Rural Health Clinics

Impact of the ACA and Health System

Change on the Iowa Safety Net

University of Iowa

Public Policy Center

*DRAFT*

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# Rural Health Clinics

## Introduction

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.[[1]](#endnote-1) RHCs are required to provide out-patient primary care services and basic laboratory services.[[2]](#endnote-2)

Eligibility Criteria for being certified as a RHC by the Centers for Medicare and Medicaid Services (CMS): 1

* 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.[[3]](#endnote-3)

As of January 2012, 142 CMS-certified Rural Health Clinics (RHC) operated in 58 Iowa counties.[[4]](#endnote-4) 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.[[5]](#endnote-5) RHCs are either provider-based (owned by hospital) or freestanding (provider owned). In Iowa, 76 percent of RHCs are provider-based owned by hospitals.[[6]](#endnote-6)

In a recent statewide health assessment, 92 of 99 counties identified access to health services as an issue.[[7]](#endnote-7) Inadequate transportation has long been identified as a major access issue in rural Iowa where 44 percent [this would now be 40 percent] of Iowans live and 22 percent of rural Iowans are over the age of 65.[[8]](#endnote-8) 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]](#endnote-9) Payment is based on an all-inclusive payment methodology, subject to a maximum payment per visit and annual reconciliation.[[10]](#endnote-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]](#endnote-11) Laboratory tests are paid separately.[[12]](#endnote-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]](#endnote-13)

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

Table 1: Revenues and Expenses of RHCs nationally in 2000(8)

|  |
| --- |
| **Total Revenues, Expenses, and Adjusted-Cost-Per-Visit** |
| Total Total Adjusted Cost  Revenues N Expenses N Per Visit N |
| All RHCs $641,683 229 $681,457 229 $71.51 229 |
| Independent RHCs $690,669 148 $731,174 148 $66.31 148 |
| Provider-Based RHCs $552,176 81 $590,617 81 $81.01 81 |

**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 2: Proportion of Revenues and Patient Visits of RHCs by Payer nationally in 2000 (8):



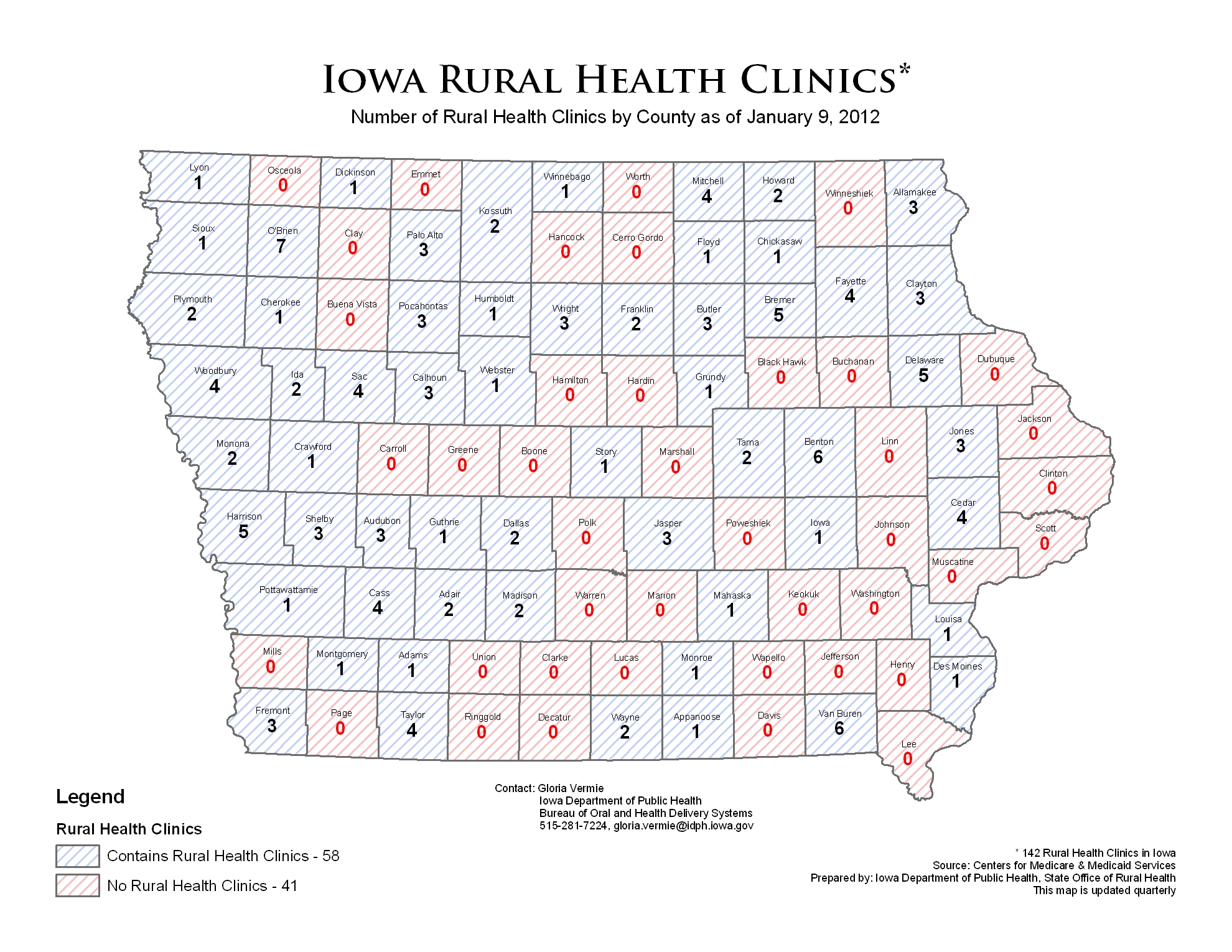
**Source: 2000 National Survey of Rural Health Clinics, Muskie School of Public Service, University of Southern Maine**

