

Issue	Health Reform Law: P.L. 111-148 as amended by P.L. 111-152	Implementation
<p>Definitions</p>	<p>“Health disparity population” is defined in the bill as defined in Section 485E (Sec. 931) Current Law: <i>“a population is a health disparity population if, as determined by the Director of the Center after consultation with the Director of the Agency for Healthcare Research and Quality, there is a significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates in the population as compared to the health status of the general population, in addition to the meaning so given, the Director may determine that such term includes populations for which there is a significant disparity in the quality, outcomes, cost, or use of healthcare services or access to or satisfaction with such services as compared to the general population.”</i> (PHSA Sec. 485E)</p> <p>“Cultural Competency” shall be defined by the Secretary in a manner consistent with section 1707(d)(3). (Sec. 5001) Current Law: <i>“The Secretary shall ensure that information and services provided pursuant to subsection (b) are provided in the language, educational, and cultural context that is most appropriate for the individuals for whom the information and services are intended.”</i> (PHSA Sec. 1707(d)(3))</p>	
<p>Health Insurance Exchanges</p>	<p>Consumer Choice and Insurance Competition through Health Benefit Exchanges (Affordable Choices of Health Benefit Plans) An entity that serves as a navigator under a grant for the establishment of an exchange shall: conduct public education activities to raise awareness of the availability of qualified health plans; distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits; facilitate enrollment in qualified health plans; provide referrals to any applicable office of health insurance consumer assistance or ombudsman; and, provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange or Exchanges. (Sec. 1311)</p> <p>Special Rules The manager’s amendment amends Section 1311(g)(1), “Rewarding Quality Through Market Based Incentives” in the Exchanges, by adding incentives payments for the implementation of activities to reduce health and healthcare disparities, including through the use of language services, community outreach, and cultural competency trainings. (Sec. 1303 of manager’s amendment)</p>	<p>Date: FY 2014 – 2015 Grant available 2014</p> <p>Date: FY2011 – 2015 (must be self-sustained by 01/2015)</p>

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Health Insurance Exchanges (cont.)	<p>Nondiscrimination Prohibits an individual from being excluded from participation in, be denied benefits of, or be subject to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, or any program or activity that is administered by an Executive Agency. The enforcement mechanisms provided for under title VI, title IX, section 504 or the Age Discrimination Act are applicable for use under violation of this section. (Sec. 1557)</p>	<p>Date: Immediate</p>
Individual and Group Market	<p>Development and Utilization of Uniform Explanation of Coverage Documents and Standardized Definition The Secretary shall develop standards for use by the group health plan and a health insurance offering group or individual health insurance coverage, in compiling and providing a summary of benefits and coverage. This explanation shall accurately describe the benefits and coverage under the applicable plan or coverage. In developing the standards the Secretary shall consult with the National Association of Insurance Commissioners, a working group composed of representatives of health insurance-related consumer advocacy organizations, health insurance issuers, healthcare professionals, patient advocates including those representing individuals with limited English proficiency, and other qualified individuals. In developing such standards the Secretary shall provide for the following: the standards shall ensure that the summary is presented in a uniform manner; the summary is presented in a culturally and linguistically appropriate manner and utilizes terminology understandable by the average plan enrollee; the summary includes uniform definitions to enable the consumer to compare health insurance coverage; and a contact number for the consumer to call with any further questions. (Sec. 1001, amends Sec. 2715 of Public Health Services Act)</p> <p>Appeals Process Requires a group health plan and a health insurance issuer offering group or individual health insurance coverage to implement an effective appeals process for appeals of coverage determinations and claims. The process at a minimum shall: have an internal claims appeal process; provide notice to enrollees in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the existence of an ombudsman to assist with the appeals process; and, allow an enrollee to review their file, present evidence or testimony and receive continued coverage pending the outcome of the appeal. (Sec. 1001, amends Sec.2719 of Public Health Service Act)</p>	<p>Date: FY2011 \$: Imposes a fine of \$1000 per each failure to comply.</p> <p>Date: FY2011</p>

