AGENDA ITEM 10

EXECUTIVE OFFICER'S REPORT.

Date: November 5, 2013

To: CBOT Members

From: Heather Martin, Executive Officer

Subject: Executive Officer Report – November 7, 2013, Board Meeting

Operations

Staff
The Board currently has 8.2 personnel years (PYs) or positions with a 0.8 PY vacancy due to required staffing reductions. Due to revenue concerns and conflicting workload estimates, we are unable to justify the need for additional staff at this time.

BreEZe Project:
The BrEZe projected deployment date for Release 2 has been pushed out again (date TBD). Some key activities include:

- Renewal form *drafts* have been submitted to the vendor, but b/b review & approval is still underway
- Pre-configuration tasks have begun and staff interviews will start taking place in December
- Data conversion preparation for Release 2 and Release 3 Boards is underway
- Preparation for Release 2 interface design is underway

Pending Regulations
Detailed information about pending rulemaking files and priority of future regulatory amendments is contained in Agenda Item 8.

Budget
The FY 2013/14 revenue projection was estimated at $1.08m; as of the first quarter $425k has been received, which is approximately 39% of the annual projection. The Board has spent $405k of its $1.4m budget; approximately 71% of the budget remains.
(Expenditure and Revenue reports attached)

Performance Measures
The performance measures for the 1st quarter of 2013/14 were not available as of today's date.

Other Informational Items

- The "Summary of Healthcare Reform" that highlights key provisions of the Patient Protection and Affordable Care Act is included.
- The recently printed 2013 Laws and Regulations booklet is also included. A 160+ page version is available on the Board's website.

DEPT OF CONSUMER AFFAIRS - REGULATORY BOARDS
RECEIPTS BY ORGANIZATION AND SOURCE
AS OF 09/30/13

ENY: 13 FFY: 13
SECTION: 11 CA BD OF OCCUPATIONAL THERAPY
SUB-SECTION: 00
UNIT: 00
SUB-UNIT: 00
SUB-SUB-UNIT: 00
INDEX: 1475 CA BD OF OCCUPATIONAL THERAPY

PROGRAM PG EL CMP TSK	PCA	REF	SOURCE	ASRC	DESCRIPTION	PLANNED RECEIPTS	ACTUAL RECEIPTS CURRENT MONTH	ACTUAL RECEIPTS YEAR-TO-DATE	BALANCE
67 00 000 000 73017					REIMB - CA BD OF OCCUPATIONAL THERAPY				
		001	991937	01	FINGERPRINT REPORTS	22,000.00	1,666.00	5,733.00	16,267.00
		001	991937	02	EXTERNAL/PRIVATE/GRANT	0.00	0.00	1,420.00	1,420.00-
*TOTAL SOURCE 991937						22,000.00	1,666.00	7,153.00	14,847.00
*TOTAL PROG 67						22,000.00	1,666.00	7,153.00	14,847.00
*TOTAL REFERENCE 001						22,000.00	1,666.00	7,153.00	14,847.00
67 00 000 000 83017					REVENUE CA BD OF OCCUPATIONAL THERAPY				
		980	125600	CU	OTA DUP LIC FEE-$15.00	0.00	180.00	495.00	495.00-
		980	125600	CV	OTA DUP CERT FEES-$15.00	0.00	45.00	120.00	120.00-
		980	125600	FT	CITATION/FINE FTB COLLECTION	0.00	100.00	100.00	100.00-
		980	125600	00	OTHER REGULATORY FEES	30,000.00	0.00	0.00	30,000.00
		980	125600	18	CITATION & FINE FEE COLLECTED-VAR	0.00	5,774.00	15,823.00	15,823.00-
*TOTAL SOURCE 125600						30,000.00	6,099.00	16,538.00	13,462.00
		980	125700	OC	OT INITIAL LIC FEE-$VAR	0.00	11,792.00	29,297.00	29,297.00-
		980	125700	OD	OTA INITIAL CERT FEE-$VAR	0.00	4,748.00	9,353.00	9,353.00-
		980	125700	OE	OT LIMITED PERMIT-$75.00	0.00	1,425.00	1,800.00	1,800.00-
		980	125700	OJ	OTA LIMITED PERMIT $75.00	0.00	150.00	750.00	750.00-
		980	125700	00	OTHER REGULATORY LICENSES AND PER	145,000.00	0.00	0.00	145,000.00
		980	125700	90	OVER/SHORT FEES	0.00	85.00	228.00	228.00-
		980	125700	91	SUSPENDED REVENUE	0.00	75.00	75.00	75.00-
*TOTAL SOURCE 125700						145,000.00	18,275.00	41,503.00	103,497.00
		980	125800	BP	OT INACTIVE RENEWAL LIC FEE-$25.0	0.00	1,625.00	3,100.00	3,100.00-
		980	125800	BQ	OTA INACTIVE RENEWAL CERT FEE-$25	0.00	150.00	350.00	350.00-
		980	125800	C1	AUTOMATED REVENUE REFUND CLAIM	0.00	675.00	975.00	975.00-
		980	125800	00	RENEWAL FEES	841,000.00	0.00	0.00	841,000.00
		980	125800	2W	BIENNIAL RENEWAL-OT $150	0.00	144,600.00	295,731.00	295,731.00-

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		980	125800	2X	BIENNIAL RENEWAL-OTA $150	0.00	27,250.00	53,200.00	53,200.00-
		980	125800	90	OVER/SHORT FEES	0.00	0.00	5.00	5.00-
*TOTAL SOURCE 125800						841,000.00	174,300.00	353,361.00	487,639.00
		980	125900	TM	DELINQ BIENNIAL-OT $75	0.00	1,125.00	2,850.00	2,850.00-
		980	125900	TN	DELINQ BIENNIAL-OTA $75	0.00	150.00	525.00	525.00-
		980	125900	00	DELINQUENT FEES	16,000.00	0.00	0.00	16,000.00
*TOTAL SOURCE 125900						16,000.00	1,275.00	3,375.00	12,625.00
		980	142500	00	MISCELLANEOUS SERVICES TO THE PUB	8,000.00	0.00	0.00	8,000.00
		980	142500	90	MISC. SER TO PUBLIC - GENERAL	0.00	645.00	2,430.00	2,430.00-
*TOTAL SOURCE 142500						8,000.00	645.00	2,430.00	5,570.00
		980	150300	00	INCOME FROM SURPLUS MONEY INVESTM	10,000.00	0.00	0.00	10,000.00
*TOTAL SOURCE 150300						10,000.00	0.00	0.00	10,000.00
		980	161000	02	REVENUE CANCELLED WARRANTS	0.00	132.00	145.00	145.00-
*TOTAL SOURCE 161000						0.00	132.00	145.00	145.00-
		980	161400	91	DISHONORED CHECK FEE-VAR	0.00	25.00	50.00	50.00-
*TOTAL SOURCE 161400						0.00	25.00	50.00	50.00-
		980	164300	00	PENALTY ASSESSMENTS	8,000.00	0.00	0.00	8,000.00
		980	164300	99	PENALTY ASSESSMENTS	0.00	515.00	880.00	880.00-

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PROGRAM
PG EL CMP TSK PCA DESCRIPTION

REF	SOURCE	ASRC	DESCRIPTION	PLANNED RECEIPTS	ACTUAL RECEIPTS CURRENT MONTH	ACTUAL RECEIPTS YEAR-TO-DATE	BALANCE
*TOTAL SOURCE 164300				8,000.00	515.00	880.00	7,120.00
*TOTAL PROG 67				1,058,000.00	201,266.00	418,282.00	639,718.00
*TOTAL REFERENCE 980				1,058,000.00	201,266.00	418,282.00	639,718.00
*TOTAL INDEX 1475				1,080,000.00	202,932.00	425,435.00	654,565.00
*TOTAL SEC 11				1,080,000.00	202,932.00	425,435.00	654,565.00

DEPARTMENT OF CONSUMER AFFAIRS

CA BD OF OCCUPATIONAL THERAPY

BUDGET REPORT

AS OF 9/30/2013

FM 03

CA BD OF OCCUPATIONAL THERAPY

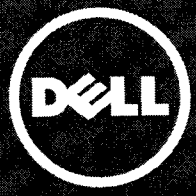
	DESCRIPTION	BUDGET	CURR. MONTH	YR-TO-DATE	ENCUMBRANCE	YTD + ENCUMBRANCE	BALANCE	PCNT REMAIN
PERSONAL SERVICES								
SALARIES AND WAGES								
003 00	CIVIL SERVICE-PERM	319,965	26,495	80,156	0	80,156	239,809	
033 04	TEMP HELP (907)	4,000	3,970	10,939	0	10,939	(6,939)	
063 00	STATUTORY-EXEMPT	77,956	7,015	21,045	0	21,045	56,911	
063 01	BD/COMMSN (901,920	20,000	0	0	0	0	20,000	
TOTAL SALARIES AND WAGES		**421,921**	**37,480**	**112,139**	**0**	**112,139**	**309,782**	**73.42%**
STAFF BENEFITS								
103 00	OASDI	31,006	2,205	6,656	0	6,656	24,350	
104 00	DENTAL INSURANCE	2,206	213	638	0	638	1,568	
105 00	HEALTH/WELFARE INS	83,407	3,585	10,756	0	10,756	72,651	
106 01	RETIREMENT	79,580	7,166	21,613	0	21,613	57,967	
125 00	WORKERS' COMPENSAT	10,225	0	0	0	0	10,225	
125 15	SCIF ALLOCATION CO	0	309	1,202	0	1,202	(1,202)	
132 00	NONINDUST DISABLTY	2,000	0	0	0	0	2,000	
133 00	UNEMPLOYMENT INSUR	3,000	0	0	0	0	3,000	
134 00	OTHER-STAFF BENEFI	100	1,902	5,688	0	5,688	(5,588)	
135 00	LIFE INSURANCE	200	7	21	0	21	179	
136 00	VISION CARE	744	69	207	0	207	537	
137 00	MEDICARE TAXATION	5,281	529	1,580	0	1,580	3,701	
TOTAL STAFF BENEFITS		**217,749**	**15,984**	**48,362**	**0**	**48,362**	**169,387**	**77.79%**
TOTAL PERSONAL SERVICES		**639,670**	**53,464**	**160,501**	**0**	**160,501**	**479,169**	**74.91%**
OPERATING EXPENSES & EQUIPMENT								
FINGERPRINTS								
213 04	FINGERPRINT REPORT	22,000	1,666	4,067	0	4,067	17,933	
TOTAL FINGERPRINTS		**22,000**	**1,666**	**4,067**	**0**	**4,067**	**17,933**	**81.51%**
GENERAL EXPENSE								
201 00	GENERAL EXPENSE	27,216	0	0	0	0	27,216	
206 00	MISC OFFICE SUPPLI	0	793	793	0	793	(793)	
213 02	ADMIN OVERHEAD-OTH	0	1,452	1,452	0	1,452	(1,452)	
223 00	LIBRARY PURCH/SUBS	0	326	460	1,340	1,800	(1,800)	
TOTAL GENERAL EXPENSE		**27,216**	**2,571**	**2,705**	**1,340**	**4,045**	**23,171**	**85.14%**

CA BD OF OCCUPATIONAL THERAPY

	DESCRIPTION	BUDGET	CURR. MONTH	YR-TO-DATE	ENCUMBRANCE	YTD + ENCUMBRANCE	BALANCE	PCNT REMAIN
PRINTING								
241 00	PRINTING	8,245	0	0	0	0	8,245	
TOTAL PRINTING		**8,245**	**0**	**0**	**0**	**0**	**8,245**	**100.00%**
COMMUNICATIONS								
251 00	COMMUNICATIONS	5,449	0	0	0	0	5,449	
252 00	CELL PHONES,PDA,PA	0	23	52	0	52	(52)	
253 00	CENT COMM (CALNET,	0	281	281	0	281	(281)	
257 01	TELEPHONE EXCHANGE	0	297	304	0	304	(304)	
TOTAL COMMUNICATIONS		**5,449**	**601**	**636**	**0**	**636**	**4,813**	**88.33%**
POSTAGE								
261 00	POSTAGE	14,655	0	0	0	0	14,655	
263 00	POSTAGE METER	0	4	4	0	4	(4)	
263 05	DCA POSTAGE ALLO	0	1,472	3,771	0	3,771	(3,771)	
263 06	EDD POSTAGE ALLO	0	0	1,136	0	1,136	(1,136)	
TOTAL POSTAGE		**14,655**	**1,476**	**4,911**	**0**	**4,911**	**9,744**	**66.49%**
TRAVEL: IN-STATE								
291 00	TRAVEL: IN-STATE	16,146	0	0	0	0	16,146	
292 00	PER DIEM-I/S	0	192	192	0	192	(192)	
294 00	COMMERCIAL AIR-I/S	0	0	186	0	186	(186)	
297 00	RENTAL CAR-I/S	0	119	119	0	119	(119)	
TOTAL TRAVEL: IN-STATE		**16,146**	**311**	**497**	**0**	**497**	**15,649**	**96.92%**
TRAINING								
331 00	TRAINING	5,499	0	0	0	0	5,499	
TOTAL TRAINING		**5,499**	**0**	**0**	**0**	**0**	**5,499**	**100.00%**
FACILITIES OPERATIONS								
341 00	FACILITIES OPERATI	44,894	0	0	0	0	44,894	
343 00	RENT-BLDG/GRND(NON	0	4,537	13,772	42,175	55,947	(55,947)	
TOTAL FACILITIES OPERATIONS		**44,894**	**4,537**	**13,772**	**42,175**	**55,947**	**(11,053)**	**-24.62%**
C/P SVS - EXTERNAL								
402 00	CONSULT/PROF SERV-	13,000	0	0	0	0	13,000	
TOTAL C/P SVS - EXTERNAL		**13,000**	**0**	**0**	**0**	**0**	**13,000**	**100.00%**
DEPARTMENTAL SERVICES								
424 03	OIS PRO RATA	129,400	0	32,350	0	32,350	97,050	
427 00	INDIRECT DISTRB CO	77,807	0	19,452	0	19,452	58,355	

CA BD OF OCCUPATIONAL THERAPY

	DESCRIPTION	BUDGET	CURR. MONTH	YR-TO-DATE	ENCUMBRANCE	YTD + ENCUMBRANCE	BALANCE	PCNT REMAIN
427 01	INTERAGENCY SERVS	105	0	0	0	0	105	
427 30	DOI - PRO RATA	2,498	0	625	0	625	1,873	
427 34	PUBLIC AFFAIRS PRO	3,508	0	877	0	877	2,631	
427 35	CCED PRO RATA	4,454	0	1,113	0	1,113	3,341	
TOTAL	**DEPARTMENTAL SERVICES**	**217,772**	**0**	**54,417**	**0**	**54,417**	**163,355**	**75.01%**
	CONSOLIDATED DATA CENTERS							
428 00	CONSOLIDATED DATA	0	17	35	0	35	(35)	
TOTAL	**CONSOLIDATED DATA CENTERS**	**0**	**17**	**35**	**0**	**35**	**(35)**	**0.00%**
	DATA PROCESSING							
431 00	INFORMATION TECHNO	3,817	0	0	0	0	3,817	
445 00	SOFTWARE-IT PURCH,	0	0	0	2,717	2,717	(2,717)	
TOTAL	**DATA PROCESSING**	**3,817**	**0**	**0**	**2,717**	**2,717**	**1,100**	**28.81%**
	CENTRAL ADMINISTRATIVE SERVICES							
438 00	PRO RATA	62,114	0	15,529	0	15,529	46,586	
TOTAL	**CENTRAL ADMINISTRATIVE SERVICES**	**62,114**	**0**	**15,529**	**0**	**15,529**	**46,586**	**75.00%**
	EXAMINATIONS							
404 03	C/P SVS - EXT SUB	0	0	94	0	94	(94)	
TOTAL	**EXAMINATIONS**	**0**	**0**	**94**	**0**	**94**	**(94)**	**0.00%**
	ENFORCEMENT							
396 00	ATTORNEY GENL-INTE	133,243	16,870	42,378	0	42,378	90,866	
397 00	OFC ADMIN HEARNG-I	1,000	0	0	0	0	1,000	
414 31	EVIDENCE/WITNESS F	0	0	1,840	0	1,840	(1,840)	
418 97	COURT REPORTER SER	0	79	379	0	379	(379)	
427 31	DOI - INVESTIGATIO	229,280	0	57,320	0	57,320	171,960	
TOTAL	**ENFORCEMENT**	**363,523**	**16,949**	**101,917**	**0**	**101,917**	**261,606**	**71.96%**
TOTAL	**OPERATING EXPENSES & EQUIPMEN**	**804,330**	**28,127**	**198,579**	**46,232**	**244,811**	**559,519**	**69.56%**
	CA BD OF OCCUPATIONAL THERAPY	**1,444,000**	**81,591**	**359,080**	**46,232**	**405,312**	**1,038,688**	**71.93%**
		1,444,000	**81,591**	**359,080**	**46,232**	**405,312**	**1,038,688**	**71.93%**



Services

Summary of Healthcare Reform

By: Kevin Fickenscher, M.D., CPE, FACPE, FAAFP
Harry Greenspun, M.D.