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]](#endnote-14)

## RHC Provider Network

There were 142 RHCs in Iowa as of January 2012 (Figure 1).[[15]](#endnote-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]](#endnote-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 (10):



**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:[[17]](#endnote-17)

**Table 3: Provider FTEs by type in Iowa**

|  |  |
| --- | --- |
| **Provider Type** | **FTEs** |
| Physician | 198.92 |
| Physician Assistant | 78.49 |
| Nurse Practitioner | 62.65 |
| Other Personnel | 523.12 |

**Source: Rural Health Clinics Health Systems (POS) Site Directory. HRSA, 2011.**

The National Health Service Corps (NHSC), a program for placing clinicians in underserved areas, staff many RHCs.[[18]](#endnote-18)

### Services Provided

HRSA’s data also indicated the following services being available at RHCs and reimbursable by Medicare and Medicaid (Table 4).[[19]](#endnote-19) Service reimbursement shown in Table 4 is nationally applicable.

**Table 4: Services available at RHCs as reimbursable by Medicare and Medicaid**



**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, 8 percent were uninsured and 13 percent received Medicaid.[[20]](#endnote-20)

\* 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 2011, 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 and encounter count in 2011\*:**

|  |  |
| --- | --- |
|  |  |
|  |  |

\* Age🡪 n=31 RHCs for unduplicated patients, n= 21-24 for encounters; Insurance status🡪 n=26-28 RHCs for unduplicated patients, n= 29-32 for encounters

