Approved: March 2, 2011
Date

MINUTES OF THE SENATE WAYS AND MEANS COMMITTEE

The meeting was called to order by Chairperson Carolyn McGinn at 10:30a.m. on January 31, 2011, in Room 548-S of the Capitol.

Senator Emler, excused

Committee staff present:
Jill Wolters, Office of the Revisor of Statutes
Daniel Yoza, Office of the Revisor of Statutes
David Wiese, Office of the Revisor of Statutes
Alan Conroy, Director, Legislative Research Department
J. G. Scott, Chief Fiscal Analyst, Legislative Research Department
Aaron Klaassen, Senior Fiscal Analyst, Legislative Research Department
Dorothy Hughes, Fiscal Analyst, Legislative Research Department
Brea Short, Intern, Senator McGinn's Office
Jan Lunn, Committee Assistant
Josh Lewis, Chief of Staff

Conferees appearing before the Committee:
Dennis Taylor, Acting Secretary, Department of Administration (DofA)

Others attending:
See attached list.

Introduction of Senator Marci Francisco
Senator McGinn welcomed Senator Marci Francisco to the Senate Ways and Means Committee. Senator Francisco is replacing Senator Janis Lee.

Announcements
Chairperson McGinn announced the Senate Ways and Means Committee would meet in Room 144-S on Tuesday and Wednesday, February 1 and 2.

Senator McGinn called attention to follow-up responses from the following individuals:

Dustin Moyer, Kansas Health Policy Authority, submitted a response related to the agency's Cost Recovery Audit Contract, which was discussed at the January 19, 2011, committee meeting (Attachment 1).

Suzanne Cleveland, Kansas Health Institute, submitted a response related to "Minimum Requirements for Health Insurance through Health Insurance Exchanges under the Affordable Care Act," which was discussed at the January 19 meeting (Attachment 2).

Robert Moser, MD, Kansas Department of Health and Environment (KDHE), submitted the agency's 2011 Annual Report. This was referenced during his presentation on January 26, 2011. This report is available on the KDHE website at: http://www.kdheks.gov/reports/2010_Annual_Report.pdf

These attachments are considered to be part of this permanent record.

Bill Introductions
There were no bill introductions

Confirmation Hearing – Dennis Taylor, Department of Administration (DOA)
Acting Secretary Taylor reviewed his "Senate Confirmation Information Summary" with committee members (Attachment 3), highlighting his personal, educational, and professional background.

Senator Kelly questioned how Mr. Taylor would balance his responsibilities in the Department of Administration with his personal consulting business, Dennis Taylor and Associates. Mr. Taylor responded that business closed approximately five years ago. He indicated his full attention would be directed to his role as Secretary of the Department of Administration.

Responding to Senator Schodorf's question regarding Acting Secretary Taylor's philosophy for the Department of Administration and the Office of the Repealer, Mr. Taylor responded his focus will be on the continuous improvement process for all state agencies, but specifically, those agencies with central responsibilities under the Department of Administration. In addition, a primary goal of the Office of the Repealer is to identify and eliminate conflicting legislation. Acting Secretary Taylor described his strategy to:

- meet with all stakeholders,
- develop a baseline related to current processes,
- obtain more data and assess current satisfaction levels, and
- establish performance expectations and develop a strategic performance plan.

Insofar as repealing legislation, Acting Secretary Taylor indicated that could be handled either by statutory change through the legislative process or through rules or regulations process. Mr. Taylor indicated legislators could contact him at dennis.taylor@da.ks.gov with constituents' suggestions of legislation to consider for repeal.

Chairperson McGinn inquired about the staffing composition in the Department of Administration. Mr. Taylor indicated there would not be a deputy secretary, A. J. Kotich has been hired as chief counsel, and Mark McGivern has been hired as the Director of Business Process Improvement. Mr. Taylor elaborated "business process improvement" means rules and regulations, statutes, and the internal method in which a business process is managed. Currently, the position of Director of the Division of Information Systems and Communication (DISC) is vacant. Assessment of staffing needs to improve efficiency and effectiveness will continue.

Responding to Senator Francisco's question regarding what complementary information that DOA would furnish during a statutory repeal process, Mr. Taylor reported that data and other information sources would be searched as well as researching other states' statutes for information.

Senator Schmidt shared her experience with the electronic mail system within the state government system, which would enable many constituents to contact legislators, department representatives, and state employees without knowledge of the department in which they work.

