



Public Health, Workforce, and Quality Provisions in the House Health Reform Legislation (H.R. 3200)

C. Stephen Redhead, Coordinator
Specialist in Health Policy

August 4, 2009

Congressional Research Service

7-5700

www.crs.gov

R40745

Summary

Health care reform is at the top of the domestic policy agenda for the 111th Congress, driven by concerns about the growing ranks of the uninsured and the unsustainable growth in spending on health care and health insurance. But efforts to improve access to care and control rising health care costs also will require changes to the health care delivery system. Experts point to a growing body of evidence of the health care system's failure to consistently provide high-quality care to all Americans. Major challenges to the delivery of high-quality care include improving patient safety by eliminating medical errors, eradicating disparities in care, reducing the burden of chronic disease, and eliminating unnecessary and ineffective care that compromises quality, drives up costs, and neglects the needs of patients.

The health reform debate has embraced a number of proposals to address these challenges and improve the delivery of health care services. They include initiatives to encourage individuals to adopt healthier lifestyles, and to change the way that physicians and other providers treat and manage disease. Delivery reform proposals focus on expanding the primary care workforce, encouraging the use of clinical preventive services, and strengthening the role of chronic care management. However, health care delivery reform cannot happen unless mechanisms are in place to drive change in the systems of care. Key drivers include performance measurement and the public dissemination of performance information, comparative effectiveness research, adoption of health information technology, and, most importantly, the alignment of payment incentives with high-quality care.

Congress took an important first step toward reforming the health care delivery system when it enacted the American Recovery and Reinvestment Act (ARRA; P.L. 111-5) in February 2009. ARRA included \$1.1 billion for comparative effectiveness research and established an interagency advisory panel to help coordinate and support the research. It also incorporated the Health Information Technology for Economic and Clinical Health (HITECH) Act, which is intended to promote the widespread adoption of health information technology (HIT) for the electronic sharing of clinical data among hospitals, physicians, and other health care stakeholders.

The health reform legislation (H.R. 3200) introduced in the House and approved by the Committees on Ways and Means, Energy and Commerce, and Education and Labor includes numerous provisions intended to increase the primary care and public health workforce, promote preventive services, and strengthen quality measurement, among other things. H.R. 3200 would amend and expand on many of the existing health workforce programs authorized under Title VII (health professions) and Title VIII (nursing) of the Public Health Service Act (PHSA). It would create a Public Health Workforce Corps and establish a new loan repayment program, modeled on the National Health Service Corps (NHSC), for individuals who agree to practice in medically underserved areas with unmet health care needs. The House bill also would make a number of changes to the Medicare Graduate Medical Education (GME) program, which subsidizes medical residency programs, in part to encourage the training of more primary care physicians.

In addition, H.R. 3200 would bolster quality improvement activities, including performance measurement, and broaden Medicare and Medicaid coverage of clinical preventive services. The legislation would establish a multi-billion dollar Public Health Investment Fund to provide additional funding for these and other new programs and activities.

Contents

Introduction	1
Health Care Delivery Reform.....	1
Drivers of Reform.....	2
American Recovery and Reinvestment Act.....	3
Overview of Report.....	3
Public Health Investment Fund.....	4
Sec. 2002. Public Health Investment Fund.....	4
Health Centers	5
Background and Issues.....	5
Sec. 2101. Increased Funding for Community Health Centers.....	5
Sec. 2511. School-Based Health Clinics	6
Health Workforce.....	6
Background and Issues.....	6
National Health Service Corps	7
Sec. 2201. National Health Service Corps	7
Sec. 2202. Authorization of Appropriations	7
Promotion of Primary Care and Dentistry.....	8
Sec. 2211. Frontline Health Providers.....	8
Sec. 2212. Primary Care Student Loans	9
Sec. 2213. Primary Care Training and Enhancement.....	9
Sec. 2214. Training of Medical Residents in Community-Based Settings.....	9
Sec. 2215. Training in Dentistry	10
Sec. 2216. Authorization of Appropriations	10
Nursing Workforce.....	10
Sec. 2221. Amendments to the Public Health Service Act	10
Sec. 2531. Grants for Nursing Training and Pipeline Programs.....	11
Sec. 2551. Reducing Student-to-School Nurse Ratios	12
Public Health Workforce	12
Sec. 2231. Public Health Workforce Corps	12
Sec. 2232. Enhancing the Public Health Workforce	12
Sec. 2233. Public Health Training Centers.....	13
Sec. 2234. Preventive Medicine and Public Health Training Grant Program	13
Sec. 2235. Authorization of Appropriations	13
Workforce Diversity, Cultural Competency, and Interdisciplinary Care.....	13
Sec. 2241. Faculty Loan Repayments	14
Sec. 2242. Nursing Workforce Diversity Grants	14
Sec. 2243. Coordination of Diversity and Cultural Competency Programs	14
Sec. 2251. Cultural and Linguistic Competency Training.....	14
Sec. 2252. Innovations in Interdisciplinary Care Training.....	14
Health Workforce Evaluation and Assessment	14
Sec. 2261 and Sec. 2271. Health Workforce Evaluation and Assessment.....	15
Authorization of Appropriations.....	15
Sec. 2281. Authorization of Appropriations	15
Medicare Graduate Medical Education.....	16
Sec. 1501. Distribution of Unused Residency Positions	16
Sec. 1502. Increasing Training in Non-Provider Settings	16

Sec. 1503. Rules for Counting Resident Time for Non-Patient Care Activities	17
Sec. 1504. Preservation of Resident Cap Positions from Closed Hospitals	17
Sec. 1505. Improving Accountability for Approved Medical Residency Training	17
Quality	17
Background and Issues	17
Quality Measurements	17
Sec. 1441. Establishment of National Priorities for Quality Improvement	18
Sec. 1442. Development of New Quality Measures	18
Sec. 1443. Selection of Quality Measures	19
Sec. 1444. Application of Quality Measures	19
Sec. 1445. Consensus-Based Entity Funding	20
Best Practices and Key Health Indicators	20
Sec 2401. Implementation of Best Practices in the Delivery of Health Care	20
Sec 2402. Assistant Secretary for Health Information	21
Sec 2403. Authorization of Appropriations	21
Public Reporting of Health Care-Associated Infections	21
Sec. 1461. Public Reporting of Health Care-Associated Infection	21
Comparative Effectiveness Research	21
Sec. 1401. Center for Comparative Effectiveness Research	22
Sec. 1802. Comparative Effectiveness Research Trust Fund	22
Medicare and Medicaid Nursing Homes	22
Secs. 1411-1445. Improving Transparency, Enforcement, and Staff Training	22
Health Disparities	23
Background and Issues	23
Secs. 1221-1224. Medicare Beneficiaries with Limited English Proficiency	23
Prevention and Wellness	24
Background and Issues	24
Coverage of Clinical Preventive Services	25
Sec. 122. Essential Benefits Package Defined	25
Sec. 1305. Medicare Coverage and Waiver of Cost-Sharing	25
Sec. 1306. Waiver of Medicare Deductible for Colorectal Cancer Screening	25
Sec. 1310. Expanding Access to Vaccines under Medicare	26
Sec. 1311. Expansion of Medicare Covered Preventive Services at FQHCs	26
Sec. 1711. Medicaid Coverage of Preventive Services	26
Sec. 1712. Medicaid Coverage of Tobacco Cessation Products	26
Provisions in the Public Health Service Act	27
Sec. 2301. Prevention and Wellness	27
Employer-Provided Wellness Programs	28
Sec. 2552. Wellness Program Grants	29
National Medical Device Registry	30
Background and Issues	30
Sec. 2521. National Medical Device Registry	30

Appendixes

Appendix. Acronyms Used in the Report	31
---	----

Contacts

Author Contact Information	32
Acknowledgments	32

Introduction

Health care reform is at the top of the domestic policy agenda for the 111th Congress, driven by concerns about the growing ranks of the uninsured and the unsustainable growth in spending on health care and health insurance. Improving access to care and controlling rising costs will require changes to both the financing and delivery of health care. Experts point to a growing body of evidence of the health care system's failure to consistently provide high-quality care to all Americans.

In a November 2008 report outlining its goals for health reform, the National Priorities Partnership, representing all the major stakeholder groups in the health sector, identified four major challenges to the delivery of high-quality care.¹ The first is to improve patient safety by eliminating medical errors and other adverse events. These errors mostly result from faulty systems, processes, and conditions that lead to mistakes. The second challenge is to eradicate disparities in care. Racial and ethnic minorities and low-income groups face disproportionately higher rates of disease, disability, and mortality, largely because of variations in access to care, and quality of care. The third challenge is to reduce the burden of chronic disease, which affects almost half of all Americans and accounts for three-quarters of health care spending. The final challenge is to eliminate unnecessary and ineffective care that compromises quality, drives up costs, and neglects the needs of patients. According to the Institute of Medicine, an estimated 30%-40% of health care spending is wasted on unnecessary and even unsafe care.²

Health Care Delivery Reform

While primarily focused on health care financing issues, the health reform debate has embraced a number of proposals to address these challenges and improve the delivery of health care services. They include initiatives to encourage individuals to adopt healthier lifestyles, and to change the way that physicians and other providers treat and manage disease. Delivery reform proposals focus on (1) expanding the primary care workforce, (2) encouraging the use of clinical preventive services, and (3) strengthening the role of chronic care management. The current system places a high value on specialty care, rather than primary care. Patients with multiple chronic conditions often receive care from several providers in different settings. Among other things, this can compromise patients' understanding of their conditions and ways to manage them. And the incomplete or inaccurate transfer of information among providers can lead to poor outcomes. Care coordination is seen as an important aspect of health care that helps avoid waste, and the over- and underuse of medications, diagnostic tests, and therapies.

Health workforce policy has emerged as an important component of the health reform debate. Transforming the nation's health care delivery system—from one that is focused on fragmented specialty care for acute illness to one that places a greater emphasis on primary care, disease prevention, and the coordination and management of care for chronic illness across settings—will require significant changes in health professions education and training. While some advisory

¹ National Priorities Partnership, *National Priorities and Goals: Aligning Our Efforts to Transform America's Healthcare*. Washington, DC: National Quality Forum, 2008. For more information on the work of the Partnership, go to <http://www.nationalprioritiespartnership.org/>.

² Institute of Medicine, National Academy of Engineering, *Building a Better Delivery System: A New Engineering/Health Care Partnership*. Washington, DC: National Academies Press, 2005.

groups have warned of a future physician shortage, based on the growing patient demand for services, others caution that simply adding more physicians to the current health care system will increase costs and not improve accessibility or quality. Currently, the number of physicians per capita varies significantly across the country. But that variation is largely driven by where physicians like to live and practice, rather than by patient need. Moreover, higher physician supply is not associated with better patient outcomes or satisfaction, or improved quality of care.³ Instead of focusing on overall physician supply, health policy analysts recommend a workforce policy that couples the training of more primary care physicians (and other primary care providers) with the promotion and development of integrated systems of care.