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Language Access	<p>Special Rules The manager's amendment amends Section 1331(e) to provide for transparency in coverage. The amendment requires plans in the state exchanges to submit information in plain language. Plain language is further defined as "language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well-organized, and follows other best practices of plain language writing. (Sec. 1303 of manager's amendment)</p>	Date: FY 2013
Quality Improvements	<p>National Strategy for Quality Improvement in Healthcare Establishes a national strategy, through a transparent collaborative process, to improve delivery of healthcare services, patient health outcomes, and population health. The Secretary shall ensure that priorities will: have the greatest potential for improving the health outcomes, efficiency, and patient-centeredness of healthcare for all populations; identify areas in the delivery of healthcare services that have potential for rapid improvement in the quality and efficiency of patient care; address gaps in quality, efficiency, comparative effectiveness information, and health outcome measures and data aggregation techniques; improve Federal payment policy to emphasize quality and efficiency; enhance the use of healthcare data; address the healthcare provided to patients with high-cost chronic diseases; improve research and dissemination of strategies and best practices to improve patient safety and reduce medical errors, preventable admissions and readmissions, and healthcare associated infections; and, reduce health disparities across health disparity populations and geographic areas. (Sec.3011)</p> <p>Quality Improvement Technical Assistance and Implementation The Director, through the Center for Quality Improvement and Patient Safety of the Agency for Healthcare Research and Quality shall award technical assistance grants or contracts to eligible entities, including providers of services and suppliers for which there are disparities in care among subgroups of patients, to provide technical support to institutions that deliver healthcare so that such institutions understand, adapt and implement the models and practices identified by the Center, including the Quality Improvement Networks Research Program. (Sec. 3501)</p>	<p>Date: FY 2011 (updated annually) \$: Budget Neutral</p> <p>Date: FY 2010 - 2014 \$: \$20,000,000 Must have matching fund of equal to \$1 for each \$5.</p>

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<p>Quality Improvements (cont.)</p>	<p>Maternal, Infant and Early Childhood Home Visiting Programs The purpose is to strengthen and improve maternal, infant and early childhood home visiting programs, improve coordination of services, and provide comprehensive services to improve outcomes for families who reside in at risk communities. As a condition for receiving funding, each state shall conduct an assessment that identifies: communities with concentrations of premature birth, low-birth weight infants, and infant mortality, poverty, crime, domestic violence, high rates of high-school dropouts, substance abuse, unemployment, or child maltreatment; the quality of existing childhood home visitation programs in the state, and the extent that these programs meet the needs of eligible families; and the state's capacity to provide substance abuse treatment and counseling to individuals or families in need. The Secretary shall award grants to entities to enable the entities to deliver services under early childhood visitation programs. Recipients of these grants must be able to demonstrate improvement in the following areas: improved maternal and newborn health, prevention of child injuries, abuse and neglect, improvement in school readiness and achievement, reduction in crime or domestic violence, improvements in family economic self-sufficiency, and improvements in coordination and referrals for other community resources and support. The bill grants authority to the Secretary to conduct an evaluation of the programs which shall include: an assessment of early childhood home visitation programs on child and parent outcomes, and the effectiveness of such programs on different populations, and to analyze the potential for the programs to improve healthcare practices, eliminate health disparities, and improve healthcare system qualities, efficiencies, and reduce costs. (Sec. 2951)</p> <p>Establishing Community Health Teams to Support the Patient-Centered Medical Home Establishes Health Teams pursuant to a grant or contract. These Health Teams shall: establish contractual agreements with primary care providers to provide support services; support patient-centered medical homes; collaborate with local primary care providers to coordinate disease prevention, chronic disease management and case management; collaborate with local health providers to develop and implement interdisciplinary care plans that integrate clinical and community preventative health promotion services; incorporate all healthcare stakeholders in program design and oversight; and, provide support for local primary care givers to provide quality-driven, cost-effective, culturally appropriate, and patient- and family- centered healthcare. (Sec. 3502)</p>	<p>Date: FY 2011 – 2015 (Secretary shall determine the length) \$: FY 2010 - \$100,000,000 FY 2011 - \$250,000,000 FY 2012 - \$350,000,000 FY 2013 & FY 2014 - \$400,000,000</p> <p>Date: FY 2011 – 2014 (FY 2014 must have plan to be financially sustainable long-term) \$: Authorized to be appropriated such sums as may be necessary</p>

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<p>Quality Improvements (cont.)</p>	<p>Programs to Facilitate Shared Decision-Making. Establishes a program to facilitate collaboration processes between patients and caregivers that engage the patient in decision-making by providing the patient with information about trade-offs among treatment options, and facilitates the incorporation of patient preferences and values into the medical plan. The Secretary shall establish a program to award grants or contracts to develop, update and produce patient decision aids for preference sensitive care to assist the provider in educating the patient concerning the relative safety, effectiveness, and cost of treatment or, where appropriate, palliative care options. The patient decision aids shall be required: to be designed to engage the patients; present up-to-date clinical evidence about risks and benefits of treatment options in a form and manner that is age-appropriate and can be adapted for patients, caregivers, and authorized representatives from a variety of cultural and educational backgrounds to reflect the varying needs of consumers and diverse levels of health literacy; and, to address healthcare decisions across age span, including those affecting vulnerable populations including children. (Sec. 3506)</p> <p>Quality Measure Development The Secretary, in consultation with the Director of the Agency for Healthcare Research and Quality and the Administrators of CMS, shall identify gaps where no quality measures exist and existing measures that need improvement, updating or expansion. The Secretary shall award grants, contracts, or intergovernmental agreements to develop, improve, update, or expand quality measures. Priority for the grants shall be given to the development of quality measures that allow the assessment of: health outcomes and functional status of patients; the management and coordination of care across episodes of care; the use of shared decision-making tools; the meaningful use of health information technology; the safety, effectiveness, patient-centeredness, appropriateness, and timeliness of care; the efficiency of care; the equity of health services and health disparities across health disparity populations and geographic areas; patient experience and satisfaction; and, the use of innovative strategies and methodologies identified under section 933. (Sec. 3013)</p>	<p>Date: As soon as practicable (18 month initial contract) \$: Authorized to be appropriated such sums as may be necessary for FY2010 and each subsequent fiscal year.</p> <p>Date: FY 2010 – 2014, not less than triennially \$: \$75,000,000 for each fiscal year 2010 – 2014.</p>