Table of Contents

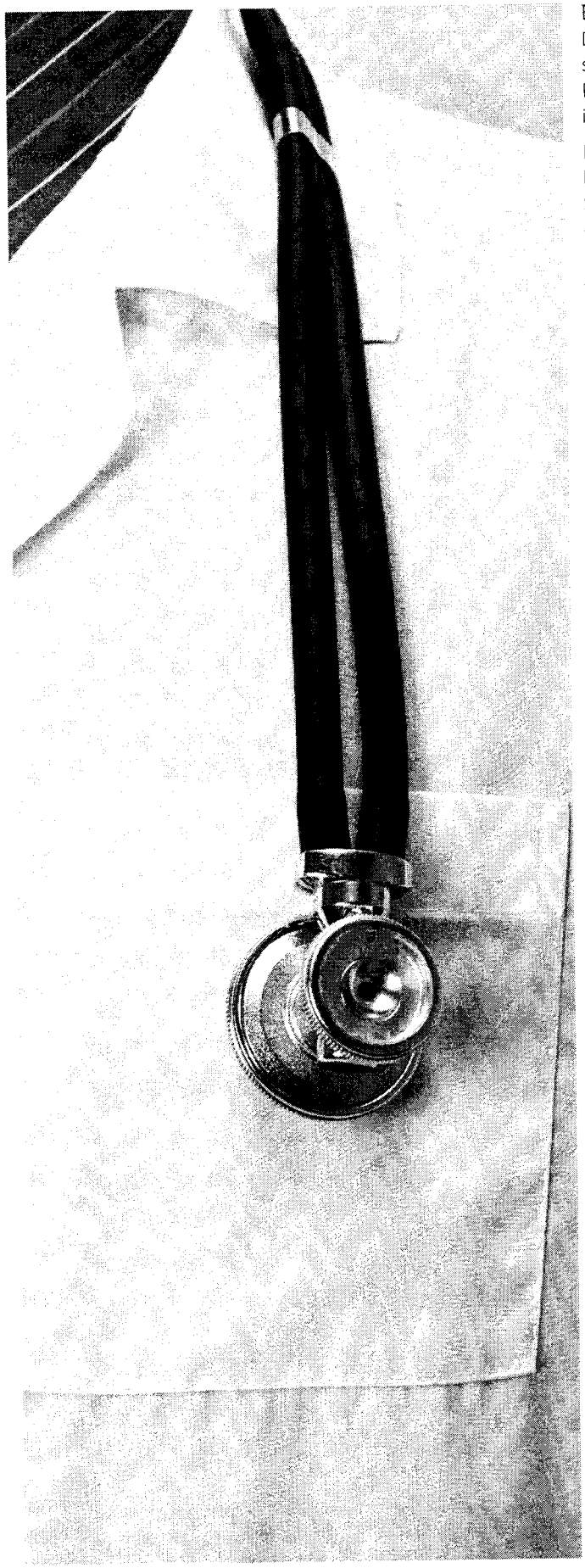
Kevin Fickenscher, M.D., CPE, FACPE, FAAFP
One of the nation's visionary leaders in healthcare, Kevin Fickenscher is Chief Strategy and Development Officer of Dell Healthcare Services.

A physician executive and leader with extensive experience in strategic and operational development with complex healthcare organizations, Dr. Fickenscher has provided leadership for various organizations related to organizational transformation and development, physician management, health policy analysis, leadership development, information management, clinical quality and resource/care management, among other areas.

Dr. Fickenscher is a regular participant at the national level in discussions, debates, and presentations related to the future of the U.S. healthcare system. In May 2007, *Modern Healthcare* ranked Dr. Fickenscher as No. 12 on 'The 50 Most Powerful Physician Executives in Healthcare, 2007.' Dr. Fickenscher is also an avid thought leader and publishes his blog, The Washington Report, on the Dell website.

Harry Greenspun, M.D.
Dr. Greenspun is the Chief Medical Officer of Dell Services, providing strategic leadership with a clinical perspective. He has held a diverse range of clinical and executive roles across the healthcare industry, giving him a unique perspective on the challenges and opportunities faced in health IT. Dr. Greenspun was named No. 18 on *Modern Healthcare's* '50 Most Powerful Physician Executives in Healthcare, 2010.'

Over the course of his career, Dr. Greenspun has held many key roles in implementing company- and industry-wide policies. Prior to working for Dell Services, he served as Chief Medical Officer for Northrop Grumman Corporation, where he provided subject matter expertise, thought leadership, and strategic direction for the company. More than a decade ago, Dr. Greenspun founded a company that tracked clinical outcomes in cardiac surgery, which later became the healthcare practice of an open-source software company.



Executive Summary

Dell Services is pleased to present the following comprehensive summary and analysis of key provisions found in the Patient Protection and Affordable Care Act (PPACA, P.L. 111-148), signed into law by President Barack Obama on March 23, 2010.

Recognizing the important impact this sweeping healthcare reform law will have on our customers and the industries we serve, Dell Services felt it was critical to provide you with a detailed overview of how this legislation will change your operations and business models.

This detailed analysis highlights every key provision and mandate that will impact insurance companies, healthcare providers, hospitals, state governments, small business owners, employers, and consumers.

The passage of the Patient Protection and Affordable Care Act was significant, both historically and politically. However, there are hundreds of new mandates and accountability requirements that will likely impact your operations either immediately or over the course of the next few years. Throughout our analysis we have noted the timing of such key requirements.

We encourage you to review the entire package, but have also taken the liberty of identifying and crystallizing what we believe are the "Top Ten" provisions or mandates for each major impacted sector: payers, providers and state governments. We have also highlighted a number of important grants, pilot projects, demonstration projects and new programs within the Department of Health and Human Services that merit your attention and potential involvement.

As you review our analysis, you will see that hospitals and providers will benefit from various increases in Medicare and Medicaid reimbursements, but also have several new reporting requirements and more government accountability and scrutiny regarding payments and fees charged they must manage.

Arguably, the most impacted industry sector belongs to payers. Payers must address wide sweeping regulatory requirements, expanded coverage mandates and will need to address how they will participate, or not, in Insurance Exchanges that will be created by the states.

State governments, because of the critical role they play in managing and financing the Medicaid and the State Children's Health Insurance Programs will also have a number of new requirements, expanded coverage and new accountability mandates that they must address as well. In addition, states will be shouldering a far larger healthcare responsibility, by creating, managing, and regulating new Insurance Exchanges for both individual residents and small businesses.

The bottom line is: change is coming, and quickly, under the new law.

Dell Services is proud to provide you with this information and we stand by to assist your organization as you address the many challenges and opportunities that this landmark legislation has created. We are available to members of your team to further explain these key new requirements should you wish. In the meantime, we hope you find this analysis helpful in learning more about how the Patient Protection and Affordable Care Act will impact healthcare delivery and quality in America.

Health Reform Timeline

2010

- Plan must extend coverage to dependent children until they turn 26
- Physician-owned hospital Medicare provider agreements must be in effect prior to Dec. 31
- Tax-exempt hospitals must conduct community needs assessment and have certain charity care policies in place
- Ban on lifetime limits and restrictions on annual limits
- Standard format for presenting information on coverage options (60 days after enactment)
- Temporary high-risk insurance pool implemented (90 days after enactment)
- Medicare Part D drug discount

2011

- A 10% Medicare bonus will be given to primary care doctors and surgeons practicing in underserved areas
- Establishment of a new voluntary long-term care insurance program for disabled people
- 50% discount for brand-name drugs for Medicare recipients
- Demonstration grants for medical malpractice reform begin
- Innovation Center for CMS established
- Prohibits federal Medicaid payments to states for services related to hospital-acquired conditions
- Federal funding of Medicaid medical home program
- New funding for community health centers, school based clinics, and trauma center program
- Minimum Medical Loss Ratio (MLR) goes into effect
- Medicare Advantage rates freeze until 2012
- Employers will be required to report the value of their health plan on their W-2 tax forms

2012

- Establishment of non-profit insurance co-ops to compete with commercial plans
- Penalty on hospitals with high rates of preventable readmissions by cutting Medicare payments
- Medicare Value-based Purchasing (VBP) program begins
- Medicaid bundled payment demonstration projects begin
- Medicare Advantage reimbursement cuts begin and bonus payments implemented
- Comparative effectiveness research fee begins

2013

- Financial relationship disclosure required between providers and drug manufacturers and suppliers
- Medicaid primary care payment must be at least 100% of Medicare payment
- Medicare bundled payment demonstration project begins
- Plan administration simplification rules for eligibility and claims status go into effect

2014

- Individual and employer mandates begin
- Health insurance state-based exchanges begin
- Health plans are prohibited from limiting coverage based on pre-existing conditions
- Premiums can now only vary by age, residence, family size, and tobacco use
- Independent Payment Advisory Board (IPAB) submits first recommendation on reducing Medicare spending growth
- Expand Medicaid to 133% FPL
- Reduction in states' DSH allotment
- Guaranteed issue for individual plans, rating bands, and risk adjustment requirements go into effect

2015

- Reduce Medicare payments for hospital-acquired conditions

2018

- A new "Cadillac tax" on employer-sponsored insurance

2020

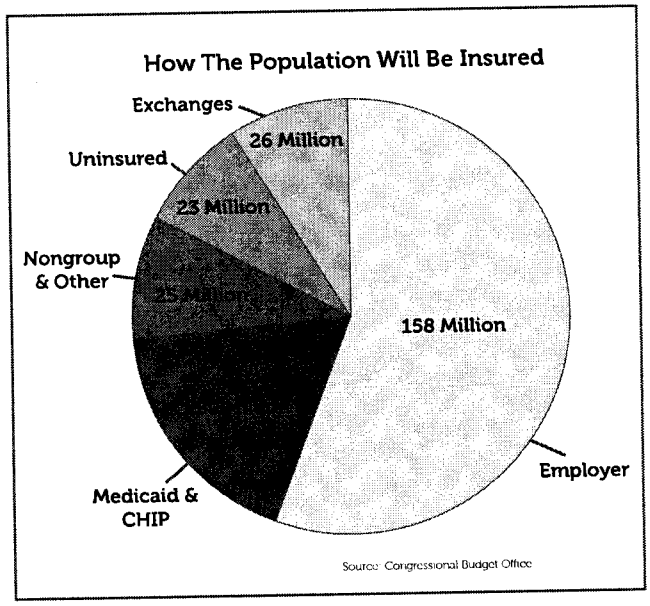
- The Medicare "doughnut hole" will officially be closed

Top Ten Impacts On Payers

1. Guaranteed issue and ban on pre-existing condition exclusions (page 7-8)
2. Ban on lifetime limits and restrictions on annual limits (page 6)
3. Consumer coverage navigation assistance (page 8)
4. Restrictions on premium rates (page 8)
5. Premium increase review requirement (page 7)
6. Expands dependent coverage (page 6)
7. Simplification of administration (page 7)
8. Improving transparency of information and audits (page 29)
9. Create new web portal for consumers (page 8)
10. Expands mandatory coverage for preventive services (page 6)

Title I Provisions: Quality, Affordable Healthcare for All Americans

Title I of the health reform package will have several drastic changes to the way the healthcare industry operates. First, it takes away the ability of insurance companies to deny coverage to American adults and children with pre-existing conditions. It also allows dependent children to remain on their parent's insurance until age 26. In an effort to improve affordability it limits the cost of premiums and cost-sharing for individuals and includes employer responsibility provisions.



Medicare will provide a $250 rebate for beneficiaries who hit the coverage gap, otherwise known as the "doughnut hole," in 2010, and fill the hole for brand and generic drugs by 2020. It also provides a more refined approach that varies rates by local fee-for-service costs on a sliding scale. As for Medicaid, it provides 100 percent federal match in 2014, 2015, and 2016, which equalizes and increases funding for Medicaid expansion by 95 percent match in 2017, 94 percent match in 2018, 93 percent match in 2019, and 90 percent thereafter. Title I also increases payments for Medicaid primary care to Medicare rates in 2013 and 2014 and provides full federal support to do so.

Payers Must:

- Not place lifetime limits or annual limits on the dollar value of benefits.
- Can place annual or lifetime per-beneficiary limits on covered benefits that are not essential health benefits to the extent that such limits are otherwise permitted.
- Not rescind coverage of an enrollee except in the case of fraud or intentional misrepresentation of material fact.
- Requires health plans to provide coverage for, and to not impose any cost sharing requirements for:
  - (1) Specified preventive items or services.
  - (2) Recommended immunizations.
  - (3) Recommended preventive care and screenings for women and children.
- Extend coverage to unmarried, adult children through 26 years of age.
- Implement an effective process for appeals of coverage determinations and claims.
- Establish new requirements for health plans related to:
  - (1) Designation of a primary care provider.
  - (2) Coverage of emergency services.
  - (3) Elimination of referral requirements for obstetrical or gynecological care.
- Health plans (including a grandfathered health plan—See definition below) must:
  - (1) Submit to the Secretary a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums.
  - (2) Provide an annual rebate to each enrollee if the Medical Loss Ratio is less than 85% for large group insurance companies and 80% for small and individual market insurance companies.

- Payers must provide the following prior to any enrollment restriction.
  - » Summary of benefits and coverage explanation to:
    (1) The applicant at the time of application.
    (2) An enrollee prior to the time of enrollment or re-enrollment.
    (3) A policy or certificate holder at the time of issuance of the policy or delivery of the certificate.
- Comply with requirements relating to the prohibition against discrimination in favor of highly compensated individuals.

Defines a "grandfathered health plan" as a group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of this Act. States that this subtitle and subtitle A shall not apply to: (1) a group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of this Act, regardless of whether the individual renews such coverage after such date of enactment, (2) an existing group health plan that enrolls new employees under this section; and (3) health insurance coverage maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers that was ratified before the date of enactment of this Act until the date on which the last of the collective bargaining agreements relating to the coverage terminates. Applies provisions related to uniform coverage documents and medical loss ratios to grandfathered health plans for plan years beginning after enactment of this Act.

HHS Secretary Must (New Payer Policy Requirements):

- Develop standards for health plans to provide an accurate summary of benefits and coverage explanation.
- Develop reporting requirements for health plans on benefits or reimbursement structures that:
  (1) Improve health outcomes.
  (2) Prevent hospital readmissions.
  (3) Improve patient safety and reduce medical errors.
  (4) Promote wellness and health.
- Establish a process for the annual review of unreasonable increases in premiums for health insurance coverage.
- Offer grants to states for offices of health insurance consumer assistance or health insurance ombudsman programs.

Hospitals Must:

- Establish and publish a list of its standard charges for items and services.

State Governments May:

- Create offices of health insurance consumer assistance or health insurance ombudsman programs.

Subtitle B - Immediate Actions to Preserve and Expand Coverage

HHS Must:

- Establish a temporary high risk health insurance pool program to provide health insurance coverage to eligible individuals with a preexisting condition. Coverage later to be shifted to Exchanges.
- Establish a temporary reinsurance program for early retirees to reimburse participating employment-based plans for a portion of costs.
- Establish a mechanism, including a website, through which a resident of, or small business in, any state may identify affordable health insurance coverage options in that state.
- Create Administrative Simplification to adopt a single set of operating rules for eligibility verification and claim status.
- Conduct a study of the fully-insured and self-insured group health plan markets related to financial solvency and the effect of insurance market reforms.

Top Ten Impacts on States

Top Ten Impacts on Providers

1. 10% increase to Medicare incentive payments for primary care physicians (page 16-17)
2. 10% increase to Medicare incentive payments for general surgeons (page 16-17)
3. Increases Medicaid for Primary Care Physicians payments to Medicare levels (page 6)
4. Administrative simplification to standardize insurance claims processing (page 7)
5. Bundling of Payments for Medicare continuum of care demonstration (page 15)
6. Adoption of a single set of operating rules for eligibility verification and claims status(page 7)
7. Expands Preventive and screening benefits (page 6, 24)
8. Drug company disclosure requires of financial relationships (page 29)
9. Limits to physician-owned hospitals (page 29)
10. Reduce Medicare payments for hospital-acquired conditions (page 17)

Subtitle C - Quality Health Insurance Coverage for All Americans

Payers Can No Longer:

- Impose any preexisting condition exclusion.
- Discriminate on the basis of any health status-related factor.
- Establish individual eligibility rules based on health status-related factors, including medical condition, claims experience, receipt of healthcare, medical history, genetic information, and evidence of insurability.
- Discriminate with respect to participation under the plan or coverage against any healthcare provider who is acting within the scope of that provider's license or certification under applicable state law.

Payers Must:

- Allow premium rates to vary only by individual or family coverage, rating area, age, or tobacco use.
- Accept every employer and individual in the state that applies for coverage.
- Renew or continue coverage at the option of the plan sponsor or the individual, as applicable.
- Create provisions governing wellness programs under the health plan, including allowing cost variances for coverage for participation.
- Offer health insurance coverage in the individual or small group market to ensure that such coverage includes the essential health benefits package.
- Require a group health plan to ensure that any annual cost-sharing imposed under the plan does not exceed specified limitations.
- Eliminate any waiting period for coverage that exceeds 90 days.
- Prohibit discriminating against individual participation in clinical trials with respect to treatment of cancer or any other life-threatening disease or condition.

Secretary of Labor Requirements:

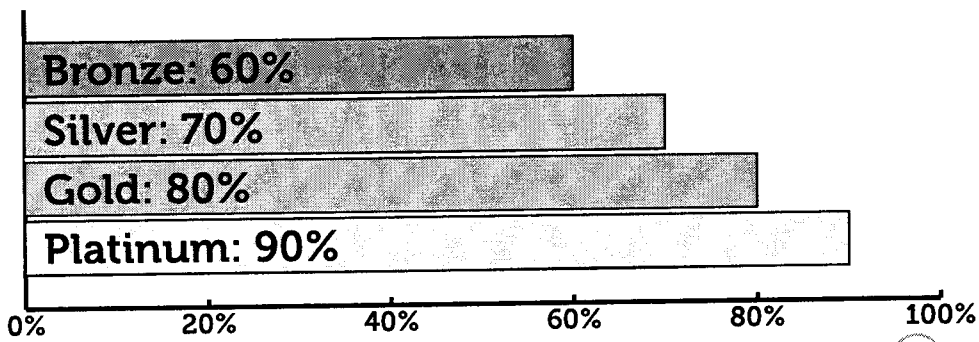
- Prepare an annual report on self-insured group health plans and self-insured employers.

Secretary Must:

- Establish the requirements of a "Qualified Healthcare Plan" for exchanges that will provide for "essential health benefits." These benefits must include:
  - » Define essential health benefits and include emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, preventive and wellness services, chronic disease management, pediatric services, and oral and vision care;
  - » Ensure that the scope of the essential health benefits is equal to the scope of benefits provided under a typical employer plan;
  - » Provide notice and an opportunity for public comment in defining the essential health benefits.

Payers Must:

- Individual and small-group plans offered in the exchanges would have to fall into one of four tiers based on the percentage of costs paid for by the plan:



- Participating Payers would have to offer plans at the silver and gold level.
- Policies must have:

  (1) An annual limit on cost-sharing beginning in 2014.

  (2) A limitation on the deductible under a small group market health plan.
- Sets forth levels of coverage for health plans defined by a certain percentage of the costs paid by the plan.
- Sets forth special rules for abortion coverage, including:

  (1) Permitting states to elect to prohibit abortion coverage in qualified health plans offered through an Exchange in the state.

  (2) Prohibiting federal funds from being used for abortion services.