Expanding the use of clinical preventive services is a key goal of delivery reform and often touted as having the potential to reduce health care costs. Such services include immunizations and other interventions that prevent the onset of disease (known as primary prevention), and screening tests that detect the presence of an incipient disease (known as secondary prevention). While there is clear evidence that clinical preventive services can improve health and may be cost-effective (i.e., providing good value for their cost), few of these interventions are cost-saving.⁴

Proponents of delivery reform have also embraced the concept of a medical home, intended to improve the quality of care through partnerships between patients and specially trained primary care physicians. The physician helps the patient manage his or her own care and coordinates services across settings (specialists' offices, hospitals, and laboratories) and types of care (acute, chronic, and preventive). Concern about the rising costs of treating chronic disease and the lack of coordination of care also has generated keen interest in disease management programs. These programs, typically focused on a specific disease such as diabetes, help patients manage their own care. Program elements include patient education, symptom monitoring, and adherence to treatment plans. Disease management programs share similarities with the medical home concept. But whereas the medical home is built around a physician-patient partnership, disease management programs typically are run by health plans or specialized vendors.

Drivers of Reform

Health care delivery reform cannot happen unless mechanisms are in place to drive change in the systems of care. Key drivers include performance measurement and the public dissemination of performance information, comparative effectiveness research, adoption of health information technology, and, perhaps most importantly, alignment of payment incentives with high-quality care. Most health policy experts concede that improvements in the quality of health care will not be fully realized unless providers have financial incentives to change the way they deliver health care services. Under fee-for-service, the predominant method of payment, physicians are paid based on the volume of billable services, rather than the value or quality of care they provide. Increasingly, public and private payers are linking a portion of provider payments to their performance on a set of quality measures. Policymakers are interested in expanding these pay-for-performance initiatives to incentivize other changes to the health care delivery system.

³ David C. Goodman and Elliott S. Fisher, "Physician Workforce Crisis? Wrong Diagnosis, Wrong Prescription," *New England Journal of Medicine*, vol. 358, no. 16 (April 17, 2008), pp. 1658-1661.

⁴ Joshua T. Cohen et al., "Does Preventive Care Save Money? Health Economics and the Presidential Candidates," *New England Journal of Medicine*, vol. 358, no. 7 (February 14, 2008), pp. 661-663.

The use of performance measures to track the quality of care is growing in both the private and public health sectors, though concerns about the development and use of such data remain. The public reporting of quality information is seen as a necessary step in helping patients make informed choices about health care services and the organizations that provide them.

American Recovery and Reinvestment Act

Congress took an important first step toward reforming the health care delivery system when it enacted the American Recovery and Reinvestment Act (ARRA; P.L. 111-5) in February 2009. ARRA included \$17 billion in supplemental funding for biomedical research, public health, and other health-related programs within the Department of Health and Human Services (HHS), including \$1.1 billion for comparative effectiveness research. It also established an interagency advisory panel to help coordinate and support the research. In addition, ARRA incorporated the Health Information Technology for Economic and Clinical Health (HITECH) Act, which is intended to promote the widespread adoption of health information technology (HIT) for the electronic sharing of clinical data among hospitals, physicians, and other health care stakeholders. Included in the ARRA health funding was \$2 billion to fund HIT grant programs authorized by the HITECH Act.⁵

HIT, which generally refers to the use of computer applications in medical practice, is widely viewed as a necessary and vital component of health care reform. It encompasses interoperable electronic health records (EHRs)—including computerized systems to order tests and medications, and support systems to aid clinical decision making—and the development of a national health information network to permit the secure exchange of electronic health information among providers. The promise of HIT comes not from automating existing practices, but rather its use as a tool to help overhaul the delivery of care. HIT has the potential to enable providers to render care more efficiently; for example, by eliminating the use of paper-based records and reducing the duplication of diagnostic tests. It can also improve the quality of care by identifying harmful drug interactions and helping physicians manage patients with multiple conditions. Moreover, the widespread use of HIT could provide large amounts of clinical data for comparative effectiveness research, performance measurement, and other activities aimed at improving health care quality.

Overview of Report

On July 14, 2009, Representative Dingell (D-MI) introduced a comprehensive health reform bill, the America's Affordable Health Choices Act of 2009 (H.R. 3200). The legislation was jointly developed by the House Committees on Ways and Means, Energy and Commerce, and Education and Labor, which share jurisdiction over the federal health statutes. All three committees have held markups and ordered H.R. 3200 to be reported, as amended. In each case, the committee considered an amendment in the nature of substitute to H.R. 3200, offered by the chairman (the "Chairman's mark").⁶

⁵ For more information, see CRS Report R40181, *Selected Health Funding in the American Recovery and Reinvestment Act of 2009*, coordinated by C. Stephen Redhead, and CRS Report R40161, *The Health Information Technology for Economic and Clinical Health (HITECH) Act*, by C. Stephen Redhead.

⁶ The Committee on Ways and Means approved H.R. 3200, as amended, on July 17, 2009; the Chairman's mark is (continued...)

H.R. 3200 consists of three divisions. Division A addresses private health insurance, including the establishment of an insurance exchange and the creation of a public option. Division B primarily deals with changes to the Medicare and Medicaid programs. Finally, Division C, entitled “Public Health and Workforce Development,” includes a series of provisions intended to increase the primary care and public health workforce, promote preventive services, and strengthen quality measurement, among other things.

This report summarizes the workforce, prevention, and quality-related provisions in H.R. 3200, which are mostly to be found in Division C. Unless otherwise noted, the report is based on the Energy and Commerce Chairman’s mark. It does not reflect amendments adopted at markup. The report is divided into the following sections: (1) Public Health Investment Fund, (2) health centers, (3) health workforce, (4) health care quality, (5) health disparities, (6) prevention and wellness, and (7) a proposed national medical device registry. Each section begins with some background on current law and practice so as to provide context for the subsequent brief descriptions of the bill’s provisions. Unless otherwise stated, references to “the Secretary” refer to the Secretary of Health and Human Services (HHS). A list of all the acronyms used in the report is in the **Appendix**. This report will be updated to reflect future legislative actions.

Public Health Investment Fund

The House legislation would amend numerous PHSA programs whose appropriations authority has expired, though many of the programs continue to receive an annual appropriation. The legislation includes new authorizations for appropriations to fund most of those programs, typically through FY2019. The House legislation also would create a multi-billion dollar Public Health Investment Fund to provide additional funds for the programs. As described below, the legislation includes several provisions authorizing the appropriation of amounts from the Fund for specified PHSA programs. These amounts would be in addition to any amounts provided through regular appropriations. To ensure that the Fund is used to supplement and not supplant regular appropriations, the authority to appropriate amounts from the Fund would be contingent on maintaining a certain level of regular appropriations for the programs.

Sec. 2002. Public Health Investment Fund

This section would establish a Public Health Investment Fund, into which the following amounts would be deposited from general revenues of the Treasury: \$4.6 billion for FY2010, \$5.6 billion for FY2011, \$6.9 billion for FY2012, \$7.8 billion for FY2013, \$9.0 billion for FY2014, \$9.4 billion for FY2015, \$10.1 billion for FY2016, \$10.8 billion for FY2017, \$11.8 billion for FY2018, and \$12.7 billion for FY2019.

(...continued)

available on the committee’s website at <http://waysandmeans.house.gov/media/pdf/111/catext3200.pdf>. The Committee on Education and Labor also approved H.R. 3200, as amended, on July 17, 2009; the Chairman’s mark is available on the committee’s website at http://edlabor.house.gov/documents/111/pdf/markup/FC/HR3200-AmericasAffordableHealthChoicesActof2009/MILLCA_158.pdf. The Committee on Energy and Committee approved its version of H.R. 3200, as amended, on July 31, 2009; the Chairman’s mark is available on the committee’s website at http://energycommerce.house.gov/Press_111/20090715/health_amendment.pdf.

Amounts in the Fund would be authorized to be appropriated for carrying out various designated provisions in Division C, as described below, and would be in addition to any other amounts authorized to be appropriated for such purposes. Amounts in the Fund could be authorized to be appropriated only if the following two conditions were met: (1) appropriations for a given fiscal year are no less than the amounts appropriated in FY2008 for (i) the Agency for Healthcare Research and Quality, (ii) the National Center for Health Statistics, (iii) the National Health Service Corps, (iv) community health centers, and (v) and various designated workforce programs under PHSA Titles VII and VIII; and (2) the amount appropriated to the Prevention and Wellness Trust, as described below, for a given fiscal year is no less the amount appropriated to the Prevention and Wellness Fund under the American Recovery and Reinvestment Act and allocated for prevention and wellness (i.e., \$650 million).⁷ Any amounts appropriated under this section would not count toward the appropriations committee allocations under the budget resolution.

Health Centers

Background and Issues

PHSA Sec. 330 authorizes the health center program, which provides grants to community health centers, migrant health centers, health centers for the homeless, and health centers for residents of public housing. Health centers are a key component of the nation's health care safety net and provide primary care and preventive services to the uninsured and underinsured. These centers are required to accept all patients regardless of ability to pay and must offer sliding scale fee arrangements for patients. Health centers are located in areas that are medically underserved and target populations with insufficient health care access. The health center program, which enjoys broad bipartisan support, has been expanded in recent years. In 2002, there were approximately 3,500 health center sites; in 2009, there are an estimated 9,000 sites.⁸ The program was reauthorized by the Health Care Safety Net Act of 2008 (P.L. 110-335).⁹ The Act also included the requirement that GAO study the economic costs and benefits of school-based health clinics (SBHCs) and their impact on student health. SBHCs are not explicitly authorized in the PHSA, but have been established pursuant to the general authority to establish community health centers. Studies show that health centers increase access to primary health care services, which helps reduce disparities and reduce costs by averting more expensive emergency room visits.

Sec. 2101. Increased Funding for Community Health Centers

This section would amend **PHSA Sec. 330** by authorizing to be appropriated for the health center program such sums as may be necessary (SSAN) for each of FY2013 through FY2019. The section also would authorize to be appropriated from the Public Health Investment Fund, in addition to any other amounts authorized to be appropriated for the program, the following amounts: \$1 billion for FY2010, \$1.5 billion for FY2011, \$2.5 billion for FY2012, \$3 billion for

⁷ The American Recovery and Reinvestment Act (P.L. 111-5) provided \$1 billion for a Prevention and Wellness Fund, administered by the Secretary. Of that total, \$650 million is for evidence-based clinical and community-based prevention and wellness programs.

⁸ An individual health center may operate multiple sites.

⁹ The health centers program is administered by HRSA. For more information, go to <http://bphc.hrsa.gov>.

FY2013, \$4 billion for FY2014, \$4.4 billion for FY2015, \$4.8 billion for FY2016, \$5.3 billion for FY2017, \$5.9 billion for FY2018, and \$6.4 billion for FY2019.

Sec. 2511. School-Based Health Clinics

This section would create a new **PHSA Sec. 399Z-1** requiring the Secretary to establish an SBHC grant program. To receive a grant, an SBHC would have to meet certain specified criteria, match 20% of the grant amount from nonfederal sources, agree to use grant funds to supplement and not supplant funds received from other sources, and demonstrate that grant funds will not be used until funds from all payers, including private insurance, Medicaid, and CHIP, are used. The Secretary would be required to give priority to qualified applicants based on their record of providing care to medically underserved children and adolescents, and of providing care in communities where a high percentage of children and adolescents are uninsured, underinsured, or eligible for Medicaid or CHIP. The section would authorize the appropriation of \$50 million for FY2010, and SSAN for FY2011 through FY2014.