**Source: Calendar Year 2011 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.

## Data Sources

1. Calendar Year 2011 Data Report – Iowa Collaborative Safety Net Provider Network.
2. Iowa Rural & Agricultural Health and Safety Resource Plan 2011. Accessed from: <http://www.idph.state.ia.us/hpcdp/common/pdf/health_care_access/healthcare.pdf> on September 1st, 2011.
3. Center for Rural Health and Primary Care. 2010 Annual Report. Iowa Department of Public Health. Accessed from: <http://www.idph.state.ia.us/hpcdp/common/pdf/health_care_access/2010_rhpc_annualreport.pdf> on August 29th, 2011.
4. Understanding community health needs in Iowa. Accessed from: <http://www.idph.state.ia.us/chnahip/common/pdf/health_needs_2011.pdf> on February 12th, 2012.
5. Iowa Rural and Agricultural Health and Safety Resource Plan. Section two: Access to health services. Accessed from: <http://www.idph.state.ia.us/hpcdp/common/pdf/health_care_access/access_health_services.pdf> on February 12th, 2012.
6. Rural health clinics factsheet. <https://www.cms.gov/MLNProducts/downloads/RuralHlthClinfctsht.pdf>
7. CMS Manual System: Pub 100-04. Medicare Claims Processing Transmittal 2343. November 4, 2011.
8. The Characteristics and Roles of Rural Health Clinics in the U.S. - A Chartbook. Edmund S. Muskie School of Public Service – Univ. of Southern Maine. Accessed from: <http://www.idph.state.ia.us/IDPHChannelsService/file.ashx?file=414721DF-ABE8-46B3-8E7D-BE38B4328B80> on August 13, 2012.
9. MSIS State Summary. Medicaid Beneficiaries and Program type for FY2008 and FY2009. Data provided as excel sheet by Bill Finerfrock.
10. Iowa Rural Health Clinics. Accessed from: <http://www.idph.state.ia.us/hpcdp/common/pdf/health_care_access/rural_health_clinic_map.pdf> on February 10th, 2012.
11. Rural Health Clinics Health Systems (POS) Site Directory. HRSA Database. Accessed from: <http://ersrs.hrsa.gov/ReportServer?/HGDW_Reports/CMS_Reports/RuralHealthClinics&rs:Format=HTML3.2> on September 5th, 2011.
12. Comparison of the Rural Health Clinic and Federally Qualified Health Center Programs. <http://www.ask.hrsa.gov/downloads/fqhc-rhccomparison.pdf>
13. National Health Service Corp, US Department of Health and Human Services. Accessed from: <http://nhsc.hrsa.gov/> on May 14, 2012.

**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.[[21]](#endnote-21) 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.[[22]](#endnote-22)

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.[[23]](#endnote-23) 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.[[24]](#endnote-24)

Finally, the ACA establishes a grant for developing teaching health centers in order to prepare primary care residents.[[25]](#endnote-25) A rural health clinic is explicitly defined by the ACA as a teaching health center.[[26]](#endnote-26) Grants under this section are limited to three years and a total award of $500,000.[[27]](#endnote-27) 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.[[28]](#endnote-28) Direct costs are calculated according to: payments per resident multiplied by the number of residents in the center’s residency program.[[29]](#endnote-29) Additionally, indirect medical education expenses are also reimbursed to a teaching health center.[[30]](#endnote-30)

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.[[31]](#endnote-31) The ACA establishes an option for states to provide health homes for individuals with chronic conditions.[[32]](#endnote-32) A rural health clinic is explicitly defined by the ACA as a designated provider capable of delivering health home services, which include: comprehensive care management, comprehensive transitional care, patient and family support, and referral to community and social support services.[[33]](#endnote-33)

The ACA amends the Public Health Service Act in order to provide grants for area health education centers.[[34]](#endnote-34) Grants are for no less than $250,000 per year per health education center and for a maximum of 12 years.[[35]](#endnote-35) The grant awards require a range of activities including: minority recruitment into the health professions and preparation of individuals for placement in underserved areas.[[36]](#endnote-36) 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.[[37]](#endnote-37)

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.[[38]](#endnote-38) Included in the funded activities are: professional training programs, need-based financial assistance, community-based training, and primary care capacity building programs.[[39]](#endnote-39) The ACA emphasizes primary care training in community-based settings. Maximum length of time for a grant is 5 years per entity.[[40]](#endnote-40)

The ACA expands the authority for MACPAC (Medicaid and CHIP Payment and Access Commission) to review and assess payment policies for rural health clinics.[[41]](#endnote-41) MACPAC’s reporting requirements are also increased by adding required reports to Congress.[[42]](#endnote-42)

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.[[43]](#endnote-43) Participating rural health clinics are reimbursed according to the ACA for reasonable costs associated with providing training to the graduate nurses.[[44]](#endnote-44)

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.[[45]](#endnote-45) 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.[[46]](#endnote-46) Priority is given to grant applicants who have a formal agreement with a rural health center.[[47]](#endnote-47)