  (3) Requiring separate accounts for payments for such services.
- Prohibits any qualified health plan offered through an Exchange from discriminating against any individual healthcare provider or healthcare facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions.

Payers May:

- Offer catastrophic coverage for individuals under age 30, with certain limitations.

Health Insurance Exchanges:

- Grants from the HHS Secretary are available to states to establish Health Insurance Exchanges within one year of enactment and until Jan. 1, 2015.
- Must be a governmental agency or non-profit entity that is established by a state.
- May not make available any health plan that is not a qualified health plan.
- Must implement procedures for certification of health plans as qualified health plans.
- Must require health plans seeking certification to submit a justification of any premium increase prior to implementation of such increase.
- American Health Benefit Exchanges will be required to:
  - » Facilitate the purchase of qualified health plans;
  - » Provide for the establishment of a Small Business Health Options Program (SHOP) Exchange that is designed to assist qualified small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market in the state;
  - » Keep an accurate accounting of all activities, receipts, and expenditures and submit to the Secretary, annually, a report concerning such accountings.

HHS Secretary Must:

- Establish criteria for the certification of health plans as qualified health plans, including requirements for:

  (1) Meeting market requirements.

  (2) Ensuring a sufficient choice of providers.
- Take certain action to reduce fraud and abuse in the administration of this title. Requires the Comptroller General to conduct an ongoing study of Exchange activities and the enrollees in qualified health plans offered through Exchanges.
- Issue regulations setting standards related to:
  - » Establishment and operation of Exchanges
  - » Offering of qualified health plans through Exchanges
  - » Establishment of the reinsurance and risk adjustment programs under Part V
- Establish and operate an Exchange within a state if the state does not have one operational by 01/01/14.
- Presume that an Exchange operating in a state before Jan. 1, 2010, that insures a specified percentage of its population meets the standards under this section.

Top Ten State Grants

State Governments May (regarding Exchanges):

- Require qualified health plans to offer additional benefits, but the states must pay for the cost of such additional benefits.
- Establish one or more subsidiary Exchanges for geographically distinct areas of a certain size.
- Allow an employer to select a level of coverage available to employees through an Exchange.
- Allow employees to choose to enroll in any qualified health plan that offers that level of coverage.
- May allow large employers to join an Exchange after 2017.

State Governments Must (regarding Exchanges):

- Apply mental health parity provisions to qualified health plans.

HHS Secretary Must (regarding CO-OP creation):

- Establish the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of qualified nonprofit health insurance issuers for both individual and small group markets.
- Set forth provisions governing the establishment and operation of CO-OP program plans. Health insurance coverage offered by a private health insurance issuer shall not be subject to federal or state laws if a qualified health plan offered under the CO-OP program is not subject to such law.
- Provide for loans and grants to establish CO-OPs.

Part IV: Additional State Flexibility to Establish Alternative Programs

HHS Secretary Must:

- Establish a basic health program under which a state may enter into contracts to offer one or more standard health plans providing at least the essential health benefits to eligible individuals in lieu of offering such individuals coverage through an Exchange. Transfers funds that would have gone to the Exchange for such individuals to the state.
- Provide for an alternative means by which the aggregate amounts of credits or reductions that would have been paid on behalf of participants in the Exchange will be paid to the state for purposes of implementing the state plan.
- Establish standards to enable states to establish and maintain a reinsurance program with certain requirements and limitations (see below).

State Governments May:

- Apply for a waiver of specified requirements under this Act with respect to health insurance coverage within that state for plan years beginning on or after Jan. 1, 2017.
- Establish one or more reinsurance entities before Jan. 1, 2014. HHS Secretary to establish standards to enable states to establish and maintain a reinsurance program under which:
  - › Health insurance issuers and third-party administrators on behalf of group health plans are required to make payments to an applicable reinsurance entity for specified plan years.
  - › Reinsurance entity uses amounts collected to make reinsurance payments to health insurance issuers that cover high-risk individuals in the individual market.
- Directs the state to eliminate or modify any state high-risk pool to the extent necessary to carry out the reinsurance program established under this section.

Director of the Office of Personnel Management (OPM) Must:

- Enter into contracts with health insurance issuers to offer at least two multistate qualified health plans through each Exchange in each state to provide individual or group coverage. Implement this subsection in a manner similar to the manner in which the Director implements the Federal Employees Health Benefits Program.

Part V - Reinsurance and Risk Adjustment

HHS Secretary Must:

- Establish and administer a program of risk corridors until calendar year 2016 under which a qualified health plan offered in the individual or small group market shall participate in a payment-adjusted system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums.

- Make payments when a plan's allowable costs exceed the target amount by a certain percentage, and directs a plan to make payments to the Secretary when its allowable costs are less than target amount by a certain percentage.

State Governments Must:

- Assess a charge on health plans and health insurance issuers if the actuarial risk of the enrollees of such plans or coverage for a year is less than the average actuarial risk of all enrollees in all plans or coverage in the state for the year.
- Provide a payment to health plans and health insurance issuers if the actuarial risk of the enrollees of such plan or coverage for a year is greater than the average actuarial risk of all enrollees in all plans and coverage in the state for the year (excludes self-insured group health plans).

Subtitle E - Affordable Coverage Choices for All Americans

Tax Credits and Cost-sharing Reductions:

- Allow individual taxpayers whose household income equals or exceeds 100%, but does not exceed 400%, of the federal poverty line (as determined in the Social Security Act [SSA]) a refundable tax credit for a percentage of the cost of premiums for coverage under a qualified health plan.
  - » Sets forth formulae and rules for the calculation of credit amounts based upon taxpayer household income as a percentage of the poverty line.
  - » Directs the Comptroller General, not later than five years after enactment of this Act, to conduct a study and report to specified congressional committees on the affordability of health insurance coverage.

Payers Must:

- Reduce the maximum limits for out-of-pocket expenses for individuals enrolled in qualified health plans whose incomes are between 100% and 400% of the poverty line.

HHS Secretary Must:

- Establish a program for verifying the eligibility of applicants for participation in a qualified health plan offered through an Exchange or for a tax credit for premium assistance based upon their income or their citizenship or immigration status.
- Require an Exchange to submit information received from an applicant to the Secretary for verification of applicant eligibility.
- Study and report to Congress by Jan. 1, 2013, on procedures necessary to ensure the protection of privacy and due process rights in making eligibility and other determinations under this Act.
- Establish a program for advance payments of the tax credit for premium assistance and for reductions of cost-sharing. Prohibits any federal payments, tax credit, or cost-sharing reductions for individuals who are not lawfully present in the United States.
- Establish a system to enroll state residents who apply to an Exchange in state health subsidy programs, including Medicaid or the Children's Health Insurance Program (CHIP, formerly known as SCHIP), if such residents are found to be eligible for such programs after screening.
- Study and report to Congress by Jan. 1, 2013, on the feasibility and implication of adjusting the application of the federal poverty level under this subtitle for different geographic areas in the United States, including its territories.

Secretary of Treasury Must:

- Disclose to Health and Human Services personnel certain taxpayer information to determine eligibility for programs under this Act or certain other social security programs.

Small Business Owners May:

- Qualified small employers (less than 25 employees with wages below $50,000 average) can elect, beginning in 2010, a tax credit for 50% of their employee healthcare coverage expenses.

Penalties On Individuals For Not Maintaining Coverage By Year

FY	Penalty amount per individual	Percent of household income, if greater
2014	$95	1%
2015	$325	2%
2016	$695	2.5%
After 2016	Indexed to CPI-U	2.5%

Subtitle F - Shared Responsibility for Healthcare

Individuals Must:

- Maintain minimal essential healthcare coverage beginning in 2014.
  - » A penalty for failure to maintain such coverage will be provided except for certain low-income individuals who cannot afford coverage, members of Indian tribes, and individuals who suffer hardship and individuals who object to healthcare coverage on religious grounds, individuals not lawfully present in the United States, and individuals who are incarcerated.

Payers Must:

- File informational returns providing identifying information regarding holders of minimum essential coverage.

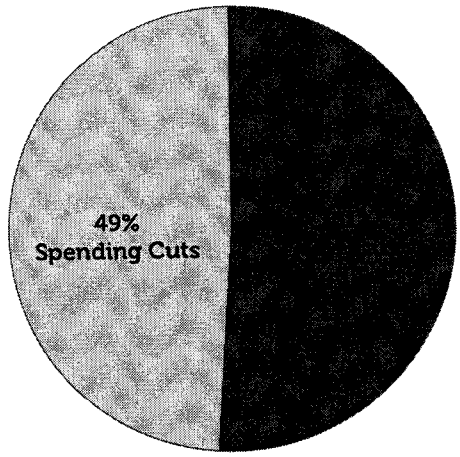
Internal Revenue Service Must:

- Send a notice to taxpayers who are not enrolled in minimum essential coverage about services available through the Exchange operating in their state.

Employers Must:

- Automatically enroll new employees (200 or more employees).
- Provide notice to employees about an Exchange:
  - » Ensure awareness regarding availability of a tax credit for premium assistance. If tax credit is accepted and employee gets coverage under an Exchange offered plan, employee will lose employer's contribution.

Sources of Funding
10 Year Total: $1.1 Trillion (2010 To 2019)



Notable Cuts:
- Educations Cuts
- Long-Term Care Insurance Premiums
- Cutting Payments To Private Medicare Advantage Plans
- Savings From Medicare, Medicaid & CHIP
- Savings From Payments To Hospitals Serving The Poor

Notable New Fees:
- Fees On Drug & Device Manufacturers & Insurers
- Excise Taxes On High-Premium Insurance Plans
- Penalties Paid By Businesses And Uninsured Individuals
- Other Taxes And Fees

Source: Congressional Budget Office

- Pay fines on large employers (employers with more than 50 full-time employees) who fail to offer their full-time employees the opportunity to enroll in minimum essential coverage or who have a waiting period for enrollment of more than 60 days.
- Requires large employers to file a report with the Secretary of the Treasury on health insurance coverage provided to their full-time employees containing:
  - » Certification as to whether such employers provide the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan.
  - » Length of any waiting period for such coverage.
  - » Months during which such coverage was available.
  - » Monthly premium for the lowest cost option in each of the enrollment categories under the plan.
  - » Employer's share of the total allowed costs of benefits provided.
  - » Identifying information about the employer and full-time employees.
  - » Imposes a penalty on employers who fail to provide such a report.

HHS Secretary May:

- Review the accuracy of information provided by large employers.

Secretary of Labor Must:

- Study and report to Congress on whether employees' wages are reduced due to fines imposed on employers.

Subtitle G - Miscellaneous Provisions

HHS Secretary Must:

- Publish on the HHS website a list of all of the authorities provided to the Secretary under this Act.
- Develop interoperable and secure standards and protocols that facilitate enrollment of individuals in federal and state health and human services programs.
- Award grants to develop and adapt technology systems to implement such standards and protocols.

The HHS Comptroller Must:

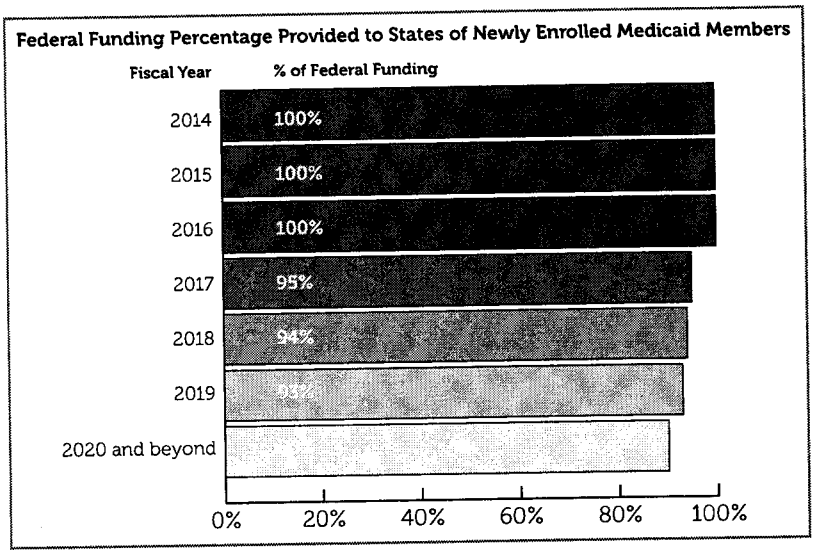
- Study denials by health plans of coverage for medical services and of applications to enroll in health insurance.

Title II: Role of Public Programs

Title II extends Medicaid while treating all States equally. It preserves CHIP, the successful children's insurance plan, and simplifies enrollment for individuals and families. Title II enhances community-based care for Americans with disabilities and provides states with opportunities to expand home-care services to people with long-term care needs. It also gives flexibility for states to adopt innovative strategies to improve care and the coordination of services for Medicare and Medicaid beneficiaries.

Medicaid Policy Changes:

- Medicaid eligibility for non-elderly individuals to be determined using an individual or household's modified gross income, without applying any income or expense disregards or assets or resources test. Exempt from this requirement are:
  - (1) Individuals eligible for Medicaid through another program.
  - (2) The elderly or Social Security Disability Insurance (SSDI) program beneficiaries.
  - (3) The medically needy.
  - (4) Enrollees in a Medicare Savings Program.
  - (5) The disabled.
- Increases the federal medical assistance percentage (FMAP):
  - (1) With respect to newly eligible individuals.
  - (2) Between Jan. 1, 2014, and Dec. 31, 2016, for states meeting certain eligibility requirements.



- Requires Medicaid benchmark benefits to include coverage of prescription drugs and mental health services.
- Extends Medicaid coverage to former foster care children who are under 26 years of age.
- Prescribes an adjustment to the FMAP determination for certain states recovering from a major disaster.

State Governments Must (regarding Medicaid):

- Extend coverage, beginning in 2014, to individuals under age 65 who are not entitled to or enrolled in Medicare and have incomes at or below 133% of the federal poverty line ($14,404 for an individual and $29,327 for a family of four in 2009).
- No longer require, as a condition of Medicaid eligibility, that an individual (or the individual's parent) apply for enrollment in qualified employer-sponsored coverage.

HHS Must (regarding Medicaid):

- Revises requirements for Medicaid payments to territories, including an increase in the limits on payments for FY2011 and thereafter.

State Governments May (regarding Medicaid):

- Expand Medicaid eligibility to such individuals as early as April 1, 2010. Provides that, between 2014 and 2016, the federal government will pay 100% of the cost of covering newly-eligible individuals.
- Revises state authority to offer a premium assistance subsidy for qualified employer-sponsored coverage to children under age 19 to extend such a subsidy to all individuals, regardless of age.

Subtitle B - Enhanced Support for the Children's Health Insurance Program:

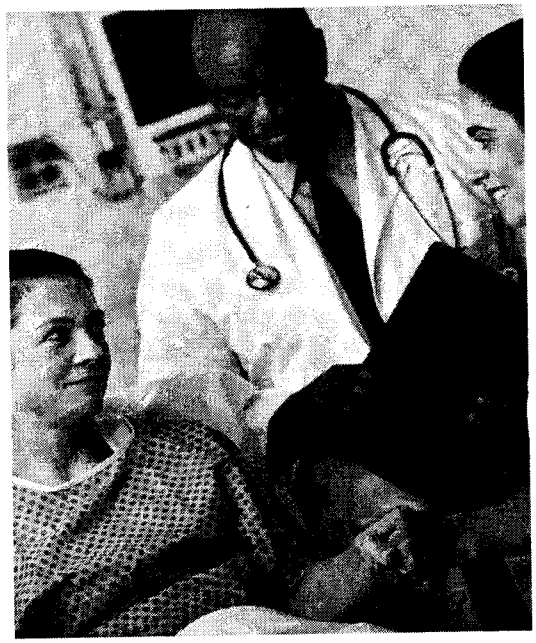
- Amends Title XXI (State Children's Health Insurance Program [CHIP, formerly known as SCHIP]) to increase the FY2016-FY2019 enhanced FMAP for states, subject to a 100% cap.
- Prohibits states from applying, before the end of FY2019, CHIP eligibility standards that are more restrictive than those under this Act.
- Deems ineligible for CHIP any targeted low-income children who cannot enroll in CHIP because allotments are capped, but who are therefore eligible for tax credits in the Exchanges.
- Prohibits enrollment bonus payments for children enrolled in CHIP after FY2013.
- Requires a state CHIP plan to use modified gross income and household income to determine CHIP eligibility, beginning Jan. 1, 2014.
- Requires a state to treat as a targeted low-income child eligible for CHIP any child determined ineligible for Medicaid as a result of the elimination of an income disregard based on expense or type of income.

State Governments Must (regarding CHIP program):

- Use modified gross income and household income to determine CHIP eligibility beginning Jan. 1, 2014.
- Not apply, before the end of FY2019, CHIP eligibility standards that are more restrictive than those under this Act.

HHS Secretary Must:

- Review benefits offered for children, and related cost-sharing imposed, by qualified health plans offered through an Exchange.
- Certify those plans whose benefits and cost-sharing are at least comparable to those provided under the particular state's CHIP plan.



Subtitle C - Medicaid and CHIP Enrollment Simplification

HHS Secretary Must (regarding Medicaid and CHIP):

- Engage in enrollment application simplification and coordination with state Health Insurance Exchanges and CHIP via state-run websites.

Hospitals May (regarding Medicaid):

- Provide Medicaid services during a period of presumptive eligibility to members of all Medicaid eligibility categories.

Subtitle D - Improvements to Medicaid Services

Medicaid Expansion:

- Requires coverage of:

  (1) Freestanding birth center services.

  (2) Concurrent care for children receiving hospice care.

States May (regarding Medicaid):

- Extend Medicaid coverage to family planning services and supplies under a presumptive eligibility period for a categorically needy group of individuals.

Subtitle E - New Options for States to Provide Long-Term Services and Supports

States May (regarding Medicaid):

- Offer home and community-based attendant services and supports to Medicaid beneficiaries with disabilities who would otherwise require care in a hospital, nursing facility, intermediate care facility for the mentally retarded, or an institution for mental diseases.
- Provide home and community-based services to individuals eligible for services under a waiver; and offer home and community-based services to specific, targeted populations.
- Create an optional eligibility category to provide full Medicaid benefits to individuals receiving home and community-based services under a state plan amendment.
- Apply Medicaid eligibility criteria to recipients of home and community-based services, during calendar year 2014 through 2019, in such a way as to protect against spousal impoverishment.