Health Workforce

Background and Issues

Existing health professions education and training programs authorized under PHSA Title VII provide funding to medical schools and other facilities to promote community-based and rural practice, primary care, and opportunities for minorities and disadvantaged students. In the early 1970s, annual funding for Title VII programs reached over \$2.5 billion (in 2009 dollars); in recent years, it has been about \$200 million. PHSA Title VIII authorizes a comparable set of programs to promote nursing education and training. Appropriations authority for most Title VII and VIII programs has expired, though many of them continue to receive funding. The National Health Service Corps (NHSC) program, authorized under PHSA Title III, provides scholarships and student loan repayments for medical students, nurse practitioners, physician assistants, and others who agree to a period of service as a primary care provider in a federally designated Health Professional Shortage Area (HPSA). NHSC clinicians may fulfill their service commitments in health centers, rural health clinics, public or nonprofit medical facilities, or within other community-based systems of care. However, there is far more demand for NHSC clinicians and there are many more clinicians interested in scholarships or loan repayment opportunities than can be met under the program's budget. Currently, HHS estimates that the NHSC is filling only 8% of the total need for primary care practitioners in HPSAs.¹⁰

Medicare subsidizes medical residency programs through its Graduate Medical Education (GME) program, which makes two types of payments to teaching hospitals. First, direct GME payments help cover the costs of the residency training program, including resident salaries and benefits, supervisory physician salaries, and administrative overhead expenses. Direct GME payments are calculated based on the product of three factors: a hospital-specific per resident amount, a weighted count of full-time equivalent (FTE) residents supported by the hospital, and the hospital's Medicare patient share. Second, indirect medical education (IME) payments, which

¹⁰ For more information on the NHSC program, see CRS Report R40533, *Health Care Workforce: National Health Service Corps*, by Bernice Reyes-Akinbileje.

vary with the intensity of a hospital's residency program, are intended to compensate hospitals for the higher costs of patient care in teaching hospitals. Those costs are the result of such factors as having sicker patients and the fact that inexperienced residents may order more tests. The IME adjustment is a percentage add-on to a hospital's Medicare payments for inpatient care and is based, in part, on the hospital's resident-to-bed ratio. IME payments only cover the residents' time spent in patient care. In 2008, the GME program provided direct and indirect payments totaling an estimated \$9 billion to more than 1,100 teaching hospitals to educate and train about 90,000 residents, approximately \$100,000 per resident. Health policy analysts view the GME program as a potentially important instrument for shaping future health workforce policy; for example, by linking the subsidies to delivery system reform and by structuring them to encourage the training of more generalists and to increase the amount of time residents spend in nonhospital settings such as community health centers and rural health clinics.¹¹

National Health Service Corps

Sec. 2201. National Health Service Corps

This section would amend **PHSA Sec. 331**, allowing the Secretary to waive certain requirements of NHSC service so that the service obligation could be fulfilled on a half-time basis (i.e., a minimum of 20 hours per week in clinical practice). It also would amend **PHSA Sec. 337**, repealing the prohibition on reappointment of members to the NHSC National Advisory Council. It would amend **PHSA Sec. 338B**, increasing the maximum annual NHSC loan repayment amount from \$35,000 to \$50,000, adjusted annually for inflation beginning in FY2012. Finally, the section would amend **PHSA Sec. 338C**, permitting teaching to be counted toward a portion of the service obligation.

Sec. 2202. Authorization of Appropriations

This section would amend **PHSA Sec. 338** by (1) authorizing to be appropriated for NHSC program operations SSAN through FY2019 and (2) authorizing to be appropriated from the Public Health Investment Fund, in addition to any other amounts authorized to be appropriated for NHSC program operations, the following amounts: \$63 million for FY2010, \$66 million for FY2011, \$70 million for FY2012, \$73 million for FY2013, \$77 million for FY2014, \$81 million for FY2015, \$85 million for FY2016, \$89 million for FY2017, \$94 million for FY2018, and \$98 million for FY2019.

In addition, the section would amend **PHSA Sec. 338H**, by authorizing to be appropriated for the NHSC scholarship and loan repayment programs SSAN for each of FY2013 through FY2019. The section would add a new **PHSA Sec. 338H-1** authorizing to be appropriated from the Public Health Investment Fund, in addition to any other amounts authorized to be appropriated for NHSC scholarships and loan repayments, the following amounts: \$254 million for FY2010, \$266 million for FY2011, \$278 million for FY2012, \$292 million for FY2013, \$306 million for FY2014, \$321 million for FY2015, \$337 million for FY2016, \$354 million for FY2017, \$372 million for FY2018, and \$391 million for FY2019.

¹¹ For a recent review of medical education in the United States and an analysis of the GME program and its potential role in health care delivery reform, see the Medicare Payment Advisory Commission's June 2009 *Report to Congress: Improving Incentives in the Medicare Program*, Chapter 1, at http://www.medpac.gov/chapters/Jun09_Ch01.pdf.

Promotion of Primary Care and Dentistry

PHSA Title VII, Part A, comprising Secs. 701-735, authorizes student loan programs for health professions students. Sec. 735 establishes general provisions for the administration of the student loan fund. Title VII, Part C, Sec. 747, authorizes grants for health professions schools to develop and operate training programs in family medicine, general internal medicine, general pediatrics, physician assistants and general and pediatric dentistry. Funds may also be used to provide financial assistance to medical students, interns, residents, and faculty who are participants in such programs.

The House legislation includes the following six sections that would establish or amend existing programs to increase the supply of primary care providers. The first such provision would create a new loan repayment program, analogous to the NHSC program, for individuals who agree to practice in medically underserved areas whose health care needs are not being met by the NHSC.

Sec. 2211. Frontline Health Providers

This section would amend the **PHSA Title III**, by adding at the end a new Subpart XI–Health Professional Needs Areas, and creating in that subtitle four new sections as described below.

PHSA Sec. 340H would require the Secretary to establish the Frontline Health Professional Loan Repayment Program. It would require the Secretary to designate “health professional needs areas” (as defined), establish eligibility requirements for loan repayors, and define “primary health services” as family medicine, internal medicine, pediatrics, obstetrics and gynecology, dentistry, and mental health.

PHSA Sec. 340I would require the Secretary to contract with individuals who agree to serve in a health professional needs area as either a full-time primary health services provider, or as a part-time or full-time provider of other health services, for a period of two or more years. The Secretary would be required to pay, for each year of service, an amount on the principal and interest of the educational loan of the individual that is not more than 50% of the average award made under the NHSC Loan Repayment Program for the previous fiscal year. Individuals would be allowed to satisfy the service requirement through employment at specified practice settings. Statutory provisions for the NHSC Loan Repayment Program would apply to the Frontline Health Professional Loan Repayment Program, where appropriate. Finally, the section would require the Secretary to transfer all unobligated funds from this program to the NHSC for the purpose of recruiting participants for the following year.

PHSA Sec. 340J would require the Secretary to submit an annual report to Congress on the Frontline Health Professional Loan Repayment Program.

PHSA Sec. 340K would require the following allocation of funds obligated for each fiscal year for loan repayments: (1) 90% must be allocated for physicians and other health professionals providing primary health services, and (2) 10% must be allocated for non-physicians and non-primary health professionals.

Sec. 2212. Primary Care Student Loans

PHSA Sec. 735 establishes general provisions for the administration of the student loan fund for medical students and health professions students. Implementing regulations regarding the eligibility and selection of loan applicants require health professions schools to take into account, regardless of the tax status of the student, the expected contribution from parents, spouse, self, or other family members.

This section would amend **PHSA Sec. 735**, inserting a new subsection that would permit the Secretary to determine the financial resources available to individuals seeking assistance under this program. Also, it would require a new regulation eliminating the requirement that a health professions school take into account the expected financial contribution of parents and other family members.

Sec. 2213. Primary Care Training and Enhancement

This section would amend **PHSA Sec. 747** to require the Secretary to award grants or enter into contracts for a variety of activities to support training programs in primary care—defined as family medicine, general internal medicine, general pediatrics, or geriatrics—and for capacity building. Entities eligible for the training grants would include accredited public or nonprofit hospitals, schools of medicine or osteopathic medicine, accredited physician assistant training programs, public or private nonprofit entities, or a consortium of two or more of these entities. However, only schools of medicine or osteopathic medicine would be eligible for capacity building grants. The Secretary would be required to give preference to qualified applicants based on an applicant’s record of (1) training primary care providers and individuals from minority groups or disadvantaged backgrounds, (2) having its graduates practicing in primary care, and/or (3) supporting teaching programs targeting vulnerable populations.

Sec. 2214. Training of Medical Residents in Community-Based Settings

This section would redesignate current PHSA Sec. 748—Advisory Committee on Training in Primary Care Medicine and Dentistry as Sec. 749A, and create a new **PHSA Sec. 748**, requiring the Secretary to award grants or contracts for planning and/or operating primary care residency training programs in community-based settings. Eligible entities would be (1) Medicare GME-eligible non-hospital providers or (2) teaching health centers as defined in Sec. 1502(d) of this bill.¹² The Secretary would be required to give preference to qualified applicants that are an FQHC or a rural health clinic, and to programs that would address the health care needs of vulnerable populations, or that have a demonstrated record of training individuals from disadvantaged backgrounds or who practice in underserved areas or in areas experiencing health disparities.

¹² Among other things, Sec. 1502(d) would amend the SSA to allow for direct and indirect GME payments to qualified teaching health centers, such as federally qualified health centers and rural health centers that develop and operate an accredited primary care residency program for which GME funding would be available if such program were operated by a hospital. It would also establish a demonstration project to facilitate affiliations between teaching health centers and teaching hospitals to encourage residency training in community-based settings. See the discussion of the bill’s GME provisions and Sec. 1502.

Sec. 2215. Training in Dentistry

This provision would create a new **PHSA Sec. 749**, requiring the Secretary to award grants or contracts to support and develop dental training programs for general, pediatric, and public health dentists, and dental hygienists. Eligible entities would include accredited schools of dentistry or public health, training programs in dental hygiene, public or nonprofit private hospitals, training programs in dental hygiene, or consortia of these entities. The program would require the Secretary to give preference to entities meeting similar criteria as for the grant program established in Sec. 2213 of this bill.

Sec. 2216. Authorization of Appropriations

This section would add a new **PHSA Sec. 799C**, authorizing to be appropriated from the Public Health Investment Fund, in addition to any other amounts authorized to be appropriated for such purposes, the following amounts to carry out PHSA Title III, Part D, Subpart XI (as established in Sec. 2211 of this bill, regarding frontline health providers) and PHSA Secs. 747, 748, and 749, as added or amended by this bill: \$240 million for FY2010, \$253 million for FY2011, \$265 million for FY2012, \$278 million for FY2013, \$292 million for FY2014, \$307 million for FY2015, \$322 million for FY2016, \$338 million for FY2017, \$355 million for FY2018, and \$373 million for FY2019. The section also would reauthorize PHSA Sec. 747 through FY2019.