Senator McGinn moved that the Senate approve and consent to the appointment of Mr. Dennis Taylor, Secretary of Administration, serving at the pleasure of the Governor; the motion was seconded by Senator Kelly, which passed on a voice vote.

The meeting was adjourned at 11:42 a.m.

SENATE WAYS AND MEANS
GUEST LIST
January 31, 2011

NAME	AFFILIATION
DEREK HEIN	HEIN LAW FIRM
David Clark	Senator John Vratil
Karen Taylor	Visitor
Diane Gjerstad	USD259 Wichita
Tracy Russell	SQE
Rick Random	USD 500 (KCKS)
Dennis Taylor	Dept. of Administration
[illegible]	Budget
Brett Cooper	visitor
DAVID HASTINGS	KBI
ML Dyck	KSBTP
Lydia Buster	Federico Consulting
Mary Jane Stankiewicz	KARA
[illegible]	KDHE
ALAN BURT	SECRETARY OF STATE
Jane Carter	KCSDE
TERRY FORSYTH	KNEA
Mary Blubaugh	KSBN
Stephanie Bunten	Judicial Branch
Leigh Keck	Capitol Strategies
Paige Rowthier	Hein Law Firm
Sherry A Diel	KS Real Estate Comm
Tara Mays	KDOT
Seeta Allen	Legis.
Nathan Lindsey	Kearney & Associates
Kelly Navinsky-Wenzel	Kearney & Assoc.
Jana El-Koubysi	KSAG
TOM DAY	KCC

Jan Lunn

From: Moyer, Dustin [KHPA] [Dustin.Moyer@khpa.ks.gov]
Sent: Thursday, January 27, 2011 12:39 PM
To: Jan Lunn
Cc: Amy Deckard
Subject: Recovery Audit Contract

Jan,
Sorry about the delay in returning this information.
The Cost Recovery Audit contract was awarded to Health Data Insight (HDI) in early December. Payment to HDI is based on a 17% contingency fee. HDI has estimated they will recover a total of $16.08 million over the period of the contract which is from FY 2011-2013. Of the $16.08 million total the state will receive $6.5 million for Medicaid and State Employee Health Plan recoveries and the federal government will receive $6.8 million for their portion of Medicaid payments.
Please let me know if you have any further questions.

Dustin Moyer
Legislative Liaison
Kansas Health Policy Authority
Landon State Office Building
900 SW Jackson Ave., Suite 900
Topeka, Kansas 66612
(785)-296-7762

Senate Ways and Means
Date: 01/31/11
Attachment: 1

KANSAS HEALTH INSTITUTE

MEMO

To: Senate Financial Institutions and Insurance Committee

From: Kansas Health Institute

Date: January 18, 2011

Re: Minimum Requirements for Health Insurance Plans Offered through Health Insurance Exchanges under the Affordable Care Act

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Introduction

The Affordable Care Act (ACA) makes significant changes in the regulations governing providers of large, small and non-group health insurance. In addition to the regulatory changes, the ACA also authorizes the creation of new state-based health insurance exchanges designed to provide coverage to both individuals and small groups. Federal subsidies also will be provided through the exchanges to eligible persons.
Certain distinctions will exist between plans offered inside the exchanges and plans offered outside the exchanges; this memo will briefly describe these distinctions.[i]

Requirements for New Plans

With exceptions, by 2014, the following regulations will apply to new individual and small group plans regardless of whether they are offered inside or outside of an exchange. Insurance companies will be:

- Prohibited from imposing lifetime and annual limits (lifetime limit prohibition became effective in 2010).
- Prohibited from cancelling policies – a practice known as rescission –except in cases of fraud (became effective in 2010).
- Required to cover recommended preventive services at no cost to plan beneficiaries (became effective in 2010).
- Required to extend coverage of dependent children to age 26 (became effective in 2010).
- Limited to the use of only four rating factors; age, family composition, geographic location and tobacco use.
- Required to issue and renew coverage to all who apply.
- Required to cover "essential health benefits", a federally defined list of basic benefits.
- Required to adhere to cost-sharing limits defined by the law.
- Required to implement new risk-adjustment strategies and offer standardized plans.[ii]

Requirements for Exchange Plans

In general, for a health insurance plan to be offered through a health insurance exchange it must be certified to be a "Qualified Health Plan" (QHP); note, however, that QHPs may also be offered outside of the exchanges. In order to be a QHP, a plan must do the following:

- Adhere to marketing requirements that do not discourage enrollment of persons with significant health needs.
- Ensure sufficient choice of providers.
- Include "essential community providers" that mainly serve the low-income and medically underserved.
- Implement quality improvement strategies with increased reimbursement or other incentives for goals such as reduction in hospital readmission rates or successful incorporation of health and wellness programs.