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<p>Comparative Effectiveness</p>	<p>Patient-Centered Outcomes Research Institute Establishes the Patient-Centered Outcomes Research Institute as a non-profit corporation. The Institute is funded through the Patient-Centered Outcomes Research Trust Fund (PCORTF), and is available without further appropriations. The Institute is intended to assist patients, clinicians, purchasers, and policy-makers in making informed health decisions by advancing quality and relevance of evidence concerning matters of disease, disorders and other health conditions, and if they can be appropriately and effectively prevented, diagnosed, treated, monitored, and managed through research and evidence synthesis. The Institute is required to identify research priorities by taking into account factors of disease incidence, prevalence, and burden in the United States, gaps in evidence in terms of clinical outcomes, practice variations and health disparities in terms of delivery and outcomes of care, and the potential for new evidence to improve patient health and well-being. Not less frequently than every five years, the Institute shall audit the overall effectiveness of the Institute's work. This audit shall include an analysis of the extent to which research findings are used by healthcare decision-makers, the effect of the dissemination of such findings on reducing practice variation and disparities in healthcare, and the effect of research conducted and disseminated on innovation and the healthcare economy. (Sec. 6301)</p> <p>Addressing Subpopulations Specifies that patient subpopulations will be considered during the research. (Sec. 6301)</p>	<p>Date: FY 2010 \$: Saves \$0.3 billion over 10years off-budget</p>
<p>Workforce</p>	<p>Advancing Research and Treatment for Pain Care Management The Secretary may award grants for the development and implementation of programs to provide education and training to healthcare professionals in pain care. The programs must include information and education on: recognized means for assessing, diagnosing, treating, and managing pain; applicable laws, regulations, rules, and policies on controlled substances; interdisciplinary approaches to the delivery of pain care; cultural, linguistic, literacy, geographic, and other barriers to care in underserved populations; and, recent findings and developments. (Sec. 4305)</p>	<p>Date: FY 2010 - 2012 \$: Authorized to be appropriated such sums as may be necessary</p>

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<p>Workforce (cont.)</p>	<p>National Health Care Workforce Commission Establishes a national commission tasked with reviewing health care workforce and projected workforce needs. The overall goal of the Commission is to provide comprehensive, unbiased information to Congress and the Administration about how to align Federal health care workforce resources with national needs. Congress will use this information when providing appropriations to discretionary programs or in restructuring other Federal funding sources. The commission shall be composed of 15 members appointed by GAO, including at least one representative of the following: health care workforce and health professional, employers, third-party payers, individuals skilled in healthcare-related research, consumers, labor unions, small businesses, state/local workforce investment boards, and educational institutions. (Sec. 5101)</p> <p>State Healthcare Workforce Development Grants Creates a competitive grant program for the purpose of enabling state partnerships to complete comprehensive planning and to carry out activities leading to coherent and comprehensive healthcare workforce development strategies at the State and local levels. Grants will support innovative approaches to increase the number of skilled healthcare workers such as healthcare career pathways for young people and adults. Planning grants would be awarded for 1 year and up to \$150,000 for “eligible partnerships” including state workforce investment boards meeting certain membership requirements. (Sec. 5102)</p> <p>Healthcare Workforce Loan Repayment Programs Priority of entering into contracts shall be granted to applicants who: are or will be working in a school; have familiarity with evidence-based methods and cultural and linguistic competence healthcare services; and demonstrate financial need. (Sec. 5203)</p> <p>Funding for National Health Services Corps Increases and extends the authorization of appropriations for the National Health Service Corps scholarship and loan repayment program for 2010–2015. Authorizes a total of \$2.7 billion for the period. Authorizes the amount appropriated in the prior year adjusted by a certain percentage based on the costs of education and the number of individuals residing in health professions shortage areas. (Sec. 5207)</p>	<p>Date: 2010 onward \$: Budget neutral</p> <p>Date: FY 2010 - 2015 \$: \$158,000,000 and as much sums as necessary for each subsequent fiscal years.</p> <p>Date: FY 2010 \$: \$35,000/year, not more than three years per loan</p> <p>Date: FY 2010 onward \$: FY2010 - \$320,461,632 FY 2011 - \$414,095,394 FY 2012 - \$535,087,442 FY 2013 - \$691,431,432 FY 2014 - \$893,456,433 FY 2015 - \$1,154,510,336 FY 2016 - FY2015 amount adjusted</p>