Nursing Workforce

PHSA Title VIII, comprising Secs. 801-855, authorizes several programs to support nursing workforce development. These programs include funding for grant and scholarship programs for graduate and undergraduate nursing education in specified areas of nursing, including cultural competency, workforce diversity, nurse faculty members, advanced education nurses, and geriatric nursing. The House legislation would modify and reauthorize several of these existing programs, and delete the cultural and linguistic competency grant program. In addition, it would authorize two new programs: a nursing training and retention program administered by the Department of Labor, and a program administered by the Department of Education to help reduce the student-to-nurse ratio in schools.

Sec. 2221. Amendments to the Public Health Service Act

This section would amend **PHSA Sec. 801** to include “nurse-managed health centers” as eligible entities for purposes of Title VIII’s nursing workforce development programs, and would insert a definition for the term into the section. It also would delete **PHSA Sec. 807**, a grant program for cultural and linguistic competence training for nurses.

The section would add a new **PHSA Sec. 809**, requiring the Secretary to submit annual reports to Congress on all of the loan and grant programs in Title VIII that do not already require an annual report (i.e., **Secs. 811, 821, 836, 846A, and 861**, as redesignated). It would delete the 10% limit on awards to doctoral program traineeships in **PHSA Sec. 811**. It also would add to the list of eligible entities meriting special consideration those that agree to expend the award to increase diversity among advanced education nurses.

The section would amend **PHSA Sec. 831**, regarding Nurse Education, Practice, and Retention Grants, to restate grant activity priorities from managed care and quality improvement to

coordinated care, quality care, and other skills needed to practice nursing. It would delete a subsection regarding preference for these grants.

The section would amend **PHSA Sec. 836** to increase the maximum amount of loan funds a recipient can receive per year from \$2,500 to \$3,300; increase the annual limit for the last two academic years from \$4,000 to \$5,200; and increase the total loan amount that may be provided to a student from \$13,000 to \$17,000. These limits would be annually adjusted for inflation beginning in FY2012. **PHSA Sec. 846** would be amended to include individuals who agree to serve for not less than two years as a faculty member at an accredited nursing school in the loan repayment program. **PHSA Sec. 846A** would be amended to raise the Nurse Faculty Loan Program limit from \$30,000 to \$35,000. These limits would be annually adjusted for inflation beginning in FY2012.

The section would delete the current **PHSA Title VIII, Part H**, related to federal, state, and local public service announcements to promote careers in nursing.

Finally, the section would amend **PHSA Sec. 871**, as redesignated, authorizing to be appropriated SSAN for each fiscal year through FY2019 for Title VIII Parts B, C, and D (i.e., Advanced Education Nursing Grants; Workforce Diversity Grants; and Nurse Education, Practice, and Retention Grants). Title VIII, Part H, as redesignated, would be amended to add a new **PHSA Sec. 872** authorizing to be appropriated from the Public Health Investment Fund, in addition to any other amounts authorized to be appropriated for such purposes, the following amounts for carrying out Title VIII programs: \$115 million for FY2010, \$122 million for FY2011, \$127 million for FY2012, \$134 million for FY2013, \$140 million for FY2014, \$147 million for FY2015, \$154 million for FY2016, \$162 million for FY2017, \$170 million for FY2018, and \$179 million for FY2019. The section also would authorize to be appropriated SSAN through FY2019 for all the remaining programs in Title VIII whose appropriations expired at the end of FY2007.

Sec. 2531. Grants for Nursing Training and Pipeline Programs

This section would require the Secretary of Labor to establish a new partnership grant program to support nurse education, practice, and retention. The program would provide matching grants to eligible entities for qualified nursing training programs, including nurse “career ladder” programs and nurse faculty development programs. Eligible entities would include partnerships of health care providers and labor unions, trade associations, or groups that represent direct health workers. In making awards, the Secretary of Labor would be required to give preference to programs that improve nurse retention; increase the diversity of the nursing workforce; improve the quality of nursing education; have demonstrated success for transitioning health care workers into nursing; have established pilot programs to increase nurse faculty; or are modeled after or affiliated with established transitioning and pilot programs mentioned above. Any awards made would require a dollar-for-dollar match by the recipient. There would be authorized to be appropriated SSAN to carry out this partnership grant program.

Sec. 2551. Reducing Student-to-School Nurse Ratios¹³

This section would authorize the Secretary of Education (in consultation with HHS) to establish a demonstration grant program for local education agencies to reduce the student-to-school nurse ratio in public elementary and secondary schools. In making awards, the Secretary of Education would be required to give special consideration to applicants that demonstrate high need, in part by providing information about current student-to-school nurse ratios. Eligible local educational agencies would be defined as those in which the student-to-school nurse ratio in the public elementary and secondary schools they serve is 750 or more students to every school nurse. High-need local educational agencies would mean those that serve at least 10,000 children from families with incomes below the poverty line, or for which at least 20% of the children are from families with incomes below the poverty line. The Secretary of Education could require non-federal matching contributions from grant recipients. To carry out this section, there would be authorized to be appropriated SSAN for each of FY2010 through FY2014.

Public Health Workforce

PHSA Title VII, Part E, Subpart 2, comprising Secs. 765-770, authorizes the Secretary to conduct programs for public health workforce development by providing grants or contracts to schools, state and local health agencies, and others to operate public health training and re-training programs. Programs include grants for Public Health Training Centers; tuition, fees, and stipends for traineeships in public health and in health administration; and residency programs in preventive medicine and dental public health. Appropriations authority for these programs has expired, though all except the health administration traineeships continue to receive funding.

Sec. 2231. Public Health Workforce Corps

This section would add three new **PHSA sections (340L, 340M, and 340N)**, requiring the Secretary to establish within the U.S. Public Health Service a Public Health Workforce Corps (PHWC), similar to the National Health Service Corps. The Secretary would be required to use the PHWC to address critical public health workforce shortages and may designate as shortage areas state, local, and tribal health departments, and federally qualified health centers (FQHCs). In exchange for a postgraduate period of service in a designated shortage area, members of the PHWC would be eligible for scholarships while in training, and loan repayment while in service.

Sec. 2232. Enhancing the Public Health Workforce

This section would replace **PHSA Sec. 765** with new language requiring the Secretary to establish a grant program for certain health professions schools, state or local health departments, or public or private nonprofit entities, for the development of training programs and assistance to students. The Secretary would be required to give preference to entities that train minority or disadvantaged professionals, that graduate individuals who serve in underserved areas, and that train professionals for work in governmental public health. The Secretary would be authorized to use this program to address severe shortages in the public health workforce in epidemiology,

¹³ This provision is present only in the Education and Labor Chairman's mark.

biostatistics, environmental health, toxicology, public health nursing, nutrition, preventive medicine, maternal and child health, and behavioral and mental health.

Sec. 2233. Public Health Training Centers

This section would amend **PHSA Sec. 766**, which authorizes the Secretary to award grants for Public Health Training Centers. Current law (1) defines these centers as accredited schools of public health, or other public or nonprofit private accredited institutions, that provide graduate or specialized training in public health and (2) authorizes grants for training activities that further the decennial “Healthy People” national health goals developed and published by the Secretary. This section would amend PHS A Sec. 766 to refer, instead of the Healthy People goals, to the National Prevention and Wellness Strategy that would be required under Sec. 2301 of this bill.

Sec. 2234. Preventive Medicine and Public Health Training Grant Program

This section would replace the current **PHSA Sec. 768**, regarding preventive medicine residency training, with new language requiring the Secretary to award grants or contracts for residency training programs in preventive medicine and public health. Eligible applicants would include schools of public health, public health departments, schools of medicine or osteopathic medicine, or public or private hospitals.

Sec. 2235. Authorization of Appropriations

This section would amend new **PHSA Sec. 799C** (as established by Sec. 2216 of this bill) to authorize appropriations through the Public Health Investment Fund for all of the public health workforce provisions summarized above (i.e., new PHS A Secs. 340L, 340M, and 340N, and amended PHS A Secs. 765, 766, and 768). For all of these activities, in addition to any other amounts authorized to be appropriated for such purposes, there would be authorized to be appropriated from the Fund the following amounts: \$51 million for FY2010, \$54 million for FY2011, \$57 million for FY2012, \$59 million for FY2013, \$62 million for FY2014, \$65 million for FY2015, \$68 million for FY2016, \$72 million for FY2017, \$75 million for FY2018, and \$79 million for FY2019. In addition, this section would authorize or reauthorize the appropriation of SSAN for the following PHS A sections through FY2019: Sec. 765 (public health workforce training grants), Sec. 766 (Public Health Training Centers), Sec. 767 (public health traineeships), Sec. 768 (preventive medicine and public health training), and Sec. 769 (health administration traineeships and special projects).

Workforce Diversity, Cultural Competency, and Interdisciplinary Care

PHSA Title VII, Part B, comprising Secs. 736-741, authorizes several programs intended to promote diversity in the health workforce. They include grants to establish Centers of Excellence at health professions schools that recruit and train significant numbers of underrepresented minority students, scholarships and other educational assistance for students from disadvantaged backgrounds, and loan repayments and fellowships for individuals from disadvantaged background who agree to serve as faculty members in health professions schools. Title VIII, Sec. 821 authorizes grants to increase nursing education opportunities for individuals from

disadvantaged backgrounds. Title VII, Part D, comprising Secs. 750-758, authorizes several grant programs to support interdisciplinary, community-based health workforce training.

The House legislation includes the following five sections that would amend several of the existing workforce diversity and interdisciplinary, community-based training programs.

Sec. 2241. Faculty Loan Repayments

This section would amend **PHSA Sec. 738(a)**, increasing the annual limit on the loan repayment amount from \$20,000 to \$35,000. Beginning in FY2012, that amount would be subject to an annual adjustment for inflation.

Sec. 2242. Nursing Workforce Diversity Grants

This section would amend **PHSA Sec. 821**, eliminating the requirement that the Secretary, in awarding nursing workforce diversity grants, take into account the recommendations of the three Invitational Congresses for Minority Nurse Leaders that were convened in the 1990s.

Sec. 2243. Coordination of Diversity and Cultural Competency Programs

This section would add a new **PHSA Sec. 739A**, requiring the Secretary to coordinate the health workforce diversity programs under Title VII, Part B and Title VIII (Sec. 821). It also would amend **PHSA Sec. 736**, directing the Secretary to submit an annual report on the Centers of Excellence program.

Sec. 2251. Cultural and Linguistic Competency Training

This section would amend **PHSA Sec. 741**, by replacing the existing grant program for training health care professionals how to reduce disparities in outcomes and provide culturally competent care with a new cultural and linguistic competency training program. The Secretary would be required to award grants to health professions schools, academic health centers, and other entities to develop, test, and implement such training programs.

Sec. 2252. Innovations in Interdisciplinary Care Training

This section would add a new **PHSA Sec. 759**, requiring the Secretary to award grants to health professions schools, academic health centers, and other entities to develop, test, and implement training programs that promote the delivery of health care services through interdisciplinary and team-based models (e.g., patient-centered medical homes) and the coordination of care across settings.