Full Text for ACA Provisions Affecting Rural Health Clinics

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

**Demonstration project on community health integration models in certain rural counties.**Act July 15, 2008, [P.L. 110-275](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14682624724&homeCsi=6362&A=0.7155077190415257&urlEnc=ISO-8859-1&&citeString=110%20PL%20275&countryCode=USA&_md5=00000000000000000000000000000000), Title I, Subtitle B, § 123,[122 Stat. 2514](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14682624724&homeCsi=6362&A=0.7155077190415257&urlEnc=ISO-8859-1&&citeString=122%20STAT%202514&countryCode=USA&_md5=00000000000000000000000000000000); March 23, 2010, [P.L. 111-148](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14682624724&homeCsi=6362&A=0.7155077190415257&urlEnc=ISO-8859-1&&citeString=111%20PL%20148&countryCode=USA&_md5=00000000000000000000000000000000), Title III, Subtitle B, Part II, § 3126, [124 Stat. 425](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14682624724&homeCsi=6362&A=0.7155077190415257&urlEnc=ISO-8859-1&&citeString=124%20STAT%20425&countryCode=USA&_md5=00000000000000000000000000000000), provides:  
   "(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 essential 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](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14682624724&homeCsi=6362&A=0.7155077190415257&urlEnc=ISO-8859-1&&citeString=42%20USC%201395I-4&countryCode=USA&_md5=00000000000000000000000000000000" \t "_parent)**[-4(g)](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14682624724&homeCsi=6362&A=0.7155077190415257&urlEnc=ISO-8859-1&&citeString=42%20USC%201395I-4&countryCode=USA&_md5=00000000000000000000000000000000" \t "_parent)); 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](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14682624724&homeCsi=6362&A=0.7155077190415257&urlEnc=ISO-8859-1&&citeString=42%20USC%201395&countryCode=USA&_md5=00000000000000000000000000000000) 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](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14682624724&homeCsi=6362&A=0.7155077190415257&urlEnc=ISO-8859-1&&citeString=42%20USC%201395I&countryCode=USA&_md5=00000000000000000000000000000000" \t "_parent)**) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act ([42 U.S.C. 1395t](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14682624724&homeCsi=6362&A=0.7155077190415257&urlEnc=ISO-8859-1&&citeString=42%20USC%201395T&countryCode=USA&_md5=00000000000000000000000000000000)), 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](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14682624724&homeCsi=6362&A=0.7155077190415257&urlEnc=ISO-8859-1&&citeString=42%20USC%201395&countryCode=USA&_md5=00000000000000000000000000000000) 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)](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14682624724&homeCsi=6362&A=0.7155077190415257&urlEnc=ISO-8859-1&&citeString=42%20USC%201395YY&countryCode=USA&_md5=00000000000000000000000000000000)).  
      "(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](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14682624724&homeCsi=6362&A=0.7155077190415257&urlEnc=ISO-8859-1&&citeString=42%20USC%201395I-4&countryCode=USA&_md5=00000000000000000000000000000000" \t "_parent)**[-4(c)](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14682624724&homeCsi=6362&A=0.7155077190415257&urlEnc=ISO-8859-1&&citeString=42%20USC%201395I-4&countryCode=USA&_md5=00000000000000000000000000000000" \t "_parent)).  
      "(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)](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14682624724&homeCsi=6362&A=0.7155077190415257&urlEnc=ISO-8859-1&&citeString=42%20USC%201395X&countryCode=USA&_md5=00000000000000000000000000000000)).  
      "(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)](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14682624724&homeCsi=6362&A=0.7155077190415257&urlEnc=ISO-8859-1&&citeString=42%20USC%201395X&countryCode=USA&_md5=00000000000000000000000000000000)).  
      "(6) Medicaid program. The term 'Medicaid program' means the program under title XIX of such Act ([42 U.S.C. 1396](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14682624724&homeCsi=6362&A=0.7155077190415257&urlEnc=ISO-8859-1&&citeString=42%20USC%201396&countryCode=USA&_md5=00000000000000000000000000000000) et seq.).  
      "(7) Medicare program. The term 'Medicare program' means the program under title XVIII of such Act ([42 U.S.C. 1395](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14682624724&homeCsi=6362&A=0.7155077190415257&urlEnc=ISO-8859-1&&citeString=42%20USC%201395&countryCode=USA&_md5=00000000000000000000000000000000) 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)](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14682624724&homeCsi=6362&A=0.7155077190415257&urlEnc=ISO-8859-1&&citeString=42%20USC%201395X&countryCode=USA&_md5=00000000000000000000000000000000))).  
         "(B) Physicians' services (as defined in section 1861(q) of the Social Security Act ([42 U.S.C. 1395x(q)](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14682624724&homeCsi=6362&A=0.7155077190415257&urlEnc=ISO-8859-1&&citeString=42%20USC%201395X&countryCode=USA&_md5=00000000000000000000000000000000)).  
         "(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);