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<p>Workforce (cont.)</p>	<p>Primary Care Training and Enhancement The Secretary shall make grants available to accredited entities to train primary care providers. Priority shall be granted to applicants that: propose a collaborative approach between academic administrative units of primary care; proposes innovative approaches to clinical teaching using models of primary care; have a record of training the greatest percentage of providers; 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 disorder, individuals with HIV/AIDS, and individuals with disabilities; or provide training in cultural competency and health literacy. (Sec. 5301)</p> <p>Training for Direct Care Workers Provides grants for entities to provide new training opportunities for direct care workers employed in long-term care settings. Eligible entities are institutions of higher education that have established a public-private educational partnership with a long-term care facility or agency or entity providing home and community based services to individuals with disabilities or other long-term care providers. Eligible individuals are those enrolled in an institution who agree to work in the field of geriatrics, disability services, long term care services and support or chronic care management for at least two years. (Sec. 5302)</p> <p>Training in General, Pediatric, and Public Health Dentistry The Secretary shall make grants available to eligible entities. Priority in awarding grants shall be made for the following: applicants that propose collaborative projects between departments of primary care medicine and department of general, pediatric and public health dentistry; have a record of training the greatest percentage of providers; 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; have a record of training individuals who are from a rural or disadvantaged background, or from unrepresented minorities; provide training in cultural competency and health literacy; or 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. (Sec. 5303)</p>	<p>Date: FY 2010 - 2014 \$: FY 2010 - \$125,000,000; authorized to be appropriated such sums as may be necessary for FY2011 - 2014.</p> <p>Date: FY 2011 - 2013 \$: \$ 10,000,000</p> <p>Date: FY 2010 - 2015 \$: FY 2010 - \$30,000,000, authorized to be appropriated such sums as may be necessary for FY2011 - 2015.</p> <p>Loan repayment: Years of service - %of loan repaid 1 - 10% 2 - 15% 3 - 20% 4 - 25% 5 - 30%</p>

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<p>Workforce (cont.)</p>	<p>Cultural Competency, Prevention, and Public Health and Individuals with Disability Training Alters Title VII – Section 741 of the Public Health Service Act by inserting the goals of dissemination of research, demonstration projects, and model curricula for cultural competency, prevention, public health proficiency, reducing health disparities, and aptitude for working with individuals with disabilities training. The bill creates grants for programs that aim to meet the goals mentioned above. (Sec. 5307)</p> <p>Grants to Promote the Community Health Workforce Defines Community Health Worker as an individual who promotes health or nutrition within the community in which the individual resides: by serving as a liaison between communities and healthcare agencies; by providing guidance and social assistance to community residents; by enhancing community residents’ ability to communicate with providers; by providing culturally and linguistically appropriate health or nutrition education; by advocating for individual and community health; and by providing referral and follow-up services or otherwise coordinating care. (Sec. 5313)</p> <p>Centers of Excellence The Centers of Excellence program, which develops a minority application pool to enhance recruitment, training, academic performance and other supports for minorities interested in careers in health, is reauthorized at 150 percent of 2005 appropriations, \$50 million, and such sums as are necessary for subsequent fiscal years. (Sec. 5401)</p> <p>Health Professions Training for Diversity Provides scholarship for disadvantaged students who commit to work in medically underserved areas as primary care providers, and expands load repayment for individuals who will serve as faculty in eligible institutions. Includes faculty at schools for physician’s assistants as eligible for faculty load repayment. (Sec. 5402)</p> <p>Interdisciplinary, community-based linkages Authorizes a total of \$130 million for each fiscal year 2010-2014 to establish community-based training and education grants for Area Health Education Centers (AHECs) and programs. Two programs are supported – Infrastructure Development Awards and Points of Service Enhancement and Maintenance Awards – targeting individuals seeking careers in the health profession from urban and rural medically underserved communities (Sec. 5403)</p>	<p>Date: FY 2010 – 2015 \$: Authorized to be appropriated such sums as may be necessary for FY2010 – 2015.</p> <p>Date: FY 2010 – 2014 \$: Authorized to be appropriated such sums as may be necessary for FY2010– 2014.</p> <p>Date: FY 2010 – 2015 \$: \$50,000,000 for each fiscal year.</p> <p>Date: FY 2010 – 2014 \$: FY 2010 – \$51,000,000, authorized to be appropriated such sums as may be necessary for FY2011 – 2014.</p> <p>Date: FY 2010 – 2014 \$: \$130,000,000 for each fiscal year.</p>