Medicaid Demonstration Program Extension:

- Extend through FY2016 the Money Follows the Person Rebalancing Demonstration; and reduce the institutional residency period to 90 days.

Subtitle F - Medicaid Prescription Drug Coverage

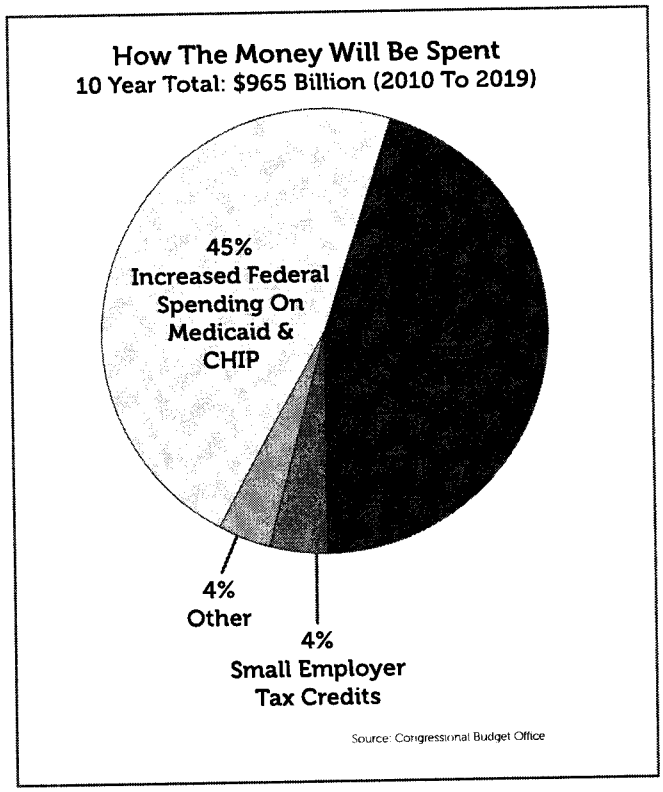
Medicaid Prescription Drug Coverage:

- Increases the minimum rebate percentage for single source drugs and innovator multiple source drugs.
- Increases the rebate for other drugs.
- Requires contracts with Medicaid-managed care organizations to extend prescription drug rebates (discounts) to their enrollees.
- Provides an additional rebate for new formulations of existing drugs.
- Sets a maximum rebate amount.
- Allows Medicaid to cover certain drugs used to promote smoking cessation, as well as barbiturates and benzodiazepines.

Subtitle G - Medicaid Disproportionate Share Hospital (DSH) Payments

Medicaid Disproportionate Share Hospital (DSH) Payments:

- Reduces allotments, except for Hawaii, by 50% or 35% once a state's uninsured rate decreases by 45%, depending on whether they have spent at least 99.9% of their allotments on average during FY2004 through FY2008.
- Requires a reduction of only 25% or 17.5% for low DSH states, depending on whether they have spent at least 99.9% of their allotments on average during FY2004-FY2008.
- Prescribes allotment reduction requirements for subsequent fiscal years. Revises DSH allotments for Hawaii for the last three quarters of FY2012 and for FY2013 and succeeding fiscal years.



Subtitle H - Improved Coordination for Dual Eligible Beneficiaries

Dual Eligible Beneficiaries:

- Declares that any Medicaid waiver for individuals dually eligible for both Medicaid and Medicare may be conducted for a period of five years, with a five-year extension, upon state request, unless the Secretary determines otherwise for specified reasons.

HHS Secretary Must:

- Establish a Federal Coordinated Healthcare Office to bring together officers and employees of the Medicare and Medicaid programs at the Centers for Medicare and Medicaid Services (CMS) to:
  - » Integrate Medicaid and Medicare benefits more effectively.
  - » Improve the coordination between the federal government and states for dual eligible individuals.

Subtitle I - Improving the Quality of Medicaid for Patients and Providers

HHS Secretary Must:

- Identify and publish a recommended core set of adult health quality measures for Medicaid eligible adults.
- Establish a Medicaid Quality Measurement Program.
- Identify current state practices that prohibit payment for healthcare-acquired conditions and to incorporate them, or elements of them, that are appropriate for application in regulations to the Medicaid program. Requires such regulations to prohibit payments to states for any amounts expended for providing medical assistance for specified healthcare-acquired conditions.

State Governments May:

- Provide coordinated care through a health home for individuals with chronic conditions.

HHS Secretary May:

- Award planning grants to states to develop a state plan to support providing coordinated care through a health home for individuals.

HHS Secretary Must:

- Establish a demonstration project to evaluate the use of bundled payments for the provision of integrated care for a Medicaid beneficiary:
  - (1) With respect to an episode of care that includes a hospitalization.
  - (2) For concurrent physicians services provided during a hospitalization.
- Establish a Medicaid Global Payment System Demonstration Project. The state shall adjust payments made to an eligible safety net hospital or network from a fee-for-service payment structure to a global capitated payment model.
- Establish the Pediatric Accountable Care Organization Demonstration Project. States to allow pediatric medical providers meeting specified requirements to be recognized as an accountable care organization for the purpose of receiving specified incentive payments.
- Establish a three-year Medicaid emergency psychiatric Demonstration project.

Subtitle J - Improvements to the Medicaid and CHIP Payment and Access Commission (MACPAC)

Medicaid and CHIP Payment and Access Commission:

- Revises MACPAC and the Medicare Payment Advisory Commission (MEDPAC) requirements to review Medicaid trends in spending, utilization, and financial performance. Requires MACPAC and MEDPAC to consult with one another on related issues.

Subtitle K - Protections for American Indians and Alaska Natives

- Sets forth special rules relating to Indians.
  - » Declares that health programs operated by the Indian Health Service (IHS), Indian tribes, tribal organizations, and Urban Indian organizations shall be the payer of last resort for services they provide to eligible individuals.
  - » Makes such organizations "Express Lane" agencies for determining Medicaid and CHIP eligibility.

HHS Secretary Must:

- Reimburse certain Indian hospitals and clinics for all Medicare part B services.

Subtitle L - Maternal and Child Health Services

HHS Secretary Must:

- Make grants to eligible entities for early childhood home visitation programs.

HHS Secretary May:

- Continue activities on postpartum depression or postpartum psychosis, including research to expand the understanding of their causes and treatment.
- Make grants to eligible entities for projects to establish, operate, and coordinate effective and cost-efficient systems for the delivery of essential services to individuals with or at risk for postpartum conditions and their families.

HHS Secretary Must:

- Allot funds to states to award grants to local organizations and other specified entities to carry out personal responsibility education programs to educate adolescents on both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, as well as on certain adulthood preparation subjects.

Title III: Improving the Quality and Efficiency of Healthcare

Title III protects and preserves Medicare for America's seniors and enhances access to healthcare services in underserved areas. Physicians are also incentivized to improve care and reduce unnecessary errors that harm patients.

Subtitle A - Transforming the Healthcare Delivery System: Linking Payment to Quality Outcomes under the Medicare Program

HHS Secretary Must:

- Establish a hospital value-based purchasing program under which value-based incentive payments are made in a fiscal year to hospitals that meet specified performance standards for a certain performance period.
- Establish value-based purchasing demonstration programs for:
  - (1) Inpatient critical access hospital services.
  - (2) Hospitals excluded from the program because of insufficient numbers of measures and cases.
- Integrate reporting on quality measures with reporting requirements for the meaningful use of electronic health records.
- Extends through 2013 the authority for incentive payments under the physician quality reporting system.
- Prescribes an incentive (penalty) for providers who do not report quality measures satisfactorily, beginning in 2015.

HHS Must:

- Requires specified new types of reports and data analysis under the physician feedback program.

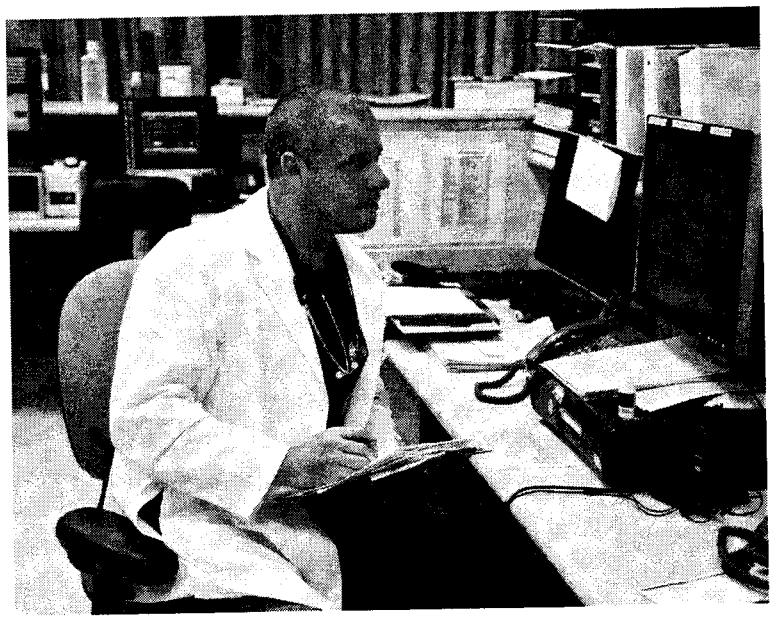
Hospitals Must:

- Requires long-term care hospitals, inpatient rehabilitation hospitals, and hospices, starting in rate year 2014, to submit data on specified quality measures. Requires reduction of the annual update of entities that do not comply.

HHS Secretary Must (Hospital and Physician Requirement):

- Establish quality reporting programs for inpatient cancer hospitals exempt from the prospective payment system.
- Develop a plan to implement value-based purchasing programs for Medicare payments for skilled nursing facilities (SNFs), home health agencies, and ambulatory surgical centers.

- Establish a value-based payment modifier, under the physician fee schedule, based upon the quality of care furnished compared to cost.
- Creates a penalty adjustment to hospital payments for high rates of hospital acquired conditions.



Part II - National Strategy to Improve Healthcare Quality

HHS Secretary Must:

- Through a transparent collaborative process, establish a National Strategy for Quality Improvement in healthcare services, patient health outcomes, and population health, taking into consideration certain limitations on the use of comparative effectiveness data.

The President Must:

- Convene an Interagency Working Group on Healthcare Quality.

HHS Secretary Must:

- At least triennially, must identify gaps where no quality measures exist as well as existing quality measures that need improvement, updating, or expansion, consistent with the national strategy for use in federal health programs.
- Award grants, contracts, or intergovernmental agreements to eligible entities for purposes of developing, improving, updating, or expanding such quality measures.
- Periodically develop and update provider-level outcome measures for hospitals and physicians, as well as other appropriate providers.
- Requires the convening of multi-stakeholder groups to provide input into the selection of quality and efficiency measures.
- Establish an overall strategic framework to carry out the public reporting of performance information.
- Collect and aggregate consistent data on quality and resource use measures from information systems used to support healthcare delivery. Authorizes the Secretary to award grants for this purpose.
- Make available to the public, through standardized websites, performance information summarizing data on quality measures.

Part III - Encouraging Development of New Patient Care Models

- Creates within CMS a Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals.

HHS Secretary Must

- Establish a shared savings program that:

  (1) Promotes accountability for a patient population.

  (2) Coordinates items and services under Medicare Parts A and B.

  (3) Encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery.
- Establish a pilot program for integrated care (involving payment bundling) during an episode of care provided to an applicable beneficiary around a hospitalization in order to improve the coordination, quality, and efficiency of healthcare services.
- Conduct a demonstration program to test a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams designed to reduce expenditures and improve health outcomes in the provision of items and services to applicable beneficiaries.
- Establish a hospital readmissions reduction program involving certain payment adjustments, effective for discharges on or after Oct. 1, 2012, for certain potentially preventable Medicare inpatient hospital readmissions.
- Create a program for hospitals with a high severity adjusted readmission rate to improve their readmission rates through the use of patient safety organizations.
- Establish a Community-Based Care Transitions Program which provides funding to eligible entities that furnish improved care transitions services to high-risk Medicare beneficiaries.

Subtitle B - Improving Medicare for Patients and Providers

Ensuring Beneficiary Access to Physician Care and Other Services:

- Extends through calendar year 2010 the floor on geographic indexing adjustments to the work portion of the physician fee schedule.
- Revises requirements for calculation of the practice expense portion of the geographic adjustment factor applied in a fee schedule area for services furnished in 2010 or 2011.
- Extends the process allowing exceptions to limitations on medically necessary therapy caps through Dec. 31, 2010.

HHS Secretary Must:

- Analyze current methods of establishing practice expense geographic adjustments and make appropriate further adjustments (a new methodology) to such adjustments for 2010 and subsequent years.

Laboratory and Rural Hospitals Impact:

- Amends the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 to extend until Jan. 1, 2010, an exception to a payment rule that permits laboratories to receive direct Medicare reimbursement when providing the technical component of certain physician pathology services that had been outsourced by certain (rural) hospitals.

Ambulance Impacts (Land and Air):

- Extends the bonus and increased payments for ground ambulance services until Jan. 1, 2011.
- Extends the payment of certain urban air ambulance services until Jan. 1, 2011 (Sec. 3106, as modified by Sec. 10312).
- Amends the Medicare, Medicaid, and SCHIP Extension Act of 2007, as modified by the American Recovery and Reinvestment Act of 2009 (ARRA), to extend for two years:

  (1) Certain payment rules for long-term care hospital services.

  (2) A certain moratorium on the establishment of certain hospitals and facilities.

Physician and Physician Assistant Impacts:

- Amends MIPPA to extend the physician fee schedule mental health add-on payment provision through Dec. 31, 2010.
- Allows a physician assistant who does not have a direct or indirect employment relationship with a SNF, but who is working in collaboration with a physician, to certify the need for post-hospital extended care services for Medicare payment purposes.

Pharmacy Impacts:

- Amends SSA title XVIII (Medicare), as modified by MIPPA, to exempt certain pharmacies from accreditation requirements until the Secretary develops pharmacy-specific standards.

Medicare Impacts:

- Creates a special Part B enrollment period for military retirees, their spouses (including widows/widowers), and dependent children, who are otherwise eligible for TRICARE (the healthcare plan under the Department of Defense [DOD]) and entitled to Medicare Part A (Hospital Insurance) based on disability or end-stage renal disease, but who have declined Medicare Part B (Supplementary Medical Insurance).

Hospital and Laboratories Impact:

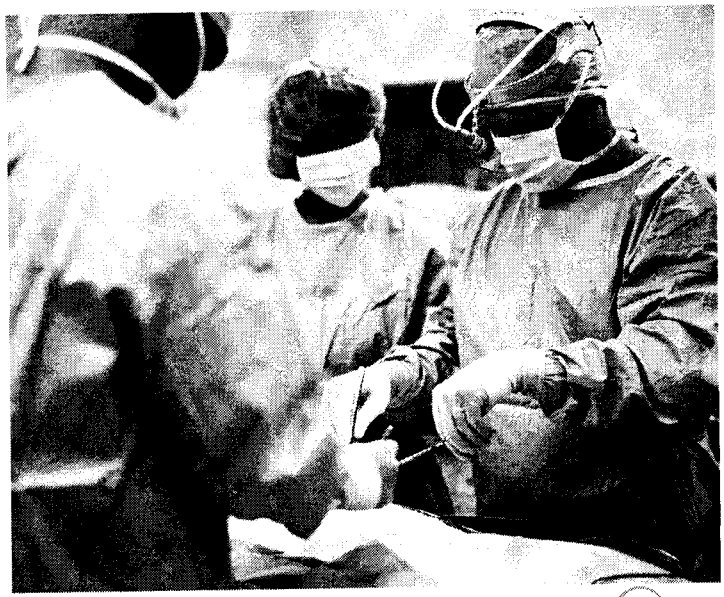
- Sets payments for dual-energy x-ray absorptiometry services in 2010 and 2011 at 70% of the 2006 reimbursement rates.

HHS Secretary Must:

- Arrange with the Institute of Medicine of the National Academies to study and report on the ramifications of Medicare reimbursement reductions for such services on beneficiary access to bone mass measurement benefits.
- Conduct a demonstration project under Medicare Part B of separate payments for complex diagnostic laboratory tests provided to individuals.

Mid-Wife Impacts (regarding payer coverage):

- Increases from 65% to 100% of the fee schedule amount provided for the same service performed by a physician the fee schedule for certified-midwife services provided on or after Jan. 1, 2011.



Rural Protections (regarding hospitals):

- Extends through 2010 hold harmless provisions under the prospective payment system for hospital outpatient department services.
- Removes the 100-bed limitation for sole community hospitals so all such hospitals receive an 85% increase in the payment difference in 2010.
- Extends from July 1, 2010, until July 1, 2011, the reasonable cost reimbursement for clinical diagnostic laboratory service for qualifying rural hospitals with under 50 beds.
- Extends the Rural Community Hospital Demonstration Program for five additional years. Expands the maximum number of participating hospitals from 20 to 30.
- Extends the Medicare-dependent Hospital Program through FY2012.
- Modifies the Medicare inpatient hospital payment adjustment for low-volume hospitals for FY2011-FY2012.
- Revises requirements for the Demonstration Project on Community Health Integration Models in Certain Rural Counties to allow additional counties as well as physicians to participate.
- Directs MEDPAC to study and report to Congress on the adequacy of payments for items and services furnished by service providers and suppliers in rural areas under the Medicare program.
- Allows a critical access hospital to continue to be eligible to receive 101% of reasonable costs for providing:

  (1) Outpatient care regardless of the eligible billing method such hospital uses.

  (2) Qualifying ambulance services.
- Extends through FY2012 FLEX grants under the Medicare Rural Hospital Flexibility Program. Allows the use of grant funding to assist small rural hospitals to participate in delivery system reforms.

Part III - Improving Payment Accuracy

HHS Secretary Must (regarding hospice and home health):

- Starting in 2014, rebase home health payments by an appropriate percentage to, among other things, reflect the number, mix, and level of intensity of home health services in an episode, and the average cost of providing care.
- Study and report to Congress on home health agency costs involved with providing ongoing access to care to low-income Medicare beneficiaries or beneficiaries in medically underserved areas, and in treating beneficiaries with varying levels of severity of illness. Authorizes a Medicare demonstration project based on the study results.
- Collect additional data and information needed to revise payments for hospice care.
- Not earlier than Oct. 1, 2013, implement, by regulation, budget-neutral revisions to the methodology for determining hospice payments for routine home care and other services, which may include per diem payments reflecting changes in resource intensity in providing such care and services during the course of an entire episode of hospice care.
- Impose new requirements on hospice providers participating in Medicare, including requirements for:

  (1) A hospice physician or nurse practitioner to have a face-to-face encounter with the individual regarding eligibility and recertification.