‘‘(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](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14683346878&homeCsi=6362&A=0.9219669318302007&urlEnc=ISO-8859-1&&citeString=42%20USC%201396&countryCode=USA&_md5=00000000000000000000000000000000) et seq.] (in this section referred to as "Medicaid") and the State Children's Health Insurance Program established under title XXI [[42 USCS §§ 1397aa](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14683346878&homeCsi=6362&A=0.9219669318302007&urlEnc=ISO-8859-1&&citeString=42%20USC%201397AA&countryCode=USA&_md5=00000000000000000000000000000000) 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](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14683346878&homeCsi=6362&A=0.9219669318302007&urlEnc=ISO-8859-1&&citeString=42%20USC%201396&countryCode=USA&_md5=00000000000000000000000000000000) et seq. or [1397aa](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14683346878&homeCsi=6362&A=0.9219669318302007&urlEnc=ISO-8859-1&&citeString=42%20USC%201397AA&countryCode=USA&_md5=00000000000000000000000000000000) 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](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14683346878&homeCsi=6362&A=0.9219669318302007&urlEnc=ISO-8859-1&&citeString=42%20USC%201395&countryCode=USA&_md5=00000000000000000000000000000000) 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](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14683346878&homeCsi=6362&A=0.9219669318302007&urlEnc=ISO-8859-1&&citeString=42%20USC%201396&countryCode=USA&_md5=00000000000000000000000000000000) et seq. or[1397aa](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14683346878&homeCsi=6362&A=0.9219669318302007&urlEnc=ISO-8859-1&&citeString=42%20USC%201397AA&countryCode=USA&_md5=00000000000000000000000000000000) 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](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14683346878&homeCsi=6362&A=0.9219669318302007&urlEnc=ISO-8859-1&&citeString=42%20USC%201395B-6&countryCode=USA&_md5=00000000000000000000000000000000)] 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](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14683346878&homeCsi=6362&A=0.9219669318302007&urlEnc=ISO-8859-1&&citeString=42%20USC%201395&countryCode=USA&_md5=00000000000000000000000000000000)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](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14683346878&homeCsi=6362&A=0.9219669318302007&urlEnc=ISO-8859-1&&citeString=42%20USC%201315B&countryCode=USA&_md5=00000000000000000000000000000000)] 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 I of the Ethics in Government Act of 1978 [[5 USCS Appx. §§ 101](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14683346878&homeCsi=6362&A=0.9219669318302007&urlEnc=ISO-8859-1&&citeString=5%20USC%20APPX%20101&countryCode=USA&_md5=00000000000000000000000000000000) et seq.] ([Public Law 95-521](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14683346878&homeCsi=6362&A=0.9219669318302007&urlEnc=ISO-8859-1&&citeString=95%20PL%20521&countryCode=USA&_md5=00000000000000000000000000000000)).  
   (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](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14683346878&homeCsi=6362&A=0.9219669318302007&urlEnc=ISO-8859-1&&citeString=5%20USC%205315&countryCode=USA&_md5=00000000000000000000000000000000); 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](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14683346878&homeCsi=6362&A=0.9219669318302007&urlEnc=ISO-8859-1&&citeString=5%20USC%205948&countryCode=USA&_md5=00000000000000000000000000000000), 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](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14683346878&homeCsi=6362&A=0.9219669318302007&urlEnc=ISO-8859-1&&citeString=41%20USC%205&countryCode=USA&_md5=00000000000000000000000000000000))) [[41 USCS § 6101](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14683346878&homeCsi=6362&A=0.9219669318302007&urlEnc=ISO-8859-1&&citeString=41%20USC%206101&countryCode=USA&_md5=00000000000000000000000000000000)];  