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<p>Workforce (cont.)</p>	<p>Workforce Diversity Grants Expands the allowable uses of nursing diversity grants to include completion of associate degrees, bridge or degree completion program, or advanced degree in nursing, as well as pre-entry preparation, advanced educational preparation, and retention activities. (Sec. 5404)</p> <p>Primary Care Extension Program Establishes Primary Care Extension Agencies to support and assist primary care providers (PCP). These agencies may: provide technical assistance, training and organizational support for community Health Teams; collect data and provision of PCP feedback from standardized measurements of processes and outcomes; collaborate with local health departments in community-based efforts to address the social and primary determinants of health, strengthen the local primary care workforce, and eliminate health disparities; and develop measures to monitor the impact of the proposed program on the health of enrollees. Defines a Health Extension Agent as any local, community-based health worker who facilitates and provides assistance to primary care practices by implementing quality improvement or system redesign, incorporates the principles of the patient-centered medical home to provide high-quality, effective, efficient, and safe primary care and to provide guidance to patients in culturally and linguistically appropriate ways, and linking practices to diverse health system resources. (Sec. 5405)</p> <p>Demonstration Projects to Address Health Professions Workforce Needs The Secretary shall award grants to States to conduct demonstration projects for purposes of developing core training competencies and certification programs for personal or home care aides. The core competencies of such demonstrations shall include: the role of personal or home care aide; consumer rights, ethics, and confidentiality; communication, cultural and linguistic competence and sensitivity, problem solving, behavior management, and relationship skills; personal care skills; healthcare support; nutritional support; infection control; safety and emergency training; and self-care. (Sec. 5507)</p> <p>Negotiated Rulemaking for Development of Methodology and Criteria for Designating Medically Underserved Populations and Health Professions Shortage Directs the Secretary, in consultation with stakeholders, to establish a comprehensive methodology and criteria for designating medically underserved populations and Health Professional Shortage Areas. (Sec. 5602)</p>	<p>Date: FY 2011 – 2014 \$: FY 2011 – 2012 – \$120,000,000; authorized to be appropriated such sums as may be necessary for FY2013 – 2014.</p> <p>Date: FY 2010 – 2014 \$: \$85,000,000; w/\$5,000,000 of total to be designated for 2010 – 2012 to carry out training programs for home care aides.</p> <p>Date: July 01, 2010</p>

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<p>Workforce (cont.)</p>	<p>State Grants to Health Care Providers Who Provide Services to a High Percentage of Medically Underserved Population or Other Special Population Establishes state grant programs for health care providers who treat a high percentage of medically underserved population or other special population in the state (Sec. 5606)</p> <p>Rural Physician Training Grants Directs the Secretary, acting through HRSA, to establish a grant program for purposes of assisting eligible entities in recruiting students mostly likely to practice in underserved rural communities, providing rural-focused training and experience, and increasing the number of recent allopathic and osteopathic medical school graduates who practice in rural communities. Appropriates \$4,000,000 for each of the FYs 2010 through 2013. (Sec. 10501(I))</p> <p>Investment in Historically Black Colleges and Universities and Minority Serving Institutions. This section amends section 371(b) of the Higher Education Act by extending funding for programs under this section created under the College Cost Reduction and Access Act of 2007 for programs at Historically Black Colleges and Universities and minority-serving institutions through 2019, including programs that help low-income students attain degrees in the fields of science, technology, engineering or mathematics by the following annual amounts: \$100 million to Hispanic Serving Institutions, \$85 million to Historically Black Colleges and Universities, \$15 million to Predominantly Black Institutions, \$30 million to Tribal Colleges and Universities, \$15 million to Alaska, Hawaiian Native Institutions, \$5 million to Asian American and Pacific Islander Institutions, and \$5 million to Native American non-tribal serving institutions. (Sec. 2104 – <i>Reconciliation Bill</i>)</p>	<p>Date: FY 2010 – 2013 \$: \$4,000,000 per fiscal year</p> <p>Date: FY 2010 – 2019 \$: \$100,000,000 – Hispanic Serving Institutions \$85,000,000 – Historically Black Institutions \$15,000,000 – Predominately Black Institutions \$30,000,000 – Tribal Institutions \$15,000,000 – Alaska & Hawaiian Native Institutions \$5,000,000 – Asian American and Pacific Islanders Institutions \$5,000,000 – Native American Non-Tribal Serving Institutions</p>
<p>Prevention</p>	<p>Personal Responsibility Education Personal Responsibility Education programs shall be designed in order to educate adolescents on abstinence and contraception for the prevention of pregnancy and sexually transmitted infections. The programs shall be required to: replicate evidence-based effective programs; be medically-accurate and complete; include activities to educate youths who are sexually active regarding responsibility; place substantial emphasis on both abstinence and the use of contraception; ensure the information and activities carried out under the program are provided in the cultural context that is most appropriate for individuals in the population group they are directed. The Secretary shall award grants to entities implementing innovative strategies and target services to high-risk, vulnerable, and culturally under-represented youth populations. (Sec. 2953)</p>	<p>Date: FY 2010 – 2014 \$: To States, FY2010 – 2013 >\$250,000. To local organizations, \$75,000,000 for each of fiscal years 2010 through 2014.</p>