Health Workforce Evaluation and Assessment

PHSA Title VII, Part E, Subpart 1, comprising Secs. 761-763, establishes various projects to support health professions workforce information and analysis, including grants to entities in order to develop analysis of and information on the health workforce, an Advisory Council on Graduate Medical Education, and an evaluation of the number of pediatric rheumatologists.

The House legislation includes the following two sections that would replace existing PHSA provisions with new language establishing an Advisory Committee on Health Workforce Evaluation and Assessment and requiring certain health workforce data collection activities.

Sec. 2261 and Sec. 2271. Health Workforce Evaluation and Assessment

Sec. 2261 would replace **PHSA Sec. 764** with new language requiring the Secretary to establish a permanent Advisory Committee on Health Workforce Evaluation and Assessment. The Advisory Committee would be required to recommend classifications, standardized methodologies, and procedures to enumerate the health workforce. In addition, the Advisory Committee would have to submit recommendations regarding health workforce supply, diversity, geographic distribution, and retention, and to suggest policies to carry out these recommendations. The Secretary would be required to consult with the Secretary of Education and the Secretary of Labor in carrying out these activities.

Sec. 2271 would replace **PHSA Sec. 761(a) and (b)** with new language requiring the Secretary to collect data on the health workforce, based on the work developed by the Advisory Committee, and data on individuals participating in specified programs authorized by the bill. The Secretary would be authorized to enter into grants or contracts with specified entities and collaborate with federal agencies and other specified organizations for the purpose of carrying out these data collection activities. Pending completion, the Secretary would be authorized to make a judgment about the classifications, methodologies, and procedures developed by the Advisory Committee with respect to their use for data collection under **PHSA Sec. 761(a)**, as amended. Secs. 2261 and 2271 each require the Secretary to submit an annual report to Congress on activities of the Advisory Committee and activities related to data collection, respectively.

Authorization of Appropriations

Sec. 2281. Authorization of Appropriations

This section would amend new **PHSA Sec. 799C** (as established by Sec. 2216 of this bill) to authorize to be appropriated from the Public Health Investment Fund the following amounts for activities in specified PHSA sections, in addition to any other amounts authorized to be appropriated for such purposes: (1) Health professions training and diversity (**PHSA Secs. 736, 737, 738, 739, and 739A**): \$90 million for FY2010; \$97 million for FY2011; \$100 million for FY2012; \$104 million for FY2013; \$110 million for FY2014; \$116 million for FY2015; \$121 million for FY2016; \$127 million for FY2017; \$133 million for FY2018; \$140 million for FY2019; and (2) Interdisciplinary training programs, the Advisory Committee on Health Workforce Evaluation and Assessment, and health workforce assessment (**PHSA Secs. 741, 759, 761, and 764**): \$91 million for FY2010; \$97 million for FY2011; \$101 million for FY2012; \$105 million for FY2013; \$111 million for FY2014; \$117 million for FY2015; \$122 million for FY2016; \$129 million for FY2017; \$135 million for FY2018; \$141 million for FY2019.

The section also would authorize to be appropriated SSAN through FY2019 for the following PHSA sections: **Sec. 736** regarding Centers of Excellence, as redesignated; **Sec. 737** regarding scholarships for disadvantaged students; **Sec. 738** regarding faculty loan repayments and fellowships; **Sec. 739** regarding educational assistance for individuals from disadvantaged backgrounds; and **Sec. 761**, as redesignated, regarding health professions workforce information and analysis. It also would amend **Sec. 741(h)**, as redesignated, regarding grants for health

professions education to add new language that would authorize to be appropriated SSAN through FY2019.

Medicare Graduate Medical Education

With certain exceptions, the GME program caps the number of residents used to calculate GME payments for individual teaching hospitals. The program also permits the redistribution of up to 75% of a teaching hospital's unused resident position to hospitals seeking to increase their medical residency programs, according to specific priorities. However, it does not set targets for the type or mix of resident physicians that a hospital trains. The GME program allows teaching hospitals to receive GME payments for the time residents rotate in nonhospital settings provided (1) they are performing patient care and (2) the hospital pays all or substantially all of the costs of the training at the nonhospital site, including costs associated with a supervising physician. But additional regulatory requirements discourage such rotations. Moreover, hospitals have a financial incentive to retain the often lower-cost clinical labor that residents provide. While experts see value in having residents gain experience in nonhospital settings such as community health centers and nursing facilities, residency programs today are largely based in inpatient, acute-care teaching hospitals. The House legislation includes the following five sections, which collectively would make a number of changes to the GME program to address these and related issues.

Sec. 1501. Distribution of Unused Residency Positions

This section would, among other things, direct the Secretary to redistribute unused residency positions and assign those slots to other qualifying facilities for training primary care physicians. A facility that qualifies for an increase in residency positions would be required to maintain its base level of primary care residents and would be required to use additional slots for the training of primary care residents. Preference would be given to (1) hospitals that have a three-year primary care training program, (2) hospitals that have a formal arrangement to train residents in health centers and other nonhospital settings and in health professional shortage areas, and (3) hospitals located in states with a low resident-to-population ratio, among other criteria.

Sec. 1502. Increasing Training in Non-Provider Settings

This section would modify the current requirements for residents who train in nonhospital settings. All time spent by a resident in such a setting would count toward the direct GME payment, provided the hospital incurred the costs of the resident's salary and benefits. Similarly, all the time spent by a resident in patient care activities in a nonhospital setting would count toward the IME payment, if the hospital incurred those same costs. The section would further require the HHS Inspector General to assess the extent to which there is an increase in time spent by medical residents training in nonhospital settings.

The section also would establish a demonstration project, under which a teaching health center would contract with a teaching hospital to provide primary care residency training. The center would be responsible for payment of the hospital's costs of the residents' salary and benefits, and would be eligible for direct GME payments to cover those costs. Residents training at the center would not be counted as the contracting hospital's residents and thus would not count toward that hospital's GME program cap. In addition, the contracting hospital would not be permitted to reduce its number of primary care residents.

Sec. 1503. Rules for Counting Resident Time for Non-Patient Care Activities

This section would, among other things, allow hospitals to count resident time spent in certain non-patient care activities, including attending conferences and seminars, when calculating IME payments in the hospital setting and direct GME payments in nonhospital settings.

Sec. 1504. Preservation of Resident Cap Positions from Closed Hospitals

This section would direct the Secretary to redistribute medical residency slots from a recently closed hospital to other hospitals in the same state, taking into account recommendations by the senior health official in the state.

Sec. 1505. Improving Accountability for Approved Medical Residency Training

This section would establish certain goals for medical residency training programs. Specifically, programs would have to train residents to (1) work in non-acute traditional settings, (2) coordinate patient care within and across settings, (3) understand the relevant cost and value of various diagnostic and treatment options, (4) work in multi-disciplinary teams, (5) identify systematic errors in health care delivery and implement solutions for such errors, and (6) be meaningful users of electronic health records.

The section also would require GAO to evaluate the extent to which medical residency training programs are meeting the above workforce goals in a range of residency programs, including primary care and specialties, and have the appropriate faculty expertise to teach the topics to achieve those goals.

Quality

Background and Issues

Numerous stakeholders, including policymakers, have engaged in a wide range of efforts to try to address the issue of health care quality. These efforts have generally focused on improving and refining metrics for measuring the quality of care delivered in a number of settings; publicly reporting comparative information on quality performance; and, in some cases, using metrics as the basis for payment policies to demand provider accountability (value-based purchasing). However, these efforts have not generally been guided by a single strategy, entity, or set of priorities or goals, nor have they benefitted from a coordinated infrastructure specifically devoted to improving health care quality.

Quality Measurements

There are no provisions in current law that require the development of national priorities for performance improvement (directed either at the Secretary or AHRQ). However, the Secretary is required by law to have in effect a contract with a consensus-based entity to perform a number of duties, including to synthesize evidence and convene stakeholders to make recommendations on

an integrated national strategy and priorities for health care performance measurement in all applicable settings.

AHRQ has significant existing statutory authorities under PHSA Title IX with respect to the development of quality measures. This includes promoting health care quality improvement by conducting and supporting research that develops and presents scientific evidence regarding all aspects of health care, including methods for measuring quality and strategies for improving quality. In addition, AHRQ's role includes the ongoing development, testing, and dissemination of quality measures, including measures of health and functional outcomes, and the compilation and dissemination of health care quality measures developed in the private and public sector.

Current law does not set forth a process for, or require, multi-stakeholder input into the selection of quality measures by the Secretary for use in CMS's quality programs, such as Medicare's Physician Quality Reporting Initiative (PQRI) or the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program.

The House legislation includes the following five sections, which together would require the development of an explicit national effort to prioritize quality improvement activities, develop a comprehensive repertoire of quality measures, formalize the role of multi-stakeholder input into the selection of quality measures for use in health care programs, create a mechanism for the evaluation of the mechanisms for collecting quality data by the Secretary, and harmonize requirements across settings for the use of endorsed measures (and instances in which non-endorsed measures may be selected).

Sec. 1441. Establishment of National Priorities for Quality Improvement

This section would amend **SSA Title XI** by adding a new Part E—Quality Improvement: Establishment of National Priorities for Performance Improvement. It would require the Secretary to establish national priorities for performance improvement and to solicit and consider recommendations from multiple outside stakeholders when establishing and updating these national priorities. For the purposes of carrying out this section, the Secretary would be required to provide for the transfer, from the Medicare Part A and Part B trust funds, of \$2 million for each of FY2010 through FY2014. The section also would authorize the appropriation of \$2 million, for each of FY2010 through FY2014, from any funds in the Treasury not otherwise appropriated.

Sec. 1442. Development of New Quality Measures

This provision would add two new sections to SSA Title XI, Part E (as established by Sec. 1441 of this bill). **SSA Sec. 1192** would require the Secretary to enter into agreements with qualified entities to develop quality measures for the delivery of health care services in the United States. The Secretary would be required, as specified, to determine areas in which quality measures for assessing health care services in the United States are needed. The section would require the Secretary to make proposed quality measures available to the public and it would authorize the Secretary to fund the testing of proposed quality measures by qualified entities and the updating, by consensus-based entities, of quality measures that have been previously endorsed by such an entity as new evidence is developed. For purposes of carrying out this section, the Secretary would be required to provide for the transfer, from the Medicare Part A and Part B trust funds, of \$25 million for each of FY2010 through FY2014. In addition, the section would authorize the

appropriation of \$25 million, for each of the FY2010 through FY2014, from any funds in the Treasury not otherwise appropriated.

SSA Sec. 1193 would require GAO to periodically evaluate the implementation of the data collection processes for quality measures used by the Secretary and to report to Congress and to the Secretary on the findings and conclusions of the results of each such evaluation.