  (2) A medical review of any stays exceeding 180 days, where the number of such cases exceeds a specified percentage of them for all hospice programs.

HHS Secretary Must (regarding physician services):

- Periodically identify physician services as being potentially under- or over-valued, and make appropriate adjustments to the relative values of such services under the Medicare physician fee schedule.

Medicare Reimbursement Policy Changes:

- Specifies reductions to Medicare DSH payments for FY2015 and ensuing fiscal years, especially to subsection (d) hospitals, to reflect lower uncompensated care costs relative to increases in the number of insured (generally, a subsection [d] hospital is an acute care hospital, particularly one that receives payments under Medicare's inpatient prospective payment system when providing covered inpatient services to eligible beneficiaries).
- Increases the presumed utilization rate for calculating the payment for advanced imaging equipment other than low-tech imaging such as ultrasound, x-rays and EKGs. Increases the technical component payment "discount" for sequential imaging services on contiguous body parts during the same visit.
- Restricts the lump-sum payment option for new or replacement chairs to the complex, rehabilitative, power-driven wheelchairs only. Eliminates the lump-sum payment option for all other power-driven wheelchairs. Makes the rental payment for power-driven wheelchairs 15% of the purchase price for each of the first three months (instead of 10%), and 6% of the purchase price for each of the remaining 10 months of the rental period (instead of 7.5%).

- Extends "Section 508" on hospital reclassifications until September 30, 2010, with a special rule for FY2010. Section 508 of the Medicare Modernization Act of 2003 allows the temporary reclassification of a hospital with a low Medicare area wage index, for reimbursement purposes, to a nearby location with a higher Medicare area wage index, so that the "Section 508 hospital" will receive the higher Medicare reimbursement rate.
- Allows a biosimilar biological product to be reimbursed at 6% of the average sales price of the brand biological product.
- Requires application of the budget neutrality requirement associated with the effect of the imputed rural floor on the area wage index under the Balanced Budget Act of 1997 through a uniform national (instead of state-by-state) adjustment to the area hospital wage index floor.

HHS Secretary Must:

- Report to Congress a plan to reform the hospital wage index system.
- Determine if the outpatient costs incurred by inpatient prospective payment system-exempt cancer hospitals, including those for drugs and biologicals, with respect to Medicare ambulatory payment classification groups, exceed those costs incurred by other hospitals reimbursed under the outpatient prospective payment system (OPPS). If this is so, the Secretary must provide for an appropriate OPPS adjustment to reflect such higher costs for services furnished on or after Jan. 1, 2011.
- Establish a Medicare Hospice Concurrent Care demonstration program under which Medicare beneficiaries are furnished, during the same period, hospice care and any other Medicare items or services from Medicare funds otherwise paid to such hospice programs.
- Conduct a study and report on the need for an additional payment for urban Medicare-dependent hospitals for inpatient hospital services under Medicare.

Medicare Part C Policy Changes (Payer Impacts):

- Bases the Medicare Advantage (MA) benchmark on the average of the bids from MA plans in each market.
- Revises the formula for calculating the annual Medicare+Choice capitation rate to reduce the national MA per capita Medicare+Choice growth percentage used to increase benchmarks in 2011.
- Increases the monthly MA plan rebates from 75% to 100% of the average per capita savings.
- Requires that bid information that MA plans are required to submit to the Secretary be certified by a member of the American Academy of Actuaries and meet actuarial guidelines and rules established by the Secretary.
- Prohibits MA plans from charging beneficiaries cost sharing for chemotherapy administration services, renal dialysis services, or skilled nursing care that is greater than what is charged under the traditional fee-for-service program.
- Requires MA plans to apply the full amount of rebates, bonuses, and supplemental premiums according to the following order:

  (1) Reduction of cost sharing,

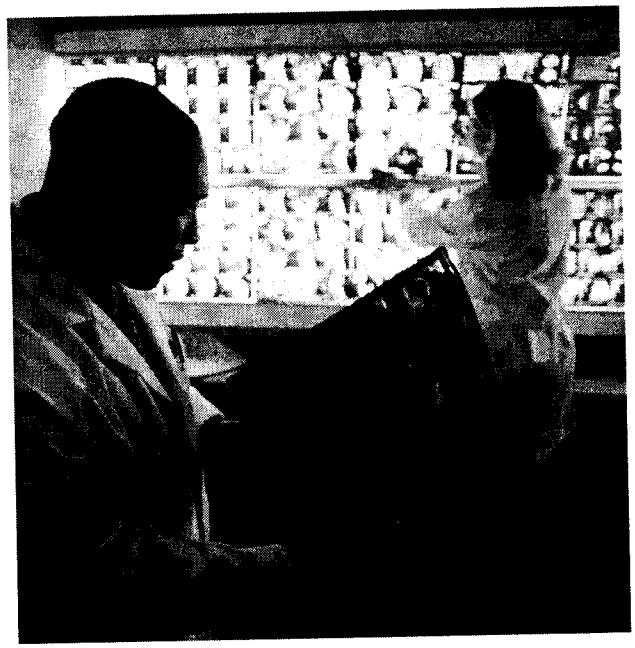
  (2) Coverage of preventive care and wellness benefits, and

  (3) Other benefits not covered under the original Medicare fee-for-service program.
- Allows beneficiaries to disenroll from an MA plan and return to the traditional Medicare fee-for-service program from Jan. 1 to March 15 of each year.
- Extends through calendar year 2012 the length of time reasonable cost plans may continue operating regardless of any other MA plans serving the area.
- Creates a new type of MA plan called an MA Senior Housing Facility Plan, which would be allowed to limit its service area to a senior housing facility (continuing care retirement community) within a geographic area.
- Declares that the Secretary is not required to accept any or every bid submitted by an MA plan or Medicare Part D prescription drug plan that proposes to increase significantly any beneficiary cost sharing or decrease benefits offered.

HHS Secretary Must:

- Acting through the CMS Chief Actuary, establish actuarial guidelines for the submission of bid information and bidding rules that are appropriate to ensure accurate bids and fair competition among MA plans.
- Establish new MA payment areas for urban areas based on the Core Based Statistical Area.
- Make monthly care coordination and management performance bonus payments, quality performance bonus payments, and quality bonuses for new and low enrollment MA plans, to MA plans that meet certain criteria.
- Provide transitional rebates for the provision of extra benefits to enrollees.
- Analyze the differences in coding patterns between MA and the original Medicare fee-for-service programs. Incorporate the results of the analysis into risk scores for 2014 and subsequent years.

- Establish a frailty payment adjustment under PACE payment rules for fully-integrated, dual-eligible SNPs. Extends authority through calendar year 2012 for SNPs that do not have contracts with state Medicaid programs to continue to operate, but not to expand their service areas.
- Require an MA organization offering a specialized MA plan for special needs individuals to be approved by the National Committee for Quality Assurance.
- Use a risk score reflecting the known underlying risk profile and chronic health status of similar individuals, instead of the default risk score, for new enrollees in MA plans that are not specialized MA SNPs.
- Request the National Association of Insurance Commissioners (NAIC) to develop new standards for certain Medigap plans.



Subtitle D - Medicare Part D Improvements for Prescription Drug Plans and MA-PD Plans

MA-Prescription Drug Plan Impacts:

- Establishes conditions for the availability of coverage for Part D drugs.
- Requires the manufacturer to participate in the Medicare coverage gap discount program.
- Excludes the MA rebate amounts and quality bonus payments from calculation of the regional low-income subsidy benchmark premium for MA monthly prescription drug beneficiaries.
- Sets forth a special rule for widows and widowers regarding eligibility for low-income assistance. Allows the surviving spouse of an eligible couple to delay redetermination of eligibility for one year after the death of a spouse.
- Provides additional funding for FY2010-FY2012 for outreach and education activities related to specified Medicare low-income assistance programs.
- Requires Part D enrollees who exceed certain income thresholds to pay higher premiums. Revises the current authority of the IRS to disclose income information to the Social Security Administration for purposes of adjusting the Part B subsidy.
- Eliminates cost sharing for certain dual-eligible individuals receiving care under a home and community-based waiver program who would otherwise require institutional care.
- Requires a prescription drug plan sponsor to:

  (1) Use a single, uniform exceptions and appeals process for determination of a plan enrollee's prescription drug coverage.

  (2) Provide instant access to this process through a toll-free telephone number and a website.
- Allows the costs incurred by AIDS drug assistance programs and by IHS in providing prescription drugs to count toward the annual out-of-pocket threshold
- Increases by $500 the 2010 standard initial coverage limit (thus decreasing the time that a Part D enrollee would be in the coverage gap).

HHS Secretary Must:

- Establish such a program (Overviewed above).
- Permit a prescription drug plan or an MA-PD plan to waive the monthly beneficiary premium for a subsidy-eligible individual if the amount of such premium is de minimis. If such premium is waived, the Secretary shall not reassign subsidy eligible individuals enrolled in the plan to other plans based on the fact that the monthly beneficiary premium under the plan was greater than the low-income benchmark premium amount.
- In the case of a subsidy eligible individual enrolled in one prescription drug plan but subsequently reassigned by the Secretary to a new prescription drug plan, to provide the individual with:

  (1) Information on formulary differences between the individual's former plan and the new plan with respect to the individual's drug regimens.

  (2) A description of the individual's right to request a coverage determination, exception, or reconsideration, bring an appeal, or resolve a grievance.

- Identify classes of clinical concern through rulemaking, including anticonvulsants, antidepressants, antineoplastics, antipsychotics, antiretrovirals, and immunosuppressants for the treatment of transplant rejection. Requires prescription drug plan sponsors to include all drugs in these classes in their formularies.
- Require sponsors of prescription drug plans to utilize specific, uniform techniques for dispensing covered Part D drugs to enrollees who reside in a long-term care facility in order to reduce waste associated with 30-day refills.
- Develop and maintain an easy-to-use complaint system to collect and maintain information on MA-PD plan and prescription drug complaints received by the Secretary until the complaint is resolved.

HHS Inspector General Must:

- Study and report to Congress on the inclusion in formularies of:

  (1) Drugs commonly used by dual eligibles.

  (2) Prescription drug prices under Medicare Part D and Medicaid.

Subtitle E - Ensuring Medicare Sustainability (Hospitals and Payer Impacts)

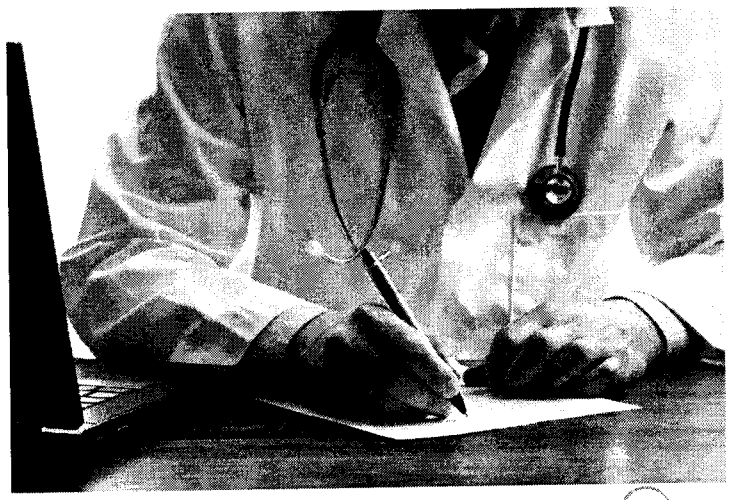
- Revises certain market basket updates and incorporates a full productivity adjustment into any updates that do not already incorporate such adjustments, including inpatient hospitals, home health providers, nursing homes, hospice providers, inpatient psychiatric facilities, long-term care hospitals, inpatient rehabilitation facilities, and Part B providers.
- Establishes a quality measure reporting program for psychiatric hospitals beginning in FY2014.
- Revises requirements for reduction of the Medicare Part B premium subsidy based on income.
- Maintains the current 2010 income thresholds for the period of 2011 through 2019.
- Establishes an Independent Medicare Advisory Board to develop and submit detailed proposals to reduce the per capita rate of growth in Medicare spending to the president for Congress to consider.
- Establishes a consumer advisory council to advise the Board on the impact of payment policies under this title on consumers.

Subtitle F - Healthcare Quality Improvements

- Directs the Center for Quality Improvement and Patient Safety of the Agency for Healthcare Research and Quality (AHRQ) to conduct or support activities for best practices in the delivery of healthcare services and support research on the development of tools to facilitate adoption of best practices that improve the quality, safety, and efficiency of healthcare delivery services.
- Requires the AHRQ Director, through the AHRQ Center for Quality Improvement and Patient Safety, to award grants or contracts to eligible entities to provide technical support or to implement models and practices identified in the research conducted by the Center.

HHS Secretary Must:

- Establish a program to provide grants to, or enter into contracts with, eligible entities to establish community-based interdisciplinary, interprofessional teams to support primary care practices, including obstetrics and gynecology practices, within the hospital service areas served by the eligible entities.
- Acting through the Patient Safety Research Center, establish a program to provide grants or contracts to eligible entities to implement medication management services provided by licensed pharmacists, as a collaborative multidisciplinary, inter-professional approach to the treatment of chronic diseases for targeted individuals, to improve the quality of care and reduce overall cost in the treatment of such diseases.
- Acting through the Assistant Secretary for Preparedness and Response, award at least four multi-year contracts or competitive grants to eligible entities to support pilot projects that design, implement, and evaluate innovative models of regionalized, comprehensive, and accountable emergency care and trauma systems.
- Support federal programs administered by the National Institutes of Health, the AHRQ, the Health Resources and Services Administration (HRSA), the CMS, and other agencies involved in improving the emergency care system to expand and accelerate research in emergency medical care systems and emergency medicine.
- Support federal programs administered by such agencies to coordinate and expand research in pediatric emergency medical care systems and pediatric emergency medicine.



- Establish three programs to award grants to qualified public, nonprofit IHS, Indian tribal, and urban Indian trauma centers to:

  (1) Assist in defraying substantial uncompensated care costs.

  (2) Further the core missions of such trauma centers, including by addressing costs associated with patient stabilization and transfer.

  (3) Provide emergency relief to ensure the continued and future availability of trauma services.

- Provide funding to states to enable them to award grants to eligible entities for trauma services.
- Establish a program to award grants or contracts to develop, update, and produce patient decision aids to assist healthcare providers and patients.
- Establish a program to provide for the phased-in development, implementation, and evaluation of shared decision making using patient decision aids to meet the objective of improving patients' understanding of their medical treatment options.
- Award grants for establishment and support of Shared Decision Making Resource Centers. Authorizes appropriations for FY2010 and subsequent fiscal years.
- Acting through the Commissioner of Food and Drugs, determine whether the addition of quantitative summaries of the benefits and risks of prescription drugs in a standardized format to the promotional labeling or print advertising of such drugs would improve healthcare decision making.
- Award grants to eligible entities or consortia to carry out demonstration projects to develop and implement academic curricula that integrate quality improvement and patient safety in the clinical education of health professionals.

HHS Must:

- Establish an Office on Women's Health within the Office of the Secretary, the Office of the Director of the CDC, the Office of the AHRQ Director, the Office of the Administrator of HRSA, and the Office of the Commissioner of Food and Drugs.
- Extends from three years to four years the patient navigator grant. Prohibits the Secretary from awarding such a grant unless the recipient entity provides assurances that patient navigators recruited, assigned, trained, or employed using grant funds meet minimum core proficiencies tailored for the main focus or intervention of the navigator involved.
- Directs the Comptroller General to study and report to Congress on whether the development, recognition, or implementation of any guideline or other standards under specified provisions of this Act would result in the establishment of a new cause of action or claim.

Subtitle G - Protecting and Improving Guaranteed Medicare Benefits

- Provides that nothing in this Act shall result in a reduction of guaranteed benefits under the Medicare program.
- States that savings generated for the Medicare program under this Act shall extend the solvency of the Medicare trust funds, reduce Medicare premiums and other cost-sharing for beneficiaries, and improve or expand guaranteed Medicare benefits and protect access to Medicare providers.
- Nothing in this Act shall result in the reduction or elimination of any benefits guaranteed by law to participants in MA plans.

President Shall:

- Establish the National Prevention, Health Promotion and Public Health Council.
- Establish the Advisory Group on Prevention, Health Promotion, and Integrative and Public Health.
  - » Appoint the Surgeon General as Chairperson of the Council
  - » Council to develop a national prevention, health promotion, and public health strategy.

HHS Must:

- Requires the Secretary and the Comptroller General to conduct periodic reviews and evaluations of every federal disease prevention and health promotion initiative, program, and agency.
- Establishes a Prevention and Public Health Fund to provide for expanded and sustained national investment in prevention and public health programs.

AHRQ (Agency For Healthcare Research & Quality) Must:

- Requires the Director of AHRQ to convene the Preventive Services Task Force to review scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of clinical preventive services for the purpose of developing recommendations for the healthcare community.

CDC Must:

- Convene an independent Community Preventive Services Task Force to review scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of community preventive interventions for the purpose of developing recommendations for individuals and organizations delivering populations-based services and other policy makers.

HHS Secretary Must:

- 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.
- Through the Director of CDC:

  (1) Establish and implement a national science-based media campaign on health promotion and disease prevention.

  (2) Enter into a contract for the development and operation of a federal website personalized prevention plan tool.

Title IV: Prevention of Chronic Disease and Improving Public Health

Title IV promotes prevention, wellness, and the public health by providing funding to these areas. It relies on innovation from small businesses and state and local governments to find the best ways to improve wellness in the workplace and in our communities. It also provides families with the tools to find the best science-based nutrition information and makes prevention and screenings a priority by waiving for America's seniors on Medicare.

Subtitle B - Increasing Access to Clinical Preventive Services

HHS Secretary Must:

- Establish a program to award grants to eligible entities to support the operation of school-based health centers.
- Acting through the Director of CDC, carry out oral health activities, including:

  (1) Establishing a national public education campaign that is focused on oral healthcare prevention and education.