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Prevention (cont.)	<p>School-Based Health Centers Establishes a grant program for eligible entities to support the operation of “school-based health centers,” as defined in the Children’s Health Insurance Program Reauthorization Act of 2009. Preference will be given to school-based health centers that serve a large population of medically underserved children. Appropriates \$50,000,000 for FYs 2010 through 2014. (Sec. 4101)</p> <p>Prevention of Chronic Disease and Improving Public Health (Community Preventive Services Task Force) Establishes an independent Community Preventive Services Task Force. The Task Force shall review scientific evidence related to effectiveness, appropriateness, and cost-effectiveness of community prevention interventions in order to develop recommendations to be published in the Guide to Community Preventive Services. The Task Force shall develop additional topic areas for new recommendations and interventions related to those topic areas. These topic areas shall include those related to specific age groups, as well as the social, economic, and physical environment that can have broad effects on the health and disease of population and health disparities among sub-populations and age groups. (Sec. 4003)</p> <p>Education and Outreach Campaign Regarding Preventive Benefits Directs the Secretary to provide for the planning and implementation of a national public-private partnership for a prevention and health promotion outreach and education campaign to raise public awareness of health improvement across the life span. Requires the Secretary to consult with the IOM to provide ongoing advice on evidence-based scientific information for policy, program development and evaluation. The campaign shall be subject to an independent evaluation every 2 years and shall report every 2 years to Congress on the effectiveness of the campaign in meeting science-based metrics. Not later than January 1, 2011, and every 3 years thereafter through January 1, 2017, the Secretary shall report to Congress on its efforts with states and Medicaid enrollees with respect to preventative and obesity-related services with the goal of reducing incidences of obesity. Appropriates the sums necessary to carry out the provisions. (Sec. 4004)</p>	<p>Date: FY 2010 - 2014 \$: \$50,000,000 for each fiscal year 2010 – 2014.</p> <p>Date: FY 2010 onward \$: Authorized to be appropriated such sums as may be necessary.</p> <p>Date: 01/01/2011 – 01/01/2017 \$: Authorized to be appropriated such sums as may be necessary, not to exceed \$500,000,000 on outreach campaign.</p>

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<p>Prevention (cont.)</p>	<p>Oral Healthcare Prevention Activities (Oral Healthcare Prevention Education Campaign) Establishes an Oral Healthcare Prevention Education Campaign. In establishing the campaign the Secretary shall ensure that activities are targeted towards specific populations such as children, pregnant women, parents, the elderly, individuals with disabilities, and ethnic and racial minorities, including Indians, Alaska Natives and Native Hawaiians in a culturally and linguistically appropriate manner. (Sec. 4102)</p> <p>Creating Healthier Communities (Community Transformation Grants) The Secretary shall award grants to State and local governmental agencies and community-based organizations for the implementation, evaluation, and dissemination of evidence-based community preventive health activities in order to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming. The grants shall be used to develop a Community Transformation Plan that includes the policy, environmental, programmatic, and infrastructure changes needed to promote healthy living and reduce disparities. Activities within the plan may focus on (but not limited to): creating healthier school environments, creating infrastructure to support active living, develop programs to target a variety of age levels, worksite wellness programs and incentives, highlighting healthy options at food venues, prioritizing strategies to reduce racial and ethnic disparities, including social, economic, and geographic determinants of health, and addressing special populations needs. (Sec. 4201)</p> <p>Removing Barriers and Improving Access to Wellness for Individuals with Disabilities Not later than 24 months after the Act's enactment, the Architectural and Transportation Barriers Compliance Board shall, in consultation with the Commissioner of the FDA, promulgate regulatory standards setting forth the minimum technical criteria for medical diagnostic equipment used in (or in conjunction with) physicians' offices, clinics, emergency rooms, hospitals, and other medical settings. Such standards shall ensure that equipment is accessible to, and usable by, individuals with accessibility needs. (Sec. 4203)</p> <p>Funding for Childhood Obesity Demonstration Project Appropriates \$25,000,000 for FYs 2010 through 2014 for the demonstration projects to develop a comprehensive and systematic model for reducing childhood obesity to be developed under the Children's Program Reauthorization Act of 2009. (Sec. 4306)</p>	<p>Date: FY 2010 - 2014 \$: Authorized to be appropriated such sums as may be necessary.</p> <p>Date: FY 2010 - 2014 \$: Authorized to be appropriated such sums as may be necessary.</p> <p>Date: FY 2012 onward</p> <p>Date: FY 2010 - 2014 \$: \$25,000,000 for fiscal years 2010 - 2014.</p>