Issuers of QHPs must also meet specific requirements such as licensure and good standing in the state, the offer of at least one QHP at both the "silver" and "gold" levels in the exchange, and maintenance of the same premium rate for a plan regardless of whether it is offered through the exchange, directly from the issuer or through an agent.

Lastly, several provisions apply specifically to plans offered through an exchange. Most significantly, those individuals with incomes between 100 and 400 percent of the Federal Poverty Level ($22,050–$88,200 for a family of four in 2010) who do not have access to affordable coverage elsewhere, may be able to receive federally subsidized coverage, but only through plans offered in the health insurance exchanges. Similarly, small employers who qualify for tax credits to offset the costs of coverage will only be able to receive those tax credits when purchasing coverage through an exchange. Some additional rules applicable only to exchange plans (the details of which are to be developed by the Secretary of HHS) include evaluation by a quality rating system and by an enrollee satisfaction system.

Conclusion

While there is substantial overlap between the rules applicable to new individual and small group plans offered either outside or inside of health insurance exchanges, a few critical distinctions exist. Many details have yet to be determined about how both the exchanges and the market outside of the exchanges will operate and much discretion is left to the states in determining how to design the health insurance marketplace.

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[i] Information adapted and summarized from Congressional Research Service Report R41269, *PPACA Requirements for Offering Health Insurance Inside Versus Outside an Exchange*.

[ii] Please note that information in this memo is not intended to be exhaustive and additional rules and regulations may apply to QHPs, issuers of QHPs and QHPs offered through health insurance exchanges.

KANSAS HEALTH INSTITUTE

MEMO

To: Senate Ways and Means Committee

From: Kansas Health Institute

Date: January 26, 2011

Re: Answers to health reform questions raised in January 19, 2011 committee meeting

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The Kansas Health Institute provided an overview of the Affordable Care Act (ACA) for the Senate Ways and Means Committee on Wednesday, January 19th. This memo includes answers and supplemental information for questions raised during the meeting.

1. How exactly are the religious belief exemptions from the individual mandate granted, and are there mechanisms in the ACA that would prevent individuals from claiming the religious exemption (or other exemptions, for that matter) and then signing up for health insurance later, when an accident or health issue necessitated coverage?

- The ACA includes two exceptions from the individual requirement to purchase health insurance coverage that are based on or related to religion. The first is the religious conscience objection, the second is based on membership in a health care sharing ministry.
- The religious conscience objection in the ACA does not list specific religious groups or religious beliefs that will qualify for the exemption. Instead, the legislation refers to the religious conscience objection that is included in section 1402(g)(1) of the federal tax code, which allows an exemption from self-employment income tax if an individual is a practicing member of a recognized religious group that, on the basis of its religious beliefs, opposes aspects of social insurance. For the precise wording used in section 1402(g)(1), see Attachment A.
- Although the exemption process under the ACA may not be exactly the same, the waiver process for a religious exemption from Social Security and Medicare and a waiver application form are available at the Social Security Administration's website: http://ssa-custhelp.ssa.gov/app/answers/detail/a_id/514/~/religious-groups-exempt-from-social-security. They may provide some general guidance.
- The other faith-based exemption from the individual mandate is membership in a health care sharing ministry. A health care sharing ministry (HCSM) does not provide insurance; rather, it is a not-for-profit religious organization that shares among its members, the burden of medical expenses. According to the Alliance of HCSMs, roughly 100,000 individuals in the United States belong to a HCSM. For more information, see http://healthcaresharing.org/hcsm/.

- The religious exemptions raise a procedural concern; what happens if an individual applies for and receives an exemption from the requirement to purchase coverage, but then becomes sick or injured and seeks coverage? In the case of religious waivers for Social Security and Medicare, the waiver allows a person to opt out of paying the requisite taxes, but it simultaneously waives their ability to collect any benefits. The process also ensures other safeguards to prevent "gaming" of the system. Exactly how the ACA's religious waivers will operate with regard to access to public or private insurance programs is not entirely clear.
- The same procedural issue stemming from the religious exemptions could arise in other exemption cases as well. Furthermore, how the state will be able to prevent individuals who are not exempt from the mandate, but who choose to pay the small financial penalty rather than comply with the requirement, from simply purchasing insurance as they need it when they are sick or injured remains a critical issue to resolve. As written, the ACA prohibits an insurer from denying coverage to an individual on the basis of a pre-existing condition. That raises concerns that individuals will not have incentive to purchase coverage in advance of an injury or illness. Many states are exploring what additional methods may be available to compel individuals to purchase insurance in a timely fashion when the ACA is fully implemented in 2014; options currently employed in both the private and public insurance markets include coordinated open enrollment periods and late enrollment penalties.

