHIP due to enrollment caps would be eligible for tax credits in state Exchanges. • States would be required to maintain eligibility levels for Medicaid until 2019. Beginning in 2014, individuals with incomes between 100-400% FPL would be eligible for subsidies to purchase insurance through the Exchanges although individuals with incomes less than 133% FPL are intended to get coverage through Medicaid..
Teaching Health Centers	• Authorizes Title VII grant program for development of Teaching Health Centers, defined as community-based ambulatory patient care centers operating a primary care residency program. • Creates new Sec. 340H in the PHSA which would provide per-resident payments to teaching health centers for operation of

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	residency programs, covering both direct and indirect costs. Establishes a baseline year and allows payment for residency slots created above the baseline. • Strictly prohibits hospitals from receiving payments for Sec. 340H reimbursed time. • Appropriates directly $230 million in funding for 340H over 5 yrs.
Medical Home & Coordinated Care Demonstrations	• Authorizes a new Center for Medicare Innovation to carry out innovative projects, such as medical homes and ACOs (below). • Creates a new Medicaid state plan option in 2011 under which enrollees with two or more chronic conditions including behavioral health conditions (especially those with at least 1 seriously and persistent mental health condition) qualify for care under a team of health providers offering a comprehensive list of services; teams can be free-standing, virtual, at a CHC, hospital, community mental health center, clinic, physician's office or group practice. • Establishes Pediatric Medicaid and Medicare demonstration projects where states apply to the CMS Secretary to allow providers who meet certain criteria to be recognized as an Accountable Care Organization (ACO) and be eligible to share in the federal and state cost savings achieved by Medicaid, CHIP and Medicare. • Establishes a new office within CMS for the coordination of care for dual eligibles.
HPSA / MUA Shortage Designation Guidelines	• Would establish a process of "negotiated rulemaking" between HHS and stakeholders to determine new criteria and methodology for defining Health Professional Shortage Area (HPSA) and Medically Underserved Area (MUA) measurements.
340B Managed Care Organization	• Would extend Medicaid rebates to 340B drugs purchased by a Medicaid Managed Care Organization (exempts covered drugs from rebate if subject to 340B discount). • Drugs Purchased by Covered Entities**.** Repeals the underlying 340B expansion to inpatient drugs and exemptions to GPO exclusion. Exempts orphan drugs from required discounts for new 340B entities.