  (2) Awarding demonstration grants for research-based dental caries disease management activities.

  (3) Awarding grants for the development of school-based dental sealant programs.

  (4) Entering into cooperative agreements with state, territorial, and Indian tribes or tribal organizations for oral health data collection and interpretation, a delivery system for oral health, and science-based programs to improve oral health.
- Update and improve the Pregnancy Risk Assessment Monitoring System as it relates to oral healthcare.
- Develop oral healthcare components for inclusion in the National Health and Nutrition Examination Survey.
- Ensure that the Medical Expenditures Panel Survey by AHRQ includes the verification of dental utilization, expenditure, and coverage findings by conducting a look-back analysis.

Medicare Expansion:

- Provide coverage of personalized prevention plan services, including a health risk assessment, for individuals.
  - » Prohibits cost-sharing for such services.
  - » Eliminates cost-sharing for certain preventive services recommended by the United States Preventive Services Task Force. Authorizes the Secretary to modify Medicare coverage consistent with the recommendations of this Task Force.
- Provide coverage of preventive services and approved vaccines. Increases the FMAP for such services and vaccines.
- Provides for coverage of counseling and pharmacotherapy for cessation of tobacco use by pregnant women.

HHS Secretary Must:

- Award grants to states to carry out initiatives to provide incentives to Medicaid beneficiaries who participate in programs to lower health risk and demonstrate changes in health risk and outcomes.
- Acting through the Director of CDC, 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.
- Acting through the Director of CDC, award grants to state or local health departments and Indian tribes to carry out pilot programs to provide public health community interventions, screenings, and clinical referrals for individuals who are between 55 and 64 years of age.

- Conduct an evaluation of community-based prevention and wellness programs and develop a plan for promoting healthy lifestyles and chronic disease self-management for Medicare beneficiaries.
- Evaluate community prevention and wellness programs that have demonstrated potential to help Medicare beneficiaries reduce their risk of disease, disability, and injury by making healthy lifestyle choices.
- Negotiate and enter into contracts with vaccine manufacturers for the purchase and delivery of vaccines for adults.
- Acting through the Director of CDC, establish a demonstration program to award grants to states to improve the provision of recommended immunizations for children and adults through the use of evidence- and population-based interventions for high-risk populations.

States May:

- Purchase additional quantities of adult vaccines from manufacturers at the applicable price negotiated by the Secretary.

HHS Must:

- Requires the Architectural and Transportation Barriers Compliance Board to promulgate standards setting forth the minimum technical criteria for medical diagnostic equipment used in medical settings to ensure that such equipment is accessible to, and usable by, individuals with accessibility needs.
- Reauthorizes appropriations for preventive health service programs to immunize children and adults against vaccine-preventable diseases without charge.
- Requires the Comptroller General to study the ability of Medicare beneficiaries who are 65 years or older to access routinely recommended vaccines covered under the prescription drug program since its establishment.

Food Labeling Requirements:

- Must label a food item offered for sale in a retail food establishment that is part of a chain with 20 or more locations under the same name to disclose on the menu and menu board:

  (1) The number of calories contained in the standard menu item.

  (2) The suggested daily caloric intake.

  (3) The availability on the premises and upon request of specified additional nutrient information.
- Self-service facilities must place adjacent to each food offered a sign that lists calories per displayed food item or per serving.
- Vending machine operators who operate 20 or more vending machines must provide a sign disclosing the number of calories contained in each article of food.

HHS Secretary Must:

- Establish a pilot program to test the impact of providing at-risk populations who utilize community health centers an individualized wellness plan designed to reduce risk factors for preventable conditions as identified by a comprehensive risk-factor assessment.

Employers Must:

- Provide a reasonable break time and a suitable place, other than a bathroom, for an employee to express breast milk for her nursing child.
- Excludes employers with less than 50 employees if such requirements would impose an undue hardship.

Subtitle D - Support for Prevention and Public Health Innovation

HHS Secretary Must:

- Acting through the Director of CDC, provide funding for research in the area of public health services and systems.
- Ensure that any federally conducted or supported healthcare or public health program, activity, or survey collects and reports specified demographic data regarding health disparities.
- Acting through the National Coordinator for Health Information Technology, develop:

  (1) National standards for the management of data collected.

  (2) Interoperability and security systems for data management.

CDC Must:

- Provide employers with technical assistance, consultation, tools, and other resources in evaluating employer-based wellness programs.
- Build evaluation capacity among workplace staff by training employers on how to evaluate such wellness programs and ensuring that evaluation resources, technical assistance, and consultation are available.
- Conduct a national worksite health policies and programs survey to assess employer-based health policies and programs.

HHS Secretary Must:

- Through the Director of CDC, establish an Epidemiology and Laboratory Capacity Grant Program to award grants to assist public health agencies in improving surveillance for, and response to, infectious diseases and other conditions of public health importance.
- Enter into an agreement with the Institute of Medicine to convene a Conference on Pain, the purposes of which shall include increasing the recognition of pain as a significant public health problem in the United States.
- (2) Establish the Interagency Pain Research Coordinating Committee.

Miscellaneous Provisions

HHS Secretary Must:

- Evaluate programs to determine whether existing federal health and wellness initiatives are effective in achieving their stated goals.

Title V: Healthcare Workforce

This title provides funding for scholarships and loan repayment programs, thus increasing the number of primary care physicians, nurses, physician assistants, mental health providers, and dentists in rural areas. It gives state and local governments flexibility and resources to develop health workforce recruitment strategies, and it funds the expansion, construction, and operation of community health centers throughout the U.S.

The purpose of this title is to improve access to, and the delivery of, healthcare services for all individuals, particularly low-income, underserved, uninsured, minority, health disparity, and rural populations.

Subtitle B - Innovations in the Healthcare Workforce

- Establishes a National Healthcare Workforce Commission to:
  - (1) Review current and projected healthcare workforce supply and demand.
  - (2) Make recommendations to Congress and the administration concerning national healthcare workforce priorities, goals, and policies.
- Establishes a healthcare workforce development grant program.

HHS Secretary Must:

- Establish the National Center for Healthcare Workforce Analysis to provide for the development of information describing and analyzing the healthcare workforce and workforce related issues. Establishes the Interagency Access to Healthcare in Alaska Task Force to:
  - (1) Assess access to healthcare for beneficiaries of federal healthcare systems in Alaska.
  - (2) Develop a strategy to improve delivery to such beneficiaries.
- Expands student loan forgiveness to include allied health professionals employed in public health agencies.
- Includes public health workforce loan repayment programs as permitted activities under a grant program to increase the number of individuals in the public health workforce.

Subtitle C - Increasing the Supply of the Healthcare Workforce

- Revises student loan repayment provisions related to the length of service requirement for the primary healthcare loan repayment program.
- Increases maximum amount of loans made by schools of nursing to students.
- Eliminates the cap on the number of commissioned officers in the Public Health Service Regular Corps.
  - » Revises the Regular Corps and the Reserve Corps (renamed the Ready Reserve Corps) in the Public Health Service.
  - » Sets forth the uses of the Ready Reserve Corps.
- Expands geriatric faculty fellowship programs to make dentists eligible. Reauthorizes and revises the geriatric education programs to allow grant funds to be used for the establishment of traineeships for individuals who are preparing for advanced education nursing degrees in areas that specialize in the care of elderly populations.
- Requires nurse-midwifery programs, in order to be eligible for advanced education nursing grants, to have as their objective the education of midwives and to be accredited by the American College of Nurse-Midwives Accreditation Commission for Midwifery Education.
- Makes nurse faculty at an accredited school of nursing eligible for the nursing education loan repayment program.
- Authorizes the establishment of the United States Public Health Sciences Track, which is authorized to award advanced degrees in public health, epidemiology, and emergency preparedness and response.

HHS Secretary Must:

- Establish and carry out a pediatric specialty loan repayment program.
- Establish the Public Health Workforce Loan Repayment Program to assure an adequate supply of public health professionals to eliminate critical public health workforce shortages in federal, state, local, and tribal public health agencies.
- Award grants for the cost of the operation of nurse-managed health clinics.
- Award grants for new training opportunities for direct care workers who are employed in long-term care settings.
- Award grants for demonstration programs to establish training programs for alternative dental healthcare providers in order to increase access to dental health services in rural and other underserved communities.
- Award grants or contracts to entities that operate a geriatric education center to offer short-term, intensive courses that focus on geriatrics, chronic care management, and long-term care.
- Award grants to institutions of higher education to support the recruitment of students for, and education and clinical experience of the students in, social work programs, psychology programs, child and adolescent mental health, and training of paraprofessional child and adolescent mental health workers.
- Acting through the Administrator of HRSA, award grants, contracts, or cooperative agreements for the development, evaluation, and dissemination of research, demonstration projects, and model curricula for health professions training in cultural competency, prevention, public health proficiency, reducing health disparities, and working with individuals with disabilities.
- Award grants or enter into contracts to enhance the nursing workforce by initiating and maintaining nurse retention programs.
- Acting through the Administrator of HRSA, enter into an agreement for the repayment of education loans in exchange for service as a faculty member at an accredited school of nursing.
- Carry out activities to address documented workforce shortages in state and local health departments in the critical areas of applied public health epidemiology and public health laboratory science and informatics.
- Establish a training demonstration program for family nurse practitioners to employ and provide one-year training for nurse practitioners serving as primary care providers in federally qualified health centers or nurse-managed health centers.

HHS Secretary May:

- Provide scholarships for mid-career professionals in the public health and allied health workforce to receive additional training in the field of public health and allied health.

CDC Must:

- Award grants to eligible entities to promote positive health behaviors and outcomes for populations in medically underserved communities through the use of community health workers.

Surgeon General Must:

- Develop:

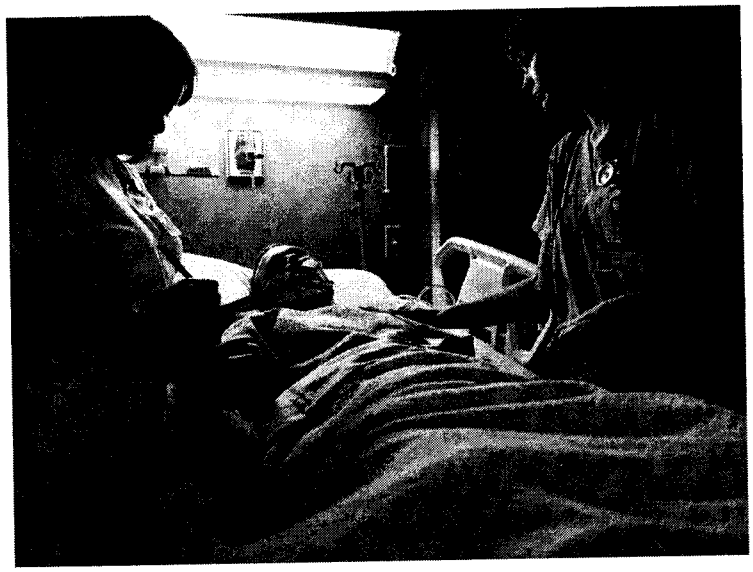
  (1) An integrated longitudinal plan for health professions continuing education.

  (2) Faculty development programs and curricula in decentralized venues of healthcare to balance urban, tertiary, and inpatient venues.

Subtitle E - Supporting the Existing Healthcare Workforce

- Revises the allocation of funds to assist schools in supporting programs of excellence in health professions education for underrepresented minority individuals and schools designated as centers of excellence.
- Makes schools offering physician assistant education programs eligible for loan repayment for health profession faculty.
  - » Increases the amount of loan repayment for such programs.

- Authorizes appropriations for:
  - (1) Scholarships for disadvantaged students attending health professions or nursing schools.
  - (2) Loan repayment for health professions faculty.
  - (3) Grants to health professions schools to assist individuals from disadvantaged backgrounds.
- Makes revisions to the grant program to increase nursing education opportunities for individuals from disadvantaged backgrounds to include providing:
  - (1) Stipends for diploma or associate degree nurses to enter a bridge or degree completion program.
  - (2) Student scholarships or stipends for accelerated nursing degree programs.
  - (3) Advanced education preparation.



HHS Secretary Must:

- Make awards for area health education center programs.
- Provide for timely dissemination of research findings using relevant resources.
- Acting through the Director of AHRQ, establish a Primary Care Extension Program to provide support and assistance to educate primary care providers about preventive medicine, health promotion, chronic disease management, mental and behavioral health services, and evidence-based and evidence-informed therapies and techniques.
  - » Award grants to states for the establishment of Primary Care Extension Program State Hubs to coordinate state healthcare functions with quality improvement organizations and area health education centers.

Subtitle F - Strengthening Primary Care and Other Workforce Improvements

- Requires Medicare incentive payments to:
  - (1) Primary care practitioners providing primary care services on or after Jan. 1, 2011, and before Jan. 1, 2016.
  - (2) General surgeons performing major surgical procedures on or after Jan. 1, 2011, and before Jan. 1, 2016, in a health professional shortage area.
- Reallocates unused residency positions to qualifying hospitals for primary care residents for purposes of payments to hospitals for graduate medical education costs.
- Revises provisions related to graduate medical education costs to count the time residents spend in non-provider settings toward the full-time equivalency if the hospital incurs the costs of the stipends and fringe benefits of such residents during such time:
- Includes toward the determination of full-time equivalency for graduate medical education costs time spent by an intern or resident in an approved medical residency training program in a non-provider setting that is primarily engaged in furnishing patient care in non-patient care activities.
- Allows up to 50% of time spent teaching by a member of the National Health Service Corps to be considered clinical practice for purposes of fulfilling the service obligation.

HHS Secretary Must:

- When a hospital with an approved medical residency program closes, increase the resident limit for other hospitals based on proximity criteria.
- Award grants:
  - » For demonstration projects that are designed to provide certain low-income individuals with the opportunity to obtain education and training for healthcare occupations that pay well and that are expected to experience labor shortages or be in high demand; and award grants to states to conduct demonstration projects for purposes of developing core training competencies and certification programs for personal or home-care aides. Authorizes appropriations for FY2009-FY2012 for family-to-family health information centers.
  - » To teaching health centers for the purpose of establishing new accredited or expanded primary care residency programs.
  - » To make payments for direct and indirect expenses to qualified teaching health centers for expansion or establishment of approved graduate medical residency training programs.
  - » To establish a graduate nurse education demonstration under which a hospital may receive payment for the hospital's reasonable costs for the provision of qualified clinical training to advance practice nurses.

Subtitle G - Improving Access to Healthcare Services

HHS Secretary Must:

- Establish, through the negotiated rulemaking process, a comprehensive methodology and criteria for designation of medically underserved populations and health professions shortage areas.
- Acting through the Administrator of the Substance Abuse and Mental Health Services Administration, award grants and cooperative agreements for demonstration projects for the provision of coordinated and integrated services to special populations through the co-location of primary and specialty care services in community-based mental and behavioral health settings.

HHS Must:

- Establishes a Commission on Key National Indicators to:

  (1) Conduct comprehensive oversight of a newly established key national indicators system.

  (2) Make recommendations on how to improve such system.
- Directs the National Academy of Sciences to enable the establishment of such system by creating its own institutional capability or by partnering with an independent private nonprofit organization to implement such system.
- Directs the Comptroller General to study previous work conducted by all public agencies, private organizations, or foreign countries with respect to best practices for such systems.

States May:

- Award grants to healthcare providers who treat a high percentage of medically underserved populations or other special populations in the state.

Title VI - Transparency and Program Integrity

Title VI of the Act aims to help patients take more control of their healthcare decisions and to strengthen the doctor-patient relationship by giving them tools to make better decisions. This title seeks to increase transparency and accountability for nursing homes and providers and also seeks to rein in waste, fraud, and abuse by imposing new disclosure requirements to identify high-risk providers. Title VI gives states new authority regarding providers and gives them flexibility to propose tort reforms that address several criteria, including reducing healthcare errors, enhancing patient safety, encouraging efficient resolution of disputes, and improving access to liability insurance.

Subtitle A - Physician Ownership and Other Transparency

- Prohibits physician-owned hospitals that do not have a provider agreement by Aug. 1, 2010, from participating in Medicare. Allows their participation in Medicare under a rural provider and hospital exception to the ownership or investment prohibition if they meet certain requirements addressing conflicts of interest, bona fide investments, patient safety issues, and expansion limitations.
- Requires drug, device, biological and medical supply manufacturers to report to the Secretary transfers of value made to a physician, physician medical practice, a physician group practice, and/or teaching hospital, as well as information on any physician ownership or investment interest in the manufacturer.

  » Provides penalties for noncompliance.

  » Preempts duplicative state or local laws.
- Provides Medicare in-office ancillary exception to the prohibition against physician self-referrals, to require a referring physician to inform the patient in writing that the patient may obtain a specified imaging service from a person other than the referring physician, a physician who is a member of the same group practice as the referring physician, or an individual directly supervised by the physician or by another physician in the group practice. Requires the referring physician also to provide the patient with a written list of suppliers who furnish such services in the area in which the patient resides.
- Requires prescription drug manufacturers and authorized distributors of record to report to the Secretary specified information pertaining to drug samples.
- Requires a pharmacy benefit manager (PBM) or a health benefits plan that manages prescription drug coverage under a contract with a Medicare or Exchange health plan to report to the Secretary information regarding the generic dispensing rate, the rebates, discounts, or price concessions negotiated by the PBM, and the payment difference between health plans and PBMs and the PBMs and pharmacies.

Subtitle B - Nursing Home Transparency and Improvement

Part I - Improving Transparency of Information (Regarding Nursing and Skilled Nursing Facilities)

- Require SNFs under Medicare and nursing facilities (NFs) under Medicaid to, upon request by the Secretary, the HHS Inspector General, the states, or a state long-term care ombudsman, make available information on ownership of the SNF or NF, including a description of the facility's governing body and organizational structure, as well as information regarding additional disclosable parties.
- Requires SNFs and NFs to operate a compliance and ethics program effective in preventing and detecting criminal, civil, and administrative violations. Directs the Secretary to establish and implement a quality assurance and performance improvement program for SNFs and NFs, including multi-unit chains of facilities.
- Requires SNFs to report separately expenditures on wages and benefits for direct care staff, breaking out registered nurses, licensed professional nurses, certified nurse assistants, and other medical and therapy staff.