Sec. 1443. Selection of Quality Measures

This section would amend **SSA Sec. 1808** to establish a process whereby multi-stakeholder groups would formally provide input into the selection of Medicare quality measures. Specifically, it would require the Secretary to publish a list of measures being considered for a subsequent rulemaking, and require the consensus-based entity that has entered into a contract with the Secretary under SSA Sec. 1890 (i.e., National Quality Forum, NQF) to convene multi-stakeholder groups to provide recommendations on the selection of individual or composite quality measures for use in public reporting of performance information or in public health care programs. The consensus-based entity, in convening multi-stakeholder groups, would be required to provide for an open and transparent process for the activities conducted pursuant to such convening. The section would further require the proposed rule to contain a summary of the recommendations made by the multi-stakeholder groups, as well as other comments received regarding the proposed measures, and the extent to which the proposed rule follows such recommendations and the rationale for not following such recommendations.

For purposes of carrying out this section, the Secretary would be required to provide for the transfer, from the Medicare Part A and Part B trust funds, of \$1 million for each of FY2010 through FY2014. In addition, the section would authorize the appropriation of \$1 million for each of FY2010 through FY2014 from any funds in the Treasury not otherwise appropriated.

Sec. 1444. Application of Quality Measures

Generally, this section would place requirements on the Secretary when selecting quality measures for use in existing quality programs for inpatient, outpatient, physician and renal dialysis services. These requirements relate to the endorsement of quality measures and specifically amend relevant sections of the SSA to (1) require the Secretary to select endorsed quality measures for the purposes of reporting quality data; (2) authorize the Secretary to select a non-endorsed measure, if feasible and practical measures were not available, providing the Secretary gives due consideration to endorsed or adopted measures; and (3) require the Secretary to submit non-endorsed measures to NQF for consideration for endorsement, and if NQF were not to endorse the measure, and the Secretary were to continue to use the measure, the Secretary would be required to include the rationale for its continued use in rulemaking.

The section would, by amending **SSA Sec. 1890(b)(2)**, require NQF to explain the reasons underlying non-endorsement of a given measure, and to provide suggestions about changes to such measure that might make such a measure potentially endorsable.

Sec. 1445. Consensus-Based Entity Funding

This section would amend **SSA Sec. 1890(d)** to provide for the transfer from the Medicare Part A and Part B trust funds of \$10 million for FY2009, and \$12 million for each of FY2010 through FY2012 to fund the activities of the consensus-based entity under contract in this section.

Best Practices and Key Health Indicators

PHSA Title IX provides AHRQ with broad general authority to conduct and support research on health care quality, including ways in which patients, consumers, purchasers, and practitioners acquire new information about best practices and health benefits, and the determinants and impact of their use of this information. In addition, AHRQ has the authority to provide financial assistance for meeting the costs of planning and establishing new centers for multidisciplinary health services research, demonstration projects, evaluations, training, and policy analysis.

There are a number of current efforts, some required by law, to collect and disseminate health statistics on the U.S. population. Those activities are primarily directed by AHRQ and the CDC National Center for Health Statistics (NCHS). AHRQ is required to submit two annual reports to Congress: one on national trends in the quality of health care provided to the American people, and the other on prevailing disparities in health care delivery as they relate to racial and socioeconomic factors in priority populations. NCHS conducts and supports statistical and epidemiological activities for the purpose of improving the effectiveness, efficiency, and quality of health services in the United States. NCHS collects statistics on (1) the extent and nature of illness and disability in the U.S. population; (2) the impact of illness and disability of the population on the U.S. economy; (3) environmental, social, and other health hazards; (4) determinants of health; (5) health resources; (6) utilization of health care; (7) health care costs and financing; and (8) family formation, growth, and dissolution.

Sec 2401. Implementation of Best Practices in the Delivery of Health Care

This section would amend **PHSA Title IX** by adding a new Part D—Implementation of Best Practices in the Delivery of Health Care, which would establish within AHRQ a Center for Quality Improvement. The Center would be required to prioritize areas for the identification, development, evaluation, and implementation of best practices for quality improvement activities in the delivery of health care services. In prioritizing these areas, the Center would have to consider the national priorities for performance improvement established pursuant to SSA Sec. 1191 (as added by this bill) and key health indicators identified by the HHS Assistant Secretary for Health Information (discussed below).

The section would require the Center to provide for the public dissemination of information with respect to best practices and activities, and to submit an annual report to the Congress and the Secretary on the activities conducted under this section. Until such time as initial national priorities have been established, priority in initial quality improvement activities and initiatives would have to be given to the following four areas: health care-associated infections, surgery, emergency room, and obstetrics.

Sec 2402. Assistant Secretary for Health Information

This section would amend **PHSA Title XVII** by adding a new Sec. 1709 to create an HHS Assistant Secretary for Health Information. The Assistant Secretary would have a number of responsibilities, mostly related to the collection, reporting, and publishing of information on key health indicators; ensuring the sharing of relevant health data between federal departments; and the development of standards for collection of health data; among others.

With respect to key health indicators, the Assistant Secretary would be required to identify key health indicators and publish statistics on such indicators not less than annually. The review, release, and dissemination of key health indicators would be subject to the same OMB regulations, rules, processes, and procedures that govern the review, release, and dissemination of Principal Federal Economic Indicators by the Bureau of Labor Statistics.

Sec 2403. Authorization of Appropriations

This section would authorize to be appropriated, out of any monies in the Public Health Investment Fund, \$300,000,000 for each of FY2010 through FY2014 and \$330,000,000 for each of FY2015 through FY2019 to carry out Part D of Title IX and Section 1709 of the PHSA.

Public Reporting of Health Care-Associated Infections

Current federal law does not, in general, require the reporting of health care-associated infections (HAIs), although such reporting is required in a number of states. Provisions in current federal law attempt to incentivize the reduction of some specific types of health-care acquired catheter-associated infections (which are only one type of HAI) in two ways: through withholding of Medicare reimbursement under certain circumstances, and through incentives for voluntary physician and hospital reporting.

Sec. 1461. Public Reporting of Health Care-Associated Infection

This section would require the Secretary to provide, by regulation, that in order to participate in Medicare and Medicaid, hospitals (including critical access hospitals) and ambulatory surgical centers would have to report certain HAIs that develop in the facility. The Secretary would be required to establish procedures regarding the validity of reported data to ensure appropriate comparisons between facilities, and to post information online in a manner that permits comparisons by facility and by patient demographic characteristics. The section also would provide that it should not be construed as preempting or otherwise affecting applicable state reporting laws.

Comparative Effectiveness Research

ARRA provided \$1.1 billion for comparative effectiveness research and created the Federal Coordinating Council for Comparative Effectiveness Research, an interagency advisory group that is required to report to the President and Congress annually.¹⁴

¹⁴ For more information, see CRS Report R40181, *Selected Health Funding in the American Recovery and* (continued...)

Sec. 1401. Center for Comparative Effectiveness Research

This section would add a new **SSA 1181**, establishing a Center for Comparative Effectiveness Research within the AHRQ, as well as an independent Comparative Effectiveness Research Commission, to oversee and evaluate the activities carried out by the Center. The Commission would consist of the AHRQ Director, the CMS Chief Medical Officer, and 15 additional members appointed by the HHS Secretary who would represent broad constituencies of stakeholders, including clinicians, patients, researchers, third-party payers, and consumers of federal and state beneficiary programs.

Sec. 1802. Comparative Effectiveness Research Trust Fund

This section would amend the Internal Revenue Code (IRC) by adding a new **IRC Sec. 9511**, establishing the Health Care Comparative Effectiveness Research Trust Fund (CERTF) to fund comparative effectiveness research activities. While activities in the initial years (2010-2012) would be funded entirely from transfers from the Medicare trust funds, the CERTF would eventually receive both public funds (from the Medicare trust funds) as well as monies from the private sector through a fee imposed on health insurance and self-insured plans.

Medicare and Medicaid Nursing Homes

Secs. 1411-1445. Improving Transparency, Enforcement, and Staff Training

The House legislation includes several provisions that would enhance a range of accountability requirements for Medicare certified skilled nursing (SNF) and Medicaid certified nursing facilities. These provisions would require SNFs and nursing facilities to maintain and make available additional information on ownership and organizational structure, as well as to establish new staff compliance and ethics training programs. The Secretary would be required to enhance the information available on the Medicare Nursing Home Compare website for SNFs and nursing facilities, and to make that information more easily accessible to long-term care consumers. A new standardized complaint form would be developed, and facilities and states would be required to make this form available to all stakeholders and consumers. The new complaint form would be accompanied by whistle-blower protections for SNF and nursing facility staff who reported quality of care problems. Additional civil money penalties would be established that both the Secretary and states could impose on nursing facilities found to have quality of care and other deficiencies that jeopardized residents' safety. In addition, SNFs and nursing facilities would be required to add additional staff training in the areas of dementia and abuse prevention, and the Secretary would be required to evaluate the content of additional staff training for certified nurse aides and supervisors.

(...continued)

Reinvestment Act of 2009, coordinated by C. Stephen Redhead.

Health Disparities

Background and Issues

Federal civil rights policy requires most health care providers to make interpretation services available to patients with limited English proficiency (LEP). HHS regulations promulgated under the Civil Rights Act require recipients of HHS financial assistance to provide meaningful access by LEP persons. Recipients of HHS assistance include hospitals; nursing homes; home health agencies; managed care organizations; universities; state, county, and local health agencies; Medicaid agencies; public and private contractors; vendors; physicians; and other providers. Providers who only receive Medicare Part B payments are not considered recipients of HHS assistance.

Research has demonstrated that Medicare beneficiaries with LEP have a harder time accessing health care than LEP seniors covered by Medicaid. Some authors have argued that this difference may be attributed to the fact that federal civil rights policies require Medicaid health care providers to offer language assistance, while physicians serving only Medicare patients are not subject to the same requirements. Although all providers are bound by the Civil Rights Act, which obligates health care professionals to make interpreters available to LEP patients, studies suggest that a lack of reimbursement for language services and poor enforcement of the Act has sometimes made it difficult for LEP Medicare beneficiaries to access translation services.

Secs. 1221-1224. Medicare Beneficiaries with Limited English Proficiency

These sections would require the Secretary to conduct a study to examine the extent to which Medicare providers utilize, offer, or make available language services for LEP, and the ways that Medicare should develop payment systems for language services. The study would include an analysis of ways to develop and structure appropriate payment systems for language services for Medicare providers; the feasibility of adopting a payment methodology for on-site interpreters; the feasibility of Medicare contracting directly with agencies that provide off-site interpretation, including telephonic and video interpretation; the feasibility of modifying the existing Medicare resource-based relative value scale (RBRVS) by using adjustments for LEP patients; and how each of these options would be funded. The potential payment systems included in the analysis could allow variations based on types of service providers, available delivery methods, and costs for providing language services. The bill also would authorize the Secretary to apply sanctions, such as civil money penalties, suspension of enrollment, and suspension of payments, to Medicare Advantage organizations that fail to provide required language services to LEP beneficiaries enrolled in their plans.