Issue	Health Reform Law: P.L. 111-148 as amended by P.L. 111-152	Implementation
<p>Prevention (cont.)</p>	<p>Diagnosed with Breast Cancer Directs the Secretary, acting through the CDC to conduct a national evidenced-based education campaign to increase awareness of young women’s knowledge regarding breast health and awareness. The CDC, not later than 60 days after the Act’s enactment, shall establish an advisory committee to assist in creating and conducting the educational campaign. The CDC shall also conduct a similar educational campaign among physicians and other health care professionals and conduct prevention research on breast cancer in younger women. Directs the Secretary to award grants to organizations to provide health information and substantive assistance to young women diagnosed with breast cancer and pre-neoplastic breast disease. (Sec. 10413)</p> <p>National Diabetes Prevention Program Directs the Secretary, acting through the CDC, to establish a national diabetes prevention program targeted at adults at high risk for diabetes in order to eliminate the preventable burden of diabetes through community-based prevention services. (Sec. 10501(g))</p> <p>Preventative Medicine and Public Health Training Grant Program Requires the Secretary, acting through HRSA and in consultation with CDC, to award grants to, or enter into contracts with, eligible entities to provide training to graduate medical residents in preventive medicine specialties. Appropriates \$43,000,000 for FY 2011 and such sums necessary for each of FYs 2012 through 2015. (Sec. 10501(m))</p>	<p>Date: FY 2010 – 2014 \$: \$9,000,000 for each fiscal year 2010 – 2014.</p> <p>Date: FY 2011 onward \$: Authorized to be appropriated such sums as may be necessary.</p> <p>Date: FY 2011 – 2015 \$: FY 2011 – \$43,000,000; FY 2012 – 2015 authorized to be appropriated such sums as may be necessary.</p>
<p>Data Collection and Reporting</p>	<p>Understanding Health Disparities: Data Collection and Analysis Amends the Public Health Service Act by adding “Title XXXI – Data Collection, Analysis, and Quality.” Title XXXI states the Secretary shall ensure any federally conducted or supported healthcare program, activity, or survey collects and reports: data on race, ethnicity, sex, primary language, and disability status; data on the smallest geographic level if it can be aggregated; and, sufficient data to generate estimates by the metrics listed above. The Secretary shall make the analyses available to the Office of Minority Health, the National Center on Minority Health and Health Disparities, AHRQ, CMS, CDC, the Indian Health Services, Office of Rural Health, and other agencies within HHS. The Title also addresses healthcare disparities in Medicaid and CHIP by standardizing collection requirements. The Secretary shall evaluate approaches for the data collection to ensure it allows for the ongoing, accurate, and timely collection and evaluation of data on disparities in healthcare services and performance. (Sec. 4302)</p>	<p>Date: FY 2010 – 2014 Program must be established by FY 2012. \$: Authorized to be appropriated such sums as may be necessary.</p>

Issue	Health Reform Law: P.L. 111-148 as amended by P.L. 111-152	Implementation
Community Health Needs Assessment	Additional Requirements for Non-Profit Tax-Exempt Hospitals Requires hospitals who wish to qualify as non-profit tax-exempt to create a community health needs assessment once every three years. The bill prevents hospitals from using extraordinary collection practices to pursue bad debt. Also requires hospitals to offer an assistance policy and to limit charges on people who qualify for financial assistance. (Sec. 4959)	Date: FY 2011 onward
Office of Minority Health	Minority Health The manager's amendment transfers the Office of Minority Health to the Office of the Secretary of Health and Human Services, to be headed by the Deputy Assistant Secretary for Minority Health. The Deputy Assistant Secretary shall retain and strengthen prior authorities for the purpose of improving minority health and the quality of healthcare minorities receive, and eliminating racial and ethnic disparities. In carrying out this section, the Deputy Assistant Secretary shall award grants, contracts, enter into memoranda of understanding, cooperative, interagency, intra-agency and other agreements with public and nonprofit private entities and organizations that are indigenous human resource providers in communities of color to assure improved health status of racial and ethnic minorities, and shall develop measures to evaluate the effectiveness of activities aimed at reducing health disparities and supporting the local community. The manager's amendment also re-designates the National Center on Minority Health and Health Disparities , as the National Institute on Minority Health and Health Disparities. The Institute will have expanded research endowments, by including centers of excellence under section 464z-4. (Sec. 10334 of manager's amendment)	Date: FY 2011 - 2016 \$: Authorized to be appropriated such sums as may be necessary.
Medicare/Medicaid Funding	Disproportionate share hospital payments. Reduce Medicare Disproportionate Share Hospital (DSH) payments initially by 75% and subsequently increase payments based on the percent of the population uninsured and the amount of uncompensated care provided. Effective fiscal year 2015. (Sec. 2551)	Date: FY 2015