HHS Secretary Must:

- Publish on the Nursing Home Compare Medicare website:

  (1) Standardized staffing data.

  (2) Links to state websites regarding state survey and certification programs.

  (3) The model standardized complaint form.

  (4) A summary of substantiated complaints.

  (5) The number of adjudicated instances of criminal violations by a facility or its employees.

- Develop a standardized complaint form for use by residents (or a person acting on a resident's behalf) in filing complaints with a state survey and certification agency and a state long-term care ombudsman program. Requires states to establish complaint resolution processes.
- Develop a program for facilities to report direct care staffing information on payroll and other verifiable and auditable data in a uniform format.

HHS Must:

- Comptroller General to study and report to Congress on the Five-Star Quality Rating System for nursing homes of CMS.

Part II - Targeting Enforcement (Nursing and Skilled Nursing Facilities)

- Requires the administrator of a SNF or a NF that is preparing to close to notify, in writing, residents, legal representatives of residents or other responsible parties, the Secretary, and the state long-term care ombudsman program in advance of the closure by at least 60 days. Requires the notice to include a plan for the transfer and adequate relocation of residents to another facility or alternative setting. Requires the state to ensure a successful relocation of residents.

Secretary May:

- Authorized to reduce civil monetary penalties by 50% for certain SNFs and NFs that self-report and promptly correct deficiencies within 10 calendar days of imposition of the penalty.

HHS Secretary Must:

- Issue regulations providing for an informal dispute resolution process after imposition of a penalty, as well as an escrow account for money penalties pending resolution of any appeals.
- Establish a demonstration project for developing, testing, and implementing a national independent monitor program to oversee interstate and large intrastate chains of SNFs and NFs.
- Conduct two SNF- and NF-based demonstration projects to develop best practice models in two areas:

  (1) One for facilities involved in the "culture change" movement.

  (2) One for the use of information technology to improve resident care.

Improving Staff Training (Nursing and Skilled Nursing Facilities)

- Requires SNFs and NFs to include dementia management and abuse prevention training as part of pre-employment initial training and, if appropriate, as part of ongoing in-service training for permanent and contract or agency staff.

Subtitle C - Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long Term Care Facilities and Providers

HHS Secretary Must:

- Establish a nationwide program for national and state background checks on prospective direct patient access employees of long-term care facilities and providers.

Subtitle D - Patient-Centered Outcomes Research (Payer Fines Included)

- Establishes the Patient-Centered Outcomes Research Institute to identify priorities for, and establish, update, and carry out, a national comparative outcomes research project agenda. Provides for a peer review process for primary research. Prohibits the Institute from allowing the subsequent use of data from original research in work-for-hire contracts with individuals, entities, or instrumentalities that have a financial interest in the results, unless approved by the Institute under a data-use agreement.
- Amends the Public Health Service Act to direct the Office of Communication and Knowledge Transfer at AHRQ to broadly disseminate the research findings published by the Institute and other government-funded research relevant to comparative clinical effective research. Prohibits the Secretary from using evidence and findings from Institute research to make a determination regarding Medicare coverage unless such use is through an iterative and transparent process that includes public comment and considers the effect on subpopulations.
- Amends the Internal Revenue Code to establish in the Treasury the Patient-Centered Outcomes Research Trust Fund. Directs the Secretary to make transfers to that Trust Fund from the Medicare Trust Funds. Imposes annual fees of $2 times the number of insured lives on each specified health insurance policy and on self-insured health plans.
- Terminates the Federal Coordinating Council for Comparative Effectiveness Research upon enactment of this Act.

Subtitle E - Medicare, Medicaid, and CHIP Program Integrity Provisions

Hospital, Physician and Payer Impacts

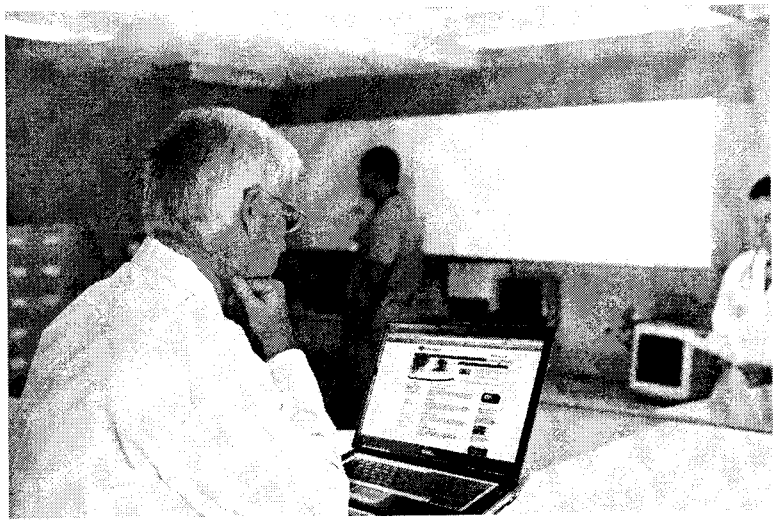
- Requires providers and suppliers applying for enrollment or revalidation of enrollment in Medicare, Medicaid, or CHIP to disclose current or previous affiliations with any provider or supplier that:
  - (1) Has uncollected debt.
  - (2) Has had its payments suspended.
  - (3) Has been excluded from participating in a federal healthcare program; or
  - (4) Has had billing privileges revoked.
- Subjects to civil monetary penalties excluded individuals who:
  - (1) Order or prescribe an item or service.
  - (2) Make false statements on applications or contracts to participate in a federal healthcare program; or
  - (3) Know of an overpayment and do not return it. Subjects the latter offense to civil monetary penalties of up to $50,000 or triple the total amount of the claim involved.
- Requires the Medicaid Integrity Program and Program contractors to provide the Secretary and the HHS Office of Inspector General with performance statistics, including the number and amount of DME overpayments recovered, the number of fraud referrals, and the return on investment for such activities.
- Reduces from three years to one year after the date of service the maximum period for submission of Medicare claims.
- Requires DME or home health services to be ordered by an enrolled Medicare-eligible professional or physician. The Secretary may extend these requirements to other Medicare items and services to reduce fraud, waste, and abuse.
- Requires a physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife, or physician assistant to have a face-to-face encounter with an individual before issuing a certification for home health services or DME. Apply the same face-to-face encounter requirement to other items and services based upon a finding that doing so would reduce the risk of fraud, waste, and abuse. Applies the same requirement, as well, to physicians making certifications for home health services under Medicaid.
- Revises civil monetary penalties for making false statements or delaying inspections. Applies specified enhanced sanctions and civil monetary penalties to MA or Part D plans that:
  - (1) Enroll individuals in an MA or Part D plan without their consent.
  - (2) Transfer an individual from one plan to another for the purpose of earning a commission.
  - (3) Fail to comply with marketing requirements and CMS guidance; or
  - (4) Employ or contract with an individual or entity that commits a violation.

HHS Secretary Must:

- Establish procedures for screening providers and suppliers participating in Medicare, Medicaid, and CHIP.
- Determine the level of screening according to the risk of fraud, waste, and abuse with respect to each category of provider or supplier.

HHS Secretary May:

- Deny enrollment in a program if these affiliations pose an undue risk to it. Requires providers and suppliers to establish a compliance program containing specified core elements.



CMS Must:

- Establish a process for making available to each state agency with responsibility for administering a state Medicaid plan or a child health plan under SSA Title XXI the identity of any provider or supplier under Medicare or CHIP who is terminated.
- Include in the integrated data repository claims and payment data from Medicare, Medicaid, CHIP, and health-related programs administered by the Departments of Veterans Affairs (VA) and Department of Defense, the Social Security Administration, and IHS.

HHS Secretary Must:

- Enter into data-sharing agreements with the Commissioner of Social Security, the VA and DOD Secretaries, and the IHS Director to help identity fraud, waste, and abuse. Requires that overpayments be reported and returned within 60 days from the date the overpayment was identified or by the date a corresponding cost report was due, whichever is later.
- Issue a regulation requiring all Medicare, Medicaid, and CHIP providers to include their National Provider Identifier on enrollment applications.
- Take into account the volume of billing for a durable medical equipment (DME) supplier or home health agency when determining the size of the supplier's and agency's surety bond.
- Authorizes the Secretary to require other providers and suppliers to post a surety bond if the Secretary considers them to be at risk.
- Establish a self-referral disclosure protocol to enable healthcare providers and suppliers to disclose actual or potential violations of the physician self-referral law.
- Secretary may reduce the amount due and owing for all violations.

HHS Secretary May:

- Withhold the federal matching payment to states for medical assistance expenditures whenever a state does not report enrollee encounter data in a timely manner to the state's Medicaid Management Information System.
- Exclude providers and suppliers' participation in any federal healthcare program for providing false information on any application to enroll or participate.
- Issue subpoenas and require the attendance and testimony of witnesses and the production of any other evidence that relates to matters under investigation or in question.
- Suspend payments to a DME provider or supplier pending a fraud investigation.
- Furnish the National Practitioner Data Bank (NPDB) with all information reported to the national healthcare fraud and abuse data collection program on certain final adverse actions taken against healthcare providers, suppliers, and practitioners. Requires the Secretary to establish a process to terminate the Healthcare Integrity and Protection Databank (HIPDB) and ensure that the information formerly collected in it is transferred to the NPDB.
- Disenroll, for up to one year, a Medicare-enrolled physician or supplier that fails to maintain and provide access to written orders or requests for payment for DME, certification for home health services, or referrals for other items and services.
- Exclude from participation in any federal healthcare program any individual or entity ordering, referring for furnishing, or certifying the need for an item or service that fails to provide adequate documentation to verify payment.
- Expand the number of areas to be included in round two of the competitive bidding program from 79 to 100 of the largest metropolitan statistical areas and use competitively-bid prices in all areas by 2016.

State Governments Must:

- Establish contracts with one or more Recovery Audit Contractors (RACs), which shall identify underpayments and overpayments and recoup overpayments made for services provided under state Medicaid plans, as well as state plan waivers.

HHS Secretary Must:

- Expand the RAC program to Medicare Parts C (Medicare+Choice) and D (Prescription Drug Program).

Subtitle F - Additional Medicaid Program Integrity Provisions

- Requires Medicaid agencies to exclude individuals or entities from participating in Medicaid for a specified period of time if the entity or individual owns, controls, or manages an entity that:

  (1) Has failed to repay overpayments during a specified period.

  (2) Is suspended, excluded, or terminated from participation in any Medicaid program; or

  (3) Is affiliated with an individual or entity that has been suspended, excluded, or terminated from Medicaid participation.

- Requires a Medicaid managed-care entity contract to provide for maintenance of sufficient patient encounter data to identify the physician who delivers services to patients (as under current law) at a frequency and level of detail to be specified by the Secretary.
- Extends the period for states to recover overpayments from 60 days to one year after discovery of the overpayment. Declares that, when overpayments due to fraud are pending, state repayments of the federal portion of such overpayments shall not be due until 30 days after the date of the final administrative or judicial judgment on the matter.
- Amends the Employee Retirement Income Security Act of 1974 (ERISA) to prohibit employees and agents of multiple employer welfare arrangements (MEWAs), subject to criminal penalties, from making false statements in marketing materials regarding an employee welfare benefit plan's financial solvency, benefits, or regulatory status.

State Governments Must:

- Terminate individuals or entities (providers) from their Medicaid programs if they were terminated from Medicare or another state's Medicaid program.
- Require any billing agents, clearinghouses, or other alternate payees that submit claims on behalf of healthcare providers to register with the state and the Secretary.
- Submit data elements from the state mechanized claims processing and information retrieval system (under the Medicaid Statistical Information System) that the Secretary determines necessary for program integrity, program oversight, and administration.
- Modify plans to prohibit the state from making any payments for items or services under a Medicaid state plan or a waiver to any financial institution or entity located outside of the United States.
- Requires state mechanized Medicaid claims processing and information retrieval systems to incorporate methodologies compatible with Medicare's National Correct Coding Initiative.

HHS Secretary Must:

- Request NAIC to develop a model uniform report form for a private health insurance issuer seeking to refer suspected fraud and abuse to state insurance departments or other responsible state agencies for investigation.

Labor Secretary Must:

- Adopt regulatory standards and/or issue orders to subject MEWAs to state law relating to fraud and abuse.
- Require MEWAs which are not group health plans to register with the Department of Labor before operating in a state.
- Issue cease-and-desist orders to temporarily shut down the operations of MEWAs conducting fraudulent activities or posing a serious threat to the public, until hearings can be completed.
- Seize a plan's assets if it appears that the plan is in a financially hazardous condition.
- Promulgate a regulation providing an evidentiary privilege that allows confidential communication among specified federal and state officials relating to investigation of fraud and abuse.

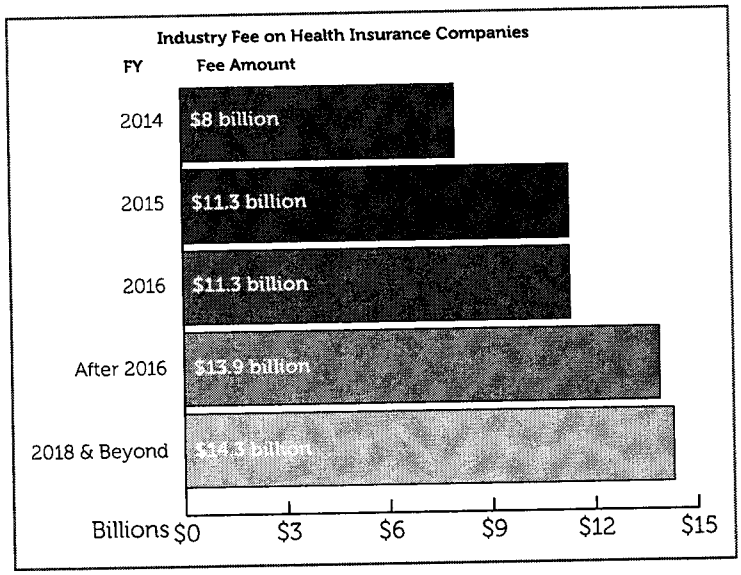
Subtitle H - Elder Justice Act of 2009

Elder Justice

- Amends Block Grants to States for Social Services with respect to elder abuse, neglect, and exploitation and their prevention.
- Requires facility owners, operators, and certain employees to report suspected crimes committed at a facility.
- Requires facility owners or operators also to:

  (1) Submit to the Secretary and to the state written notification of an impending closure of a facility within 60 days before the closure.

  (2) Include a plan for transfer and adequate relocation of all residents.
- Establishes an Elder Justice Coordinating Council.



HHS Secretary Must:

Award grants and carry out activities that provide:

(1) Greater protection to those individuals seeking care in facilities that provide long-term care services and supports.

(2) Greater incentives for individuals to train and seek employment at such facilities.

Subtitle I - Sense of the Senate Regarding Medical Malpractice (Not Required but Encouraged)

- Health reform presents an opportunity to address issues related to medical malpractice and medical liability insurance; states should be encouraged to develop and test alternative models to the existing civil litigation system; and Congress should consider state demonstration projects to evaluate such alternatives.

Title VII - Improving Access to Innovative Medical Therapies

Title VII seeks to promote innovation and save consumers money. This title specifically addresses drug companies and provides measures to make drugs more affordable and effective.

Subtitle A - Biologics Price Competition and Innovation Act of 2009

- Allows a person to submit an application for licensure of a biological product based on its similarity to a licensed biological product (the reference product).

HHS Secretary Must:

- License the biological product if it is biosimilar to or interchangeable with the reference product.
- Prohibits the Secretary from determining that a second or subsequent biological product is interchangeable with a reference product for any condition of use for specified periods based on the marketing of, and the presence or status of litigation involving, the first biosimilar biological product deemed interchangeable with the same reference product.
- Prohibits the Secretary from making approval of an application under this Act effective until 12 years after the date on which the reference product was first licensed.

Subtitle B - More Affordable Medicine for Children and Underserved Communities

- Expands the 340B drug discount program (a program limiting the cost of covered outpatient drugs to certain federal grantees) to allow participation as a covered entity by certain:

  (1) Children's hospitals.

  (2) Freestanding cancer hospitals.

  (3) Critical access hospitals.

  (4) Rural referral centers.

  (5) Sole community hospitals.
- Expands the program to include drugs used in connection with an inpatient or outpatient service by enrolled hospitals (currently, only outpatient drugs are covered under the program).
- Requires manufacturers to offer each covered entity covered drugs for purchase at or below the applicable ceiling price if such a drug is made available to any other purchaser at any price.

HHS Secretary Must (Hospital Impact):

- Establish reasonable exceptions to the prohibition on enrolled hospitals obtaining covered outpatient drugs through a group purchasing organization or other group purchasing arrangement, including for drugs unavailable through the program and to facilitate generic substitution when a generic covered drug is available at a lower price. Allows such hospitals to purchase covered drugs for inpatients through any such arrangement. Requires a hospital enrolled in the 340B drug discount program to issue a credit to a state Medicaid program for inpatient covered drugs provided to Medicaid recipients.
- Provide for improvements in compliance by manufacturers and covered entities with the requirements of the 340B drug discount program.
- Establish and implement an administrative process for resolving claims by covered entities and manufacturers of violations of such requirements.

HHS Must:

Comptroller General to report to Congress on whether those individuals served by the covered entities under the 340B drug discount program are receiving optimal healthcare services.

Title VIII - Class Act

This title provides for Americans and workers who may develop a disability. It gives them a new option to finance long-term services and care in the event of a disability. This is a self-funded and voluntary long-term care insurance choice. No taxpayer funds will be used to pay benefits under this provision.

- Establishes a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program) under which:

  (1) All employees are automatically enrolled, but are allowed to waive enrollment.

  (2) Payroll deductions pay monthly premiums.

  (3) Benefits under a CLASS Independence Benefit Plan provide individuals with functional limitations with tools that will allow them to maintain their personal and financial independence and live in the community.

Title IX - Revenue Provisions

In order to make healthcare more affordable for families and small business owners, Title IX of the Act provides tax cuts for the middle class and for families making less than $250,000. It also adds new credits to help reduce premium costs and purchase insurance.