   (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)](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14683346878&homeCsi=6362&A=0.9219669318302007&urlEnc=ISO-8859-1&&citeString=42%20USC%201396B&countryCode=USA&_md5=00000000000000000000000000000000) and [1397ee(a)](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14683346878&homeCsi=6362&A=0.9219669318302007&urlEnc=ISO-8859-1&&citeString=42%20USC%201397EE&countryCode=USA&_md5=00000000000000000000000000000000)], 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)](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14683346878&homeCsi=6362&A=0.9219669318302007&urlEnc=ISO-8859-1&&citeString=42%20USC%201397DD&countryCode=USA&_md5=00000000000000000000000000000000)], 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](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14683421354&homeCsi=6362&A=0.7955624213735505&urlEnc=ISO-8859-1&&citeString=42%20USC%201395&countryCode=USA&_md5=00000000000000000000000000000000) 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)](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14683421354&homeCsi=6362&A=0.7955624213735505&urlEnc=ISO-8859-1&&citeString=42%20USC%201395X&countryCode=USA&_md5=00000000000000000000000000000000))) 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](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14683421354&homeCsi=6362&A=0.7955624213735505&urlEnc=ISO-8859-1&&citeString=42%20USC%201301&countryCode=USA&_md5=00000000000000000000000000000000) et seq. and [1395](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14683421354&homeCsi=6362&A=0.7955624213735505&urlEnc=ISO-8859-1&&citeString=42%20USC%201395&countryCode=USA&_md5=00000000000000000000000000000000)et seq.] as may be necessary to carry out the demonstration.  
      "(4) Administration. Chapter 35 of title 44, United States Code [[44 USCS §§ 3501](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14683421354&homeCsi=6362&A=0.7955624213735505&urlEnc=ISO-8859-1&&citeString=44%20USC%203501&countryCode=USA&_md5=00000000000000000000000000000000) 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](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14683421354&homeCsi=6362&A=0.7955624213735505&urlEnc=ISO-8859-1&&citeString=42%20USC%201395X&countryCode=USA&_md5=00000000000000000000000000000000))).  
         "(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](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14683421354&homeCsi=6362&A=0.7955624213735505&urlEnc=ISO-8859-1&&citeString=42%20USC%20256&countryCode=USA&_md5=00000000000000000000000000000000)]) 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](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14683421354&homeCsi=6362&A=0.7955624213735505&urlEnc=ISO-8859-1&&citeString=42%20USC%201395X&countryCode=USA&_md5=00000000000000000000000000000000))) 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](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14683421354&homeCsi=6362&A=0.7955624213735505&urlEnc=ISO-8859-1&&citeString=42%20USC%201395C&countryCode=USA&_md5=00000000000000000000000000000000) et seq.], or enrolled under part B of such [title [42 USCS §§ 1395j](http://www.lexisnexis.com/lnacui2api/mungo/lexseestat.do?bct=A&risb=21_T14683421354&homeCsi=6362&A=0.7955624213735505&urlEnc=ISO-8859-1&&citeString=42%20USC%201395J&countryCode=USA&_md5=00000000000000000000000000000000) 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 heath dentistry, or dental hygiene;  
      (C) to plan, develop, and operate a program for the training of oral health care providers who plan to teach in general, pediatric, public health dentistry, or dental hygiene;  
      (D) to provide financial assistance in the form of traineeships and fellowships to dentists who plan to teach or are teaching in general, pediatric, or public health dentistry;  
      (E) to meet the costs of projects to establish, maintain, or improve dental faculty development programs in primary care (which may be departments, divisions or other units);  
      (F) to meet the costs of projects to establish, maintain, or improve predoctoral and postdoctoral training in primary care programs;  
      (G) to create a loan repayment program for faculty in dental programs; and  
      (H) to provide technical assistance to pediatric training programs in developing and implementing instruction regarding the oral health status, dental care needs, and risk-based clinical disease management of all pediatric populations with an emphasis on underserved children.  
   (2) Faculty loan repayment.  
      (A) In general. A grant or contract under subsection (a)(1)(G) may be awarded to a program of general, pediatric, or public health dentistry described in such subsection to plan, develop, and operate a loan repayment program under which--  
         (i) individuals agree to serve full-time as faculty members; and  
         (ii) the program of general, pediatric or public health dentistry agrees to pay the principal and interest on the outstanding student loans of the individuals.  
      (B) Manner of payments. With respect to the payments described in subparagraph (A)(ii), upon completion by an individual of each of the first, second, third, fourth, and fifth years of service, the program shall pay an amount equal to 10, 15, 20, 25, and 30 percent, respectively, of the individual's student loan balance as calculated based on principal and interest owed at the initiation of the agreement.  
   