Within six months of the completion of the study, the Secretary would be required to carry out a demonstration program under which the Secretary would award no fewer than 24 three-year grants to eligible Medicare providers to improve effective communication between providers and Medicare beneficiaries living in communities where racial and ethnic minorities, including populations that face language barriers, are underserved with respect to such services. Grantees would be required to provide the Secretary with annual reports, which would include (1) the number of Medicare beneficiaries to whom language services are provided, (2) the languages of those Medicare beneficiaries, (3) the types of language services provided, (4) the type of

interpretation, (5) the methods of providing language services, (6) the length of time for each interpretation encounter, and (7) the costs of providing language services.

The Secretary would be required to conduct an evaluation of the demonstration program and submit a report to Congress not later than one year after the completion of the program. An amount of \$16 million would be authorized to be appropriated for each fiscal year of the demonstration program.

The Secretary would be required to contract with the Institute of Medicine (IOM) for a report on the impact of language access services on the health and health care of LEP populations. The IOM report would be issued within three years of enactment of the bill.

Prevention and Wellness

Background and Issues

Prevention interventions are of two key types: those provided to individuals in clinical settings (e.g., cancer screenings) and those provided to communities (e.g., ad campaigns about exercise). Employer-provided “wellness” programs often use both types of interventions. Evidence suggests that many clinical and community-based prevention interventions can improve the health of patients and populations. However, contrary to common belief, many clinical preventive services (including cancer screenings) do not yield savings for the payer, but rather yield a net cost.¹⁵ Evidence is less clear, and there is more debate, about (1) whether clinical preventive services may yield savings in a broader context (considering, for example, the value of lost workdays prevented), and (2) what savings, if any, may accrue to the federal government or society as a result of possible expansions of community-based prevention activities.

Beneficiary cost-sharing has been shown to decrease utilization of certain preventive services, in some contexts. Based on an evidence review, the Task Force on Community Preventive Services (which is administered by CDC) recommends reducing beneficiary cost-sharing in order to increase utilization of screening mammography. However, the Task Force found insufficient evidence to make the same recommendation for cervical or colorectal cancer screening.¹⁶

Current law addresses prevention in several ways, including through (1) coverage of certain clinical preventive services under Medicare and Medicaid; (2) community-based research, disease prevention, and health promotion programs, which may be funded through federal grants; (3) support of evidence review processes to determine whether specific clinical and community-based prevention interventions are effective;¹⁷ and (4) regulation of certain employer-provided

¹⁵ See, for example, Louise B. Russell, “Preventing Chronic Disease: An Important Investment, But Don’t Count On Cost Savings,” *Health Affairs*, vol. 28, no. 1 (January/February 2009), pp. 42-45.

¹⁶ Task Force on Community Preventive Services, “Recommendations for Client- and Provider-directed Interventions to Increase Breast, Cervical, and Colorectal Cancer Screening,” *American Journal of Preventive Medicine*, vol. 35, suppl. 1 (2008), pp. S21-25. See also CDC, <http://www.thecommunityguide.org/cancer/screening/client-oriented/ReducingOutOfPocketCosts.html>.

¹⁷ See the U.S. Preventive Services Task Force, established in Section 915(a) of the PHS Act, <http://www.ahrq.gov/clinic/uspstfix.htm>; and the Task Force on Community Preventive Services, not explicitly authorized but conducted under general authorities in Title III of the PHS Act, <http://www.thecommunityguide.org/index.html>.

wellness programs, in order to strike a balance between flexibility and compliance with current federal privacy, civil rights, and other laws.¹⁸

Coverage of Clinical Preventive Services

While federal law does not mandate coverage of preventive services for state and local government and private health insurance plans, Medicare Part B covers a number of clinical preventive services, including a one-time comprehensive examination, certain periodic cancer screenings, and other services. Medicare Part B also covers vaccines against influenza, pneumococcus, and, for individuals at increased risk, hepatitis B. Medicare Part D covers any FDA-licensed vaccine, when prescribed by a recognized provider. Congress has waived cost-sharing for some, but not all, Medicare covered preventive services.

State Medicaid plans must cover a package of preventive services under the Early and Periodic Screening, Diagnostic, and Treatment Services program (EPSDT), for beneficiaries under 21 years of age. Current law does not explicitly require that Medicaid state plans cover preventive services for adults, although coverage may be required if a service meets another applicable requirement, such as a physician's service.

Sec. 122. Essential Benefits Package Defined

Sec. 100 of the bill would define “qualified health benefits plans” (QHBP) as plans that provide private health insurance, as well as the public insurance option, that meet new federal requirements regarding consumer protections and other matters, including the requirement to cover an essential benefits package. Section 122 would define the required elements of this package to include, among others, preventive services without any cost-sharing, including services recommended by the Task Force on Clinical Preventive Services (established by this bill) and vaccines recommended by the CDC.

Sec. 1305. Medicare Coverage and Waiver of Cost-Sharing

This section would amend **SSA Sec. 1861** to define “Medicare covered preventive services” as a specified list of currently covered services, and any services subsequently covered under the Secretary's administrative authority. Coverage would be subject to conditions and limitations that currently apply to each listed service, except that any cost-sharing (deductible and/or coinsurance) that currently applies would be waived.¹⁹

Sec. 1306. Waiver of Medicare Deductible for Colorectal Cancer Screening

This section would amend **SSA Sec. 1833** to clarify that coinsurance and the deductible would be waived for colorectal cancer screening services regardless of the code applied, of the

¹⁸ CRS Report R40661, *Wellness Programs: Selected Legal Issues*, coordinated by Nancy Lee Jones.

¹⁹ CBO scored this provision in H.R. 3200, the introduced bill, as increasing federal outlays by \$1.1 billion over five years and \$2.8 billion over ten years. CBO cost estimate of H.R. 3200, the America's Affordable Health Choices Act of 2009, July 17, 2009, p. 5 of 10, <http://www.cbo.gov/ftpdocs/104xx/doc10464/hr3200.pdf>. The provision is unchanged in the Chairman's mark for the Committees on Energy and Commerce and Ways and Means, as summarized above.

establishment of a diagnosis, or of the removal of tissue or other matter or other procedure that is performed in connection with and as a result of the screening test.

Sec. 1310. Expanding Access to Vaccines under Medicare

This section would provide Medicare Part B coverage for all federally recommended vaccines, defined as any approved vaccine that is recommended by the CDC upon advice from the Advisory Committee on Immunization Practices.²⁰

Sec. 1311. Expansion of Medicare Covered Preventive Services at FQHCs²¹

This section would amend **SSA Sec. 1861** to provide that FQHCs may receive Medicare reimbursement for Medicare covered preventive services, as defined in Sec. 1305 of this bill.

Sec. 1711. Medicaid Coverage of Preventive Services

This section would amend **SSA Sec. 1905** to require Medicaid state plans to cover, for all beneficiaries, preventive services that the Secretary determines are (1) services recommended by the Task Force on Clinical Preventive Services (established by this bill), or vaccines recommended by the CDC, and (2) if the Secretary determines such services or vaccines are appropriate for Medicaid beneficiaries.²² States may opt to apply cost-sharing to these services.²³

Sec. 1712. Medicaid Coverage of Tobacco Cessation Products

Federal Medicaid law excludes coverage of several classes of drugs. Smoking cessation products are among the classes of drugs that states may opt to exclude from Medicaid coverage, or otherwise restrict. This section would amend **SSA Sec. 1927** to require that state Medicaid plans cover any products approved by the FDA to promote tobacco cessation.

²⁰ CBO scored this provision in H.R. 3200, the introduced bill, as increasing federal outlays by \$200 million over 5 years and \$1.5 billion over 10 years. (Reference as above). The provision is unchanged in the “Chairman’s mark” for the Committees on Energy and Commerce and Ways and Means, as summarized above.

²¹ This provision is present only in the Ways and Means Chairman’s mark.

²² In addition, this section would clarify that vaccines covered under the Vaccines for Children (VFC) program are those recommended by the CDC Director, rather than an advisory committee to the Director. Under the VFC program, Medicaid assumes the costs for certain low-income children who receive recommended vaccinations. **SSA Sec. 1928(g)** provides that **Sec. 1928** (and, therefore, the VFC program) would cease to be in effect if federal law were to provide for immunization services for all children as part of a broad-based reform of the national health care system. This section of the bill would also strike **SSA Sec. 1928(g)**.

²³ Cost-sharing is prohibited for services furnished to individuals under 18 years of age. For more information, see CRS Report RS22578, *Medicaid Cost-Sharing Under the Deficit Reduction Act of 2005 (DRA)*, by Elicia J. Herz.

Provisions in the Public Health Service Act

Sec. 2301. Prevention and Wellness

This provision would create a new **PHSA Title XXXI**—Prevention and Wellness, consisting of several new PHSAs subtitles and sections, as described below.

Subtitle A, Sec. 3111—Prevention and Wellness Trust would establish a Prevention and Wellness Trust and authorize to be appropriated to the Trust, from the Public Health Investment Fund, the following amounts: \$2.4 billion for FY2010, \$2.8 billion for FY2011, \$3.1 billion for FY2012, \$3.4 billion for FY2013, \$3.5 billion for FY2014, \$3.6 billion for FY2015, \$3.7 billion for FY2016, \$3.9 billion for FY2017, \$4.3 billion for FY2018, and \$4.6 billion for FY2019. Amounts in the Trust would be available, for carrying out this title, as provided in advance in appropriation acts. This section also would authorize the appropriation of specified amounts for specified subtitles or sections in the new title, for each of FY2010 through FY2019. Those amounts are provided with the summary of the respective provision, below.

Subtitle B, Sec. 3121—National Prevention and Wellness Strategy would require the Secretary to submit to Congress a National Prevention and Wellness Strategy to improve the nation’s health through evidence-based clinical and community-based prevention and wellness activities, including public health infrastructure improvements. The required strategy would include goals and priorities, and identify health disparities in prevention, among other things.

Subtitle C, Secs. 3131 and 3122—Prevention Task Forces would require the Secretary to establish two task forces: a Task Force on Clinical Preventive Services, to be administered by AHRQ, and a Task Force on Community Preventive Services, to be administered by CDC. Each task force would be required, among other things, to review evidence regarding the benefits, effectiveness, appropriateness, and costs of clinical or community preventive services, respectively, and to develop and disseminate recommendations for the use of such services. Each task force would also be required to convene an advisory stakeholders board and would, in general, be subject to the Federal Advisory Committee Act (FACA). For carrying out this section, Sec. 3111 would authorize to be appropriated from the Trust \$30 million for each of FY2010 through FY2014, and \$35 million for each of FY2015 through FY2019. (See also new Subtitle G, below, regarding the transition of functions from the existing task forces to the task forces established under this section.)

Subtitle D, Secs. 3141 and 3142—Prevention and Wellness Research would require the Directors of the CDC and NIH, in conducting or supporting research on prevention and wellness, to take into consideration the National Prevention and Wellness Strategy and the recommendations of the Task Forces on Clinical and Community Preventive Services. Sec. 3142 would require the Secretary, through the CDC Director, to conduct, or award grants for, research in prevention and wellness priority areas identified in the Strategy, or by the Task Forces. For carrying out this subtitle, Sec. 3111 would authorize to be appropriated from the Trust: \$100 million for FY2010, \$150 million for FY2011, \$200 million for FY2012, \$250 million for FY2013, \$300 million for FY2014, \$315 million for FY2015, \$331 million for FY2016, \$347 million for FY2017, \$364 million for FY2018, and \$383 million for FY2019.