Issue	Health Reform Law: P.L. 111-148 as amended by P.L. 111-152	Implementation
Medicare/Medicaid Funding <i>(cont.)</i>	<p>Disproportionate Share Hospital (DSH) Payments. Advances Medicare disproportionate share hospital cuts to begin in fiscal year 2014 but lowers the ten-year reduction by \$3 billion. (Sec. 1104) Disproportionate share hospital payments. Lowers the reduction in federal Medicaid DSH payments from \$18.1 billion to \$14.1 billion and advances the reductions to begin in fiscal year 2014. Directs the Secretary to develop a methodology for reducing federal DSH allotments to all states in order to achieve the mandated reductions. Extends through FY 2013 the federal DSH allotment for a state that has a \$0 allotment after FY 2011. (Sec. 1203 – <i>Reconciliation Bill</i>)</p> <p>Funding for the territories. Increases federal funding in the Senate bill for Puerto Rico, Virgin Islands, Guam, American Samoa, and the Northern Marianas Islands by \$2 billion. Raises the caps on federal Medicaid funding for each of the territories. Allows each territory to elect to operate a Health Benefits Exchange. (Sec. 1204 – <i>Reconciliation Bill</i>)</p>	<p>Date: FY 2014 onward</p> <p>Date: FY 2014</p>
Community Health Centers	<p>Community Mental Health Centers. Establishes new requirements for community mental health centers that provide Medicare partial hospitalization services in order to prevent fraud and abuse. (Sec. 1301 – <i>Reconciliation Bill</i>)</p> <p>Community Health Centers. Increases mandatory funding for community health centers to \$11 billion over five years (FY 2011 – FY 2015). (Sec. 2303 – <i>Reconciliation Bill</i>)</p>	<p>Date: FY 2011</p> <p>Date: FY 2011 – 2015</p> <p>\$: 2011 - \$1,000,000,000 2012 - \$1,200,000,000 2013 - \$1,500,000,000 2014 - \$2,200,000,000 2015 - \$2,900,000,000</p>
Miscellaneous Provisions	<p>Improving Women’s Health Establishes an Office of Women’s Health in the Office of the Secretary, the CDC, the Substance Abuse and Mental Health Services Administration, the Agency for Healthcare Research and Quality, the Health Resources and Services Administration and the FDA. (Sec. 3509)</p>	<p>Date: FY 2010 - 2014</p> <p>\$: Authorized to be appropriated such sums as may be necessary.</p>

Issue	Health Reform Law: P.L. 111-148 as amended by P.L. 111-152	Implementation
Miscellaneous Provisions <i>(cont.)</i>	Indian Healthcare Improvement With amendment, incorporates S. 1790 entitled “A bill to amend the Indian Health Care Improvement Act to revise and extend that Act, and for other purposes.” (Sec. 10221)	Date: Immediate
Medicare Provisions for Low-Income Beneficiaries	Funding Outreach and Assistance for Low-Income Programs Provides \$45 million for outreach and education activities to State Health Insurance Programs, Administration on Aging, Aging Disabilities Resource Centers and the National Benefits Outreach and Enrollment. (Sec. 3306)	Date: FY 2010 - 2012 \$: State Health Insurance Programs, \$15,000,000 Area Agencies on Aging, \$15,000,000 Aging and Disabilities Resource Centers, \$10,000,000 National Center for Benefits and Outreach Enrollment, \$5,000,000
Readmissions	Community-Based Care Transitions Teams Beginning January 1, 2011 for a 5-year period, requires the Secretary to establish a program under which the Secretary would provide funding to hospitals and community-based entities that furnish evidence-based care transition services to Medicare beneficiaries at high risk for readmission. The law defines “high-risk Medicare beneficiaries” as a beneficiary who has attained a minimum hierarchical conditions category score, as determined by the Secretary, based on a diagnosis of multiple chronic conditions or other risk factors associated with a hospital readmission or substandard transition into post-hospitalization care, which may include 1 or more of the following: cognitive impairment, depression, a history of multiple readmissions, any other chronic disease or risk factor as determined by the Secretary. (Sec. 3026)	Date: 2011 - 2015 \$: \$500,000,000 for the period of fiscal years 2011 – 2015.

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