(b) Eligible entity. For purposes of this subsection, entities eligible for such grants or contracts in general, pediatric, or public health dentistry shall include entities that have programs in dental or dental hygiene schools, or approved residency or advanced education programs in the practice of general, pediatric, or public health dentistry. Eligible entities may partner with schools of public health to permit the education of dental students, residents, and dental hygiene students for a master's year in public health at a school of public health.  
   
(c) Priorities in making awards. With respect to training provided for under this section, the Secretary shall give priority in awarding grants or contracts to the following:  
   (1) Qualified applicants that propose collaborative projects between departments of primary care medicine and departments of general, pediatric, or public health dentistry.  
   (2) Qualified applicants that have a record of training the greatest percentage of providers, or that have demonstrated significant improvements in the percentage of providers, who enter and remain in general, pediatric, or public health dentistry.  
   (3) Qualified applicants that have a record of training individuals who are from a rural or disadvantaged background, or from underrepresented minorities.  
   (4) Qualified applicants that establish formal relationships with Federally qualified health centers, rural health centers, or accredited teaching facilities and that conduct training of students, residents, fellows, or faculty at the center or facility.  
   (5) Qualified applicants that conduct teaching programs targeting vulnerable populations such as older adults, homeless individuals, victims of abuse or trauma, individuals with mental health or substance-related disorders, individuals with disabilities, and individuals with HIV/AIDS, and in the risk-based clinical disease management of all populations.  
   (6) Qualified applicants that include educational activities in cultural competency and health literacy.  
   (7) Qualified applicants that have a high rate for placing graduates in practice settings that serve underserved areas or health disparity populations, or who achieve a significant increase in the rate of placing graduates in such settings.  
   (8) Qualified applicants that intend to establish a special populations oral health care education center or training program for the didactic and clinical education of dentists, dental health professionals, and dental hygienists who plan to teach oral health care for people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and vulnerable elderly.  
   
(d) Application. An eligible entity desiring a grant under this section shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.  
   
(e) Duration of award. The period during which payments are made to an entity from an award of a grant or contract under subsection (a) shall be 5 years. The provision of such payments shall be subject to annual approval by the Secretary and subject to the availability of appropriations for the fiscal year involved to make the payments.  
   
(f) Authorizations of appropriations. For the purpose of carrying out subsections (a) and (b), there is authorized to be appropriated $ 30,000,000 for fiscal year 2010 and such sums as may be necessary for each of fiscal years 2011 through 2015.  
   
(g) Carryover funds. An entity that receives an award under this section may carry over funds from 1 fiscal year to another without obtaining approval from the Secretary. In no case may any funds be carried over pursuant to the preceding sentence for more than 3 years.

1. The Characteristics and Roles of RHCs in the U.S. - A Chartbook. Edmund S. Muskie School of Public Service – Univ. of Southern Maine. Accessed from: <http://www.idph.state.ia.us/hpcdp/common/pdf/health_care_access/characteristics_rhc.pdf> on September 1, 2011. [↑](#endnote-ref-1)
2. The Characteristics and Roles of RHCs in the U.S. - A Chartbook. Edmund S. Muskie School of Public Service – Univ. of Southern Maine. Accessed from: <http://www.idph.state.ia.us/hpcdp/common/pdf/health_care_access/characteristics_rhc.pdf> on September 1, 2011. [↑](#endnote-ref-2)
3. The Characteristics and Roles of RHCs in the U.S. - A Chartbook. Edmund S. Muskie School of Public Service – Univ. of Southern Maine. Accessed from: <http://www.idph.state.ia.us/hpcdp/common/pdf/health_care_access/characteristics_rhc.pdf> on September 1, 2011. [↑](#endnote-ref-3)
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