Subtitle E, Sec. 3151—Delivery of Community Prevention and Wellness Services would require the Secretary, through the CDC Director, to award planning or implementation grants for programs to deliver prevention and wellness services that address priority areas identified in the

National Prevention and Wellness Strategy. Program requirements would emphasize services intended to reduce health disparities. Funds could not be used for construction, or to fund services that would otherwise be covered by public or private health care programs. For carrying out this section, Sec. 3111 would authorize to be appropriated from the Trust: \$1.1 billion for FY2010, \$1.3 billion for FY2011, \$1.4 billion for FY2012, \$1.6 billion for FY2013, \$1.7 billion for FY2014, \$1.8 billion for FY2015, \$1.9 billion for FY2016, \$2.0 billion for FY2017, \$2.1 billion for FY2018, and \$2.3 billion for FY2019.

Subtitle F, Secs. 3161 and 3162—Core Public Health Infrastructure would require the Secretary to award grants to each state health department, and authorize the Secretary to award competitive grants to state, local, and tribal health departments, to address core public health infrastructure needs. A specified funding formula would apply to the mandatory grant program; specified maintenance of effort requirements would apply to both grant programs. In addition, the Secretary, acting through the CDC Director, would be required to develop and implement a program of voluntary accreditation of state or local health departments and public health laboratories. For carrying out this section, Sec. 3111 would authorize to be appropriated from the Trust: \$800 million for FY2010, \$1.0 billion for FY2011, \$1.1 billion for FY2012, \$1.2 billion for FY2013, \$1.3 billion for FY2014, \$1.4 billion for FY2015, \$1.5 billion for FY2016, \$1.6 billion for FY2017, \$1.8 billion for FY2018, and \$1.9 billion for FY2019. In addition, new **Sec. 3162** would require the Secretary to expand and improve the core public health infrastructure and activities of the CDC to address unmet and emerging public health needs. For carrying out this section, Sec. 3111 would authorize to be appropriated from the Trust \$350 million for each of FY2010 through FY2014, and \$400 million for each of FY2015 through FY2019.

Subtitle G, Sec. 3171—General Provisions would provide certain definitions applicable to this new title, and procedures for the transition of the functions of the existing U.S. Preventive Services Task Force and Task Force on Community Preventive Services to the Task Force on Clinical Preventive Services and the Task Force on Community Preventive Services, established under Secs. 3121 and 3122 of this bill.

Employer-Provided Wellness Programs

Increasingly, employers are offering incentives to encourage their employees to participate in worksite health and wellness programs. Employer-sponsored wellness programs are subject to HIPAA's nondiscrimination rules and, depending on their design, may also be affected by other statutes such as the Americans with Disabilities Act (ADA).²⁴ Generally, HIPAA prohibits an employer-sponsored health plan from denying enrollment or increasing an individual's premium contribution based on the individual's health status. However, the law provides an exception for plans that offer financial incentives (e.g., premium rebates, lower deductibles) to join a wellness program. A program that provides an incentive simply to encourage participation is considered nondiscriminatory under HIPAA (e.g., reimbursing the cost of a gym membership, or offering an incentive to participate in a smoking cessation clinic, regardless of outcome). But a wellness program that provides an incentive based on achieving a specified health-related outcome, such as giving up smoking or reaching a stated weight loss goal, must meet certain requirements in order to be considered nondiscriminatory. Those requirements include having a program that is reasonably designed to promote health or prevent disease, offering the program to all eligible

²⁴ 42 U.S.C. §§ 12101 et seq.

employees, and providing a reasonable alternative to individuals for whom it would be unreasonably difficult or medically inadvisable to attempt to satisfy the goal.²⁵

The ADA, which in part prohibits an employer from discriminating against an individual with a disability with regard to employment and benefits, specifically exempts health programs from its requirements if (1) participation in the program is voluntary and (2) the health information is treated confidentially, kept separate from other employment records, and not used to limit health insurance coverage. However, according to Equal Employment Opportunity Commission (EEOC) guidance on ADA enforcement, offering an incentive may render a wellness program involuntary if it is required in order to participate in an employer's insurance program.²⁶

Employer-sponsored wellness programs also are subject to federal health privacy laws. Generally, individually identifiable health information acquired through a wellness program is protected under the HIPAA privacy rule if (1) the program is considered a part of the health plan, (2) the program provides and bills for health care services, or (3) the program is operated outside of the health plan by an entity that has a HIPAA-compliant business associate contract with the plan. ARRA strengthened the privacy rule's business associate requirements, making such entities criminally liable if they violate the HIPAA privacy protections. The HIPAA privacy rule allows health plans to disclose health information to employers, subject to certain conditions that include prohibiting the use of such information for employment-related actions.

Sec. 2552. Wellness Program Grants²⁷

This section would require the Secretary of Labor to establish a grant program to help employers cover the costs of providing wellness programs to their employees. Qualified employers would be those that offer a qualified health benefits plan (QHBP) to every employee and meet the health coverage participation requirements, each as defined in Division A of this bill. Allowable costs would be those attributable to the qualified wellness program (excluding the cost of food), and not to the health plan or health insurance coverage offered in connection with such a plan. Grants for a given plan year would be capped at \$200 per employee for employers with 200 or fewer employees, or \$100 per employee for employers with more than 200 employees. Grants could be provided for up to three years and would be capped at \$50,000, in total, for an employer.

A qualified wellness program would be certified by the Secretary of Labor, in coordination with the Health Choices Commissioner (established in Division A of this bill) and the CDC Director, as meeting several criteria, including (1) being consistent with current evidence-based research and best practices; (2) being culturally appropriate, and accessible for individuals with disabilities and with limited English proficiency, among others; (3) having a number of required components, including health awareness, health education, periodic screenings, employee engagement, and listed behavioral change activities (including smoking cessation and weight reduction); and (4) having supportive work policies regarding tobacco use, food choices, stress management, and physical activity. A program could not be certified unless each required program component were

²⁵ Nondiscrimination and Wellness Programs in Health Coverage in the Group Market, 71 Fed. Reg. 75014 (Dec. 13, 2006). For more information on HIPAA's nondiscrimination provisions as they apply to wellness programs, see CRS Report R40661, *Wellness Programs: Selected Legal Issues*, coordinated by Nancy Lee Jones.

²⁶ http://www.eeoc.gov/foia/letters/2009/ada_disability_medexam_healthrisk.html. For a more detailed discussion see CRS Report R40661, *Wellness Programs: Selected Legal Issues*, coordinated by Nancy Lee Jones.

²⁷ This provision is present only in the Education and Labor Chairman's mark.

available to all employees. However, employee participation could not be mandated. Also, qualified wellness programs could not provide incentives for participation.

Any employee health information collected through the wellness program would be confidential. Employers would have no access to the information. Entities offering wellness programs would be considered business associates of the health plan. There would be authorized to be appropriated SSAN to carry out this section.

National Medical Device Registry

Background and Issues

Concern about the safety of certain high-risk medical devices has led Congress to consider various tracking and postmarket surveillance mechanisms. Sec. 519(e) of the Federal Food Drug and Cosmetic Act (FFDCA) permits the Secretary to order a medical device manufacturer to adopt a method of tracking for certain devices that may create risks for patients.²⁸ The FDA Amendments Act of 2007 (P.L. 110-85) added a new Sec. 519(f), yet to be implemented, which requires medical devices to bear a unique identifier.²⁹

Sec. 2521. National Medical Device Registry

This section would add a new **FFDCA Sec. 519(g)**, requiring the Secretary to establish a public national medical device registry to facilitate analysis of postmarket safety and outcomes data on certain implantable, life-sustaining, and other types of medical devices. The Secretary would be required to establish a procedure to link specified medical device data from manufacturers with patient safety and outcomes data from disparate sources, and integrate the registry activities with certain other postmarket risk and safety activities required by the FFDCA. In addition, acting through the HHS Office of the National Coordinator for Health Information Technology, the Secretary would be required to adopt standards for the electronic exchange and use in certified electronic health records of a unique device identifier.

²⁸ For background information about the medical device approval system, see CRS Report RL32826, *The Medical Device Approval Process and Related Legislative Issues*, by Erin D. Williams

²⁹ For information on the implementation status of the unique device identifier, go to <http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/UniqueDeviceIdentifiers/default.htm>.

Appendix. Acronyms Used in the Report

AHRQ	Agency for Healthcare Research and Quality
CBO	Congressional Budget Office
CDC	Centers for Disease Control and Prevention
CERTF	Comparative Effectiveness Research Trust Fund
CHIP	Children’s Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
EPSDT	Early and Periodic Screening, Diagnostic and Treatment Services
FACA	Federal Advisory Committee Act
FDA	Food and Drug Administration
FFDCA	Federal Food, Drug, and Cosmetic Act
FQHC	Federally Qualified Health Center
FTE	full-time equivalent
GAO	Government Accountability Office
GME	Graduate Medical Education
HAI	Health Care-Associated Infection
HHS	Health and Human Services
HIT	Health Information Technology
HIPAA	Health Insurance Portability and Accountability Act
HRSA	Health Resources and Services Administration
HPSA	Health Professional Shortage Area
IME	Indirect Medical Education
IOM	Institute of Medicine
LEP	limited English proficiency
NCHS	National Center for Health Statistics
NHSC	National Health Service Corps
NIH	National Institutes of Health
NQF	National Quality Forum
OMB	Office of Management and Budget
ONCHIT	Office of the National Coordinator for Health Information Technology
PHSA	Public Health Service Act
PHWC	Public Health Workforce Corps
PQRI	Physician Quality Reporting Initiative
QHBP	Qualified Health Benefits Plan
RHQDAPU	Reporting Hospital Quality Data for Annual Payment Update
SBHC	School-Based Health Clinic
SNF	skilled nursing facilities
SSA	Social Security Act
SSAN	such sums as may be necessary

Author Contact Information

C. Stephen Redhead, Coordinator
Specialist in Health Policy
credhead@crs.loc.gov, 7-2261

Kirsten J. Colello
Specialist in Health and Aging Policy
kcolello@crs.loc.gov, 7-7839

Elayne J. Heisler
Analyst in Health Services
eheisler@crs.loc.gov, 7-4453

Sarah A. Lister
Specialist in Public Health and Epidemiology
slister@crs.loc.gov, 7-7320

Bernice Reyes-Akinbileje
Analyst in Health Resources and Services
breyes@crs.loc.gov, 7-2260

Amanda K. Sarata
Analyst in Health Policy and Genetics
asarata@crs.loc.gov, 7-7641

Erin D. Williams
Specialist in Public Health and Bioethics
ewilliams@crs.loc.gov, 7-4897

Andrew R. Sommers
Analyst in Public Health and Epidemiology
asommers@crs.loc.gov, 7-4624

Acknowledgments

The authors acknowledge the assistance of Amalia Corby-Edwards, Presidential Management Fellow, in the analysis and presentation of material on the health care workforce. Jim Hahn, Analyst in Health Care Financing, also contributed to the report.