Subtitle A - Revenue Offset Provisions (Hospital Requirements Below)

- Impose an excise tax of 40% of the excess benefit from certain high cost employer-sponsored health coverage.
- Deems any amount which exceeds payment of $8,500 for an employee self-only coverage plan and $23,000 for employees with other than self-only coverage (family plans) as an excess benefit. Increases such amounts for certain retirees and employees who are engaged in high-risk professions (e.g., law enforcement officers, emergency medical first responders, or longshoremen).
- Imposes a penalty on employers and coverage providers for failure to calculate the proper amount of an excess benefit.
- Requires employers to include in the W-2 form of each employee the aggregate cost of applicable employer-sponsored group health coverage that is excludable from the employee's gross income (excluding the value of contributions to flexible spending arrangements).
- Restricts payments from health savings accounts, medical savings accounts, and health flexible spending arrangements for medications to prescription drugs or insulin.
- Increases to 20% the penalty for distributions from a health savings account or Archer medical savings account not used for qualified medical expenses.
- Limits annual salary reduction contributions by an employee to a health flexible spending arrangement under a cafeteria plan to $2,500. Allows an annual inflation adjustment to such amount after 2011.
- Expands reporting requirements for payments of $600 or more to corporations.
- Requires tax-exempt charitable hospitals to:

  (1) Conduct a community health needs assessment every two years.

  (2) Adopt a written financial assistance policy for patients who require financial assistance for hospital care.

  (3) Refrain from taking extraordinary collection actions against a patient until the hospital has made reasonable efforts to determine whether the patient is eligible for financial assistance.

- Imposes a penalty tax on hospitals who fail to comply with the requirements of this Act.

Treasury Secretary Must:

- Report to Congress on information with respect to private tax-exempt, taxable, and government-owned hospitals regarding levels of charity care provided, bad debt expenses, unreimbursed costs, and costs for community benefit activities.
- Imposes an annual fee on the branded prescription drug sales exceeding $5 million of manufacturers and importers of such drugs beginning in 2010.
- Requires the HHS, VA, and DOD Secretaries to report to the Secretary of the Treasury on the total branded prescription drug sales within government programs within their departments.
- Imposes an annual fee on the gross sales receipts exceeding $5 million of manufacturers and importers of certain medical devices beginning in 2011.
- Imposes on any entity that provides health insurance for any United States health risk an annual fee beginning in 2011.
- Exempts entities whose net premiums written are not more than $25 million.
- Requires all entities subject to such fee to report to the Secretary of the Treasury on their net written premiums and imposes a penalty for failure to report.
- Eliminates the tax deduction for expenses for determining the subsidy for employers who maintain prescription drug plans for Medicare.

VA Secretary Must:

- Study and report to Congress by Dec. 31, 2012, on the effect of fees assessed by this Act on the cost of medical care provided to veterans and on veterans' access to medical devices and branded prescription drugs.

Part D Eligible Retirees

- Increases the adjusted gross income threshold for claiming the itemized deduction for medical expenses from 7.5% to 10% beginning after 2012.
- Retains the 7.5% threshold through 2016 for individual taxpayers who have reached age 65 before the close of an applicable taxable year.
- Imposes a limitation after Dec. 31, 2012, of $500,000 on the deductibility of remuneration paid to officers, directors, employees, and service providers of health insurance issuers who derive at least 25% of their gross premiums from providing health insurance coverage that meets the minimum essential coverage requirements established by this Act.
- Increases after Dec. 31, 2012, the hospital insurance tax rate by 0.9% for individual taxpayers earning more than $200,000 ($250,000 for married couples filing joint tax returns).
- Requires Blue Cross or Blue Shield organizations or other nonprofit organizations that provide health insurance to reimburse at least 85% of the cost of clinical services provided to their enrollees to be eligible for special tax benefits currently provided to such organizations.

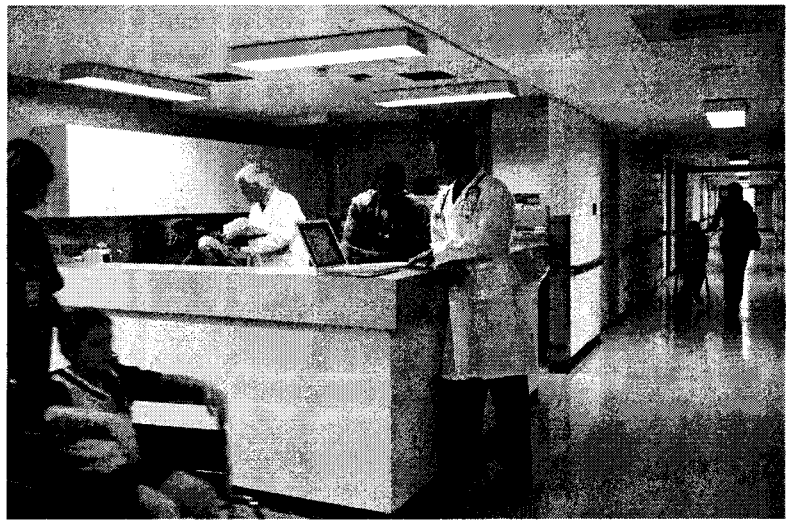
Other Provisions

- Excludes from gross income the value of certain health benefits provided to members of Indian tribes, including:
  (1) Health services or benefits provided or purchased by IHS.
  (2) Medical care provided by an Indian tribe or tribal organization to a member of an Indian tribe.
  (3) Accident or health plan coverage provided by an Indian tribe or tribal organization for medical care to a member of an Indian tribe and dependents.
  (4) Any other medical care provided by an Indian tribe that supplements, replaces, or substitutes for federal programs.
- Establishes a new employee benefit cafeteria plan to be known as a Simple Cafeteria Plan, defined as a plan that:
  (1) Is established and maintained by an employer with an average of 100 or fewer employees during a two-year period.
  (2) Requires employers to make contributions or match employee contributions to the plan.
  (3) Requires participating employees to have at least 1,000 hours of service for the preceding plan year.
  (4) Allows such employees to elect any benefit available under the plan.
- Allows a 50% tax credit for investment in any qualifying therapeutic discovery project, defined as a project that is designed to:
  (1) Treat or prevent diseases by conducting pre-clinical activities, clinical trials, and clinical studies, or carrying out research projects to approve new drugs or other biologic products.
  (2) Diagnose diseases or conditions to determine molecular factors related to diseases or conditions; or
  (3) Develop a product, process, or technology to further the delivery or administration of therapeutics.

Treasury Secretary Must:

- Directs the Secretary of the Treasury to award grants for 50% of the investment in 2009 or 2010 in such a project, in lieu of the tax credit.

Title X - Strengthening Quality, Affordable Healthcare for All Americans



Title X seeks to improve healthcare for American Indians and Alaskan natives. It reauthorizes the Indian Healthcare Improvement Act (ICHIA) and modernizes the Indian healthcare system.

Subtitle A - Provisions Relating to Title I

- Requires an offering employer to provide free choice vouchers to each qualified employee.
  - » Defines "offering employer" to mean any employer who offers minimum essential coverage to its employees consisting of coverage through an eligible employer-sponsored plan and who pays any portion of the costs of such plan.
  - » Defines "qualified employee" as an employee whose required contribution for such coverage and household income fall within a specified range.
- Requires:

  (1) A Health Insurance Exchange to credit the amount of any free choice voucher to the monthly premium of any qualified health plan in which the employee is enrolled.

  (2) The offering employer to pay any amounts so credited to the Exchange.
  - » Excludes the amount of any free choice voucher from the gross income of the employee. Permits a deduction by employers for such costs.

HHS Secretary Must:

- Seek input to determine if there could be greater uniformity in financial and administrative healthcare activities and items.
- Task the ICD-9-CM Coordination and Maintenance Committee to convene a meeting to receive input regarding and recommend revisions to the crosswalk between the Ninth and Tenth Revisions of the International Classification of Diseases. Make appropriate revisions to such crosswalk.

Subtitle B - Provisions Relating to Title II

Part I - Medicaid and CHIP

- Sets the FMAP for the state of Nebraska, with respect to all or any portion of a fiscal year that begins on or after Jan. 1, 2017, at 100% (thus requiring the federal government to pay 100% of the cost of covering newly-eligible individuals in Nebraska).
- Directs the Comptroller General to study and report to Congress on whether the development, recognition, or implementation of any specified healthcare quality guideline or other standards would result in the establishment of a new cause of action or claim (Sec. 10202).
- Creates a State Balancing Incentive Payments Program to increase the FMAP for states which offer home and community-based services as a long-term care alternative to nursing homes.

HHS Secretary Must:

- Establish a Pregnancy Assistance Fund for grants to states to assist pregnant and parenting teens and women.

Part II - Indian Healthcare Improvement

- Enacts into law the Indian Healthcare Improvement Reauthorization and Extension Act of 2009 (S. 1790), as reported by the Committee on Indian Affairs of the Senate in December 2009.
- Makes an exception to the requirement that a national Community Health Aide Program exclude dental health aide therapist services.
- Declares that the exclusion of dental health aide therapist services from services covered under the national program shall not apply where an Indian tribe or tribal organization, located in a state (other than Alaska) in which state law authorizes the use of dental health aide therapist services or mid-level dental health provider services, elects to supply such services in accordance with state law.

Subtitle C - Provisions Relating to Title III

- Deems eligible for Medicare coverage certain individuals exposed to environmental health hazards.
- Establishes floors -

  (1) On the area wage index for hospitals in frontier states.

  (2) On the area wage adjustment factor for hospital outpatient department services in frontier states.

  (3) For practice expense index for services furnished in frontier states.
- Revises the SNF prospective payment system to delay specified changes until FY2011.
- Authorizes an additional incentive payment under the physician quality reporting system in 2011 through 2014 to eligible professionals who report quality measures to CMS via a qualified Maintenance of Certification program.
- Eliminates the Medicare Advantage Regional Plan Stabilization Fund.
- Requires Medicare Part D prescription drug plans to include a comprehensive review of medications as part of their medication therapy management programs.
- Requires automatic quarterly enrollment of qualified beneficiaries, with an allowance for them to opt out.
- Transfers the Office of Minority Health to the Office of the Secretary. Establishes individual offices of minority health within HHS.
- Directs the Comptroller General to study and report to Congress on the impact on Medicare beneficiary access to high-quality dialysis services of including specified oral drugs furnished to them for the treatment of end stage renal disease in the related bundled prospective payment system.

HHS Secretary Must:

- Establish a pilot program for care of certain individuals residing in emergency declaration areas.
- Establish a program for early detection of certain medical conditions related to environmental health hazards.
- Conduct separate pilot programs, for specified kinds of hospitals and hospice programs, to test the implementation of a value-based purchasing program for payments to the provider.
- Develop a methodology to measure health plan value.
- Develop a plan to modernize CMS computer and data systems.
- Develop a Physician Compare website with information on physicians enrolled in the Medicare program and other eligible professionals who participate in the Physician Quality Reporting Initiative.
- Implement a plan to make information on physician performance public through Physician Compare, particularly quality and patient experience measures.
- Make available to qualified entities standardized extracts of Medicare claims data for the evaluation of the performance of service providers and suppliers.

HHS Secretary May:

- Provide financial incentives to Medicare beneficiaries furnished services by high quality physicians.
- Award grants to eligible entities to support community-based collaborative care networks for low-income populations.

Revises Provisions of or Related to Subtitles A, B, C, D, and E of Title IV of This Act

- Defines "high need cure" as a drug, biological product, or device:

  (1) That is a priority to diagnose, mitigate, prevent, or treat harm from any disease or condition.

  (2) For which the incentives of the commercial market are unlikely to result in its adequate or timely development.
- Establishes a Cures Acceleration Network Review Board.
- Establishes a Network of Health-Advancing National Centers of Excellence for Depression Act of 2009 or the ENHANCED Act of 2009.

HHS Secretary Must:

- Acting through the Administrator of the Substance Abuse and Mental Health Services Administration,

  (1) Award grants to establish national centers of excellence for depression.

  (2) Designate one such center as a coordinating center.
- Requires the coordinating center to establish and maintain a national, publicly available database to improve prevention programs, evidence-based interventions, and disease management programs for depressive disorders using data collected from the national centers.

- Congenital Heart Futures Act - Authorizes the Secretary, acting through the Director of CDC, to:

  (1) Enhance and expand infrastructure to track the epidemiology of congenital heart disease and to organize such information into the National Congenital Heart Disease Surveillance System; or

  (2) Award a grant to an eligible entity to undertake such activities. Authorizes the Director of the National Heart, Lung, and Blood Institute to expand, intensify, and coordinate research and related Institute activities on congenital heart disease.

- Requires an information clearinghouse to increase public access to defibrillation in schools established under such program to be administered by an organization that has substantial expertise in pediatric education, pediatric medicine, and electrophysiology and sudden death.
- Young Women's Breast Health Education and Awareness Requires Learning Young Act of 2009 or the EARLY Act requires HHS Secretary to:

  » Acting through the Director of CDC, conduct:

  (1) A national education campaign to increase awareness of young women's knowledge regarding breast health and breast cancer.

  (2) An educational campaign among physicians and other healthcare professionals to increase awareness of breast health of young women.

  (3) Prevention research on breast cancer in younger women.

  » Acting through the Director of NIH, conduct research to develop and validate new screening tests and methods for prevention and early detection of breast cancer in young women.

  » Award grants for the provision of health information to young women diagnosed with breast cancer and pre-neoplastic breast diseases.

HHS Secretary Must:

- Prepare biennially a national diabetes report card and, to the extent possible, one for each state.
- Acting through the Director of CDC,

  (1) Promote the education and training of physicians on the importance of birth and death certificate data and on how to properly complete these documents.

  (2) Encourage state adoption of the latest standard revisions of birth and death certificates.

  (3) Work with states to reengineer their vital statistics systems in order to provide cost-effective, timely, and accurate vital systems data.

- Promote improvements to the collection of diabetes mortality data.
- Conduct a study of the impact of diabetes on the practice of medicine in the United States and the level of diabetes medical education that should be required prior to licensure, board certification, and board recertification.
- Award grants to eligible employers to provide their employees with access to comprehensive workplace wellness programs.
- Acting through the Director of the National Institutes of Health (NIH), implement the Cures Acceleration Network under which grants and contracts will be awarded to accelerate the development of high need cures.

Subtitle E - Provisions Relating to Title V

- Revises provisions related to fulfillment of service obligations under the National Health Service Corps related to half-time clinical practice and teaching.
- Authorizes appropriations to HHS for debt service on, or direct construction or renovation of, a healthcare facility that provides research, inpatient tertiary care, or outpatient clinical services and that meets certain requirements, including that it is critical for the provision of greater access to healthcare within the state.
- Establishes a Community Health Center Fund to provide for expanded and sustained national investment in community health centers.

HHS Secretary Must:

- Acting through the Director of CDC, establish a national diabetes prevention program targeted at adults at high risk for diabetes.
- Develop a Medicare prospective payment system for payment for services furnished by federally qualified health centers.
- Acting through the Administrator of the HRSA, establish a grant program to assist accredited schools of allopathic or osteopathic medicine in

  (1) Recruiting students most likely to practice medicine in underserved rural communities.

  (2) Providing rural-focused training and experience.

  (3) Increasing the number of recent allopathic and osteopathic medical school graduates who practice in underserved rural communities.

- Acting through the Administrator of HRSA, award grants or enter into contracts with eligible entities to provide training to graduate medical residents in preventive medicine specialties.
- Acting through the Administrator of HRSA, establish a demonstration project to provide access to comprehensive healthcare services to the uninsured at reduced fees.

Subtitle F - Provisions Relating to Title VI

- Directs the U.S. Sentencing Commission to amend the Federal Sentencing Guidelines to provide two-level, three-level, and four-level increases in the offense level for any defendant convicted of a federal healthcare offense relating to a Government healthcare program of a loss between $1 million and $7 million, between $7 million and $20 million, and at least $20 million, respectively.
  - » Provides that a person need not have actual knowledge of the prohibition against healthcare fraud nor specific intent to violate it in order to commit healthcare fraud.
  - » Expands the scope of violations constituting a federal healthcare offense.
  - » Amends the Civil Rights of Institutionalized Persons Act to authorize the Attorney General to require access to an institution by subpoena to investigate conditions depriving residents of specified constitutional or federal rights.
- Extends medical malpractice coverage to free clinics by deeming their officers, employees, board members, and contractors to be employees of the Public Health Service.
- Amends the Federal, Drug, and Cosmetic Act to set forth circumstances under which a generic drug may be approved with a label different from the listed drug.

HHS Secretary May:

- Award demonstration grants to states for the development, implementation, and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by healthcare providers or healthcare organizations.

Subtitle H - Provisions Relating to Title IX

- Imposes a 10% excise tax on any amount paid for indoor tanning services on or after July 1, 2010. Exempts phototherapy services performed by a licensed medical professional from the definition of "indoor tanning services."
- Excludes from gross income any payments under the National Health Service Corps Loan Repayment Program and any other state loan repayment or forgiveness programs intended to increase the availability of healthcare services in underserved or health professional shortage areas.
- Increases from $10,000 to $13,170 the dollar limitation on:
  - (1) The tax credit for adoption expenses.
  - (2) The tax exclusion for employer-provided adoption assistance
  - (3) Allows an inflation adjustment to such limitation after 2010.
  - (4) Makes such credit refundable.
- Extends through 2011 the general terminating date of the Economic Growth and Tax Relief Reconciliation Act of 2001 with respect to such credit and exclusion.

Conclusion: Because we know the new healthcare reform guidelines and statutes can be both lengthy and complex, Dell Services prepared this summary report to assist hospitals, insurance companies, healthcare providers, state governments, small business owners, employers, and consumers. We hope that the compiled information will be helpful for your organization as you focus on how the new imperatives will impact your operations.

Dell Can Help: Dell Services has a full staff of healthcare business and administrative consultants, clinicians, and information technology specialists who can help you interpret and meet the reform legislation mandates. In addition, we can help you navigate through requirements and implement effective EMR/EHR solutions. In general, the sooner these solutions are in-place, the greater the funding incentives from the ARRA program.

Industry-Recognized Expertise: In addition to many other industry awards, Dell is rated #1 for IT Services in the worldwide healthcare market, based on 2009 revenue. *(Gartner IT Services Market Metrics Worldwide Market Share: Database; April 13, 2010.)*

We welcome an opportunity to explore ways in which we might assist your organization. For additional information on services and solutions designed to help you successfully update your processes or information technologies, visit dell.com/services or contact us at 888.888.3872.

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