2. How can states plan for incoming federal funding brought about by the ACA as they develop and maintain their budgets? Can states plan to use federal funding to fill budget shortfalls?

- The amount of federal funding Kansas can expect to receive from the ACA is difficult to estimate for two reasons. First, the future of the ACA is uncertain and even if the legislation is not repealed, it is likely that several funding and programmatic provisions will be changed. Second, much of the funding is only available to those states (or local or private entities) that apply. Securing federal grants requires a well-coordinated process in which state officials are alerted to opportunities and have the time and resources to make timely applications. Further, funding is often allotted to agencies or groups that can demonstrate a solid existing infrastructure or history of success within the funding/programmatic area.
- The ACA provides for a significant amount of funding that is to come from mandated appropriations and fund transfers. The remaining funding is discretionary. Attachments B and C summarize the mandated and discretionary funding available through the ACA.

3. Do states have flexibility in how they spend their Medicaid dollars?

- As of the date of enactment of the ACA, states are subject to a Maintenance of Effort (MOE) requirement which says that a state "shall not have in effect eligibility standards, methodologies, or procedures under its Medicaid or CHIP state plan (or under a Medicaid or CHIP waiver) that are more restrictive than the

eligibility standards, methodologies, or procedures" in effect on March 23, 2010. When the ACA was enacted however, states were already subject to a Medicaid MOE requirement under the American Recovery and Reinvestment Act (ARRA), which was enacted July 1, 2008. For more information, see Attachment D.

- State flexibility in determining Medicaid benefits packages will also change under the ACA. States will be required to provide most newly eligible enrollees with "essential health benefits." HHS will determine what benefits to include in the definition of essential health benefits, though general categories were outlined in the reform legislation. An Institute of Medicine panel met in early January 2011 to work on the essential health benefits definitions. These same minimum services will be required of many private insurance plans starting in 2014. See Attachment E for more information.
- States will have flexibility in determining which optional services to provide and in setting provider reimbursement rates. The ACA provides states with opportunities for funding or enhanced federal match rates for instituting new prevention and disease management programs in Medicaid.

Attachments

A: *Internal Revenue Code, 26 USC 1492(g)(1)* [Cornell University Law School]

B: *Appropriations and Fund Transfers in the Patient Protection and Affordable Care Act* [Congressional Research Service]

C: *Discretionary Funding in the Patient Protection and Affordable Care Act* [Congressional Research Service]

D: *Holding the Line on Medicaid and CHIP: Key Questions and Answers About Health Care Reform's Maintenance of Effort Requirements* [Center on Budget and Policy Priorities, Georgetown University Health Policy Institute, Center for Children and Families]

E: *Explaining Health Reform: Benefits and Cost-Sharing for Adult Medicaid Beneficiaries* [Kaiser Family Foundation]

Section 1402(g)(1) of the Internal Revenue Code Referred to in the Affordable Care Act's Religious Exemptions Provision

26 USC 1402(g) Members of certain religious faiths

(1) Exemption

Any individual may file an application (in such form and manner, and with such official, as may be prescribed by regulations under this chapter) for an exemption from the tax imposed by this chapter if he is a member of a recognized religious sect or division thereof and is an adherent of established tenets or teachings of such sect or division by reason of which he is conscientiously opposed to acceptance of the benefits of any private or public insurance which makes payments in the event of death, disability, old-age, or retirement or makes payments toward the cost of, or provides services for, medical care (including the benefits of any insurance system established by the Social Security Act). Such exemption may be granted only if the application contains or is accompanied by—

(A) such evidence of such individual's membership in, and adherence to the tenets or teachings of, the sect or division thereof as the Secretary may require for purposes of determining such individual's compliance with the preceding sentence, and

(B) his waiver of all benefits and other payments under titles II and XVIII of the Social Security Act on the basis of his wages and self-employment income as well as all such benefits and other payments to him on the basis of the wages and self-employment income of any other person, and only if the Commissioner of Social Security finds that—

(C) such sect or division thereof has the established tenets or teachings referred to in the preceding sentence,

(D) it is the practice, and has been for a period of time which he deems to be substantial, for members of such sect or division thereof to make provision for their dependent members which in his judgment is reasonable in view of their general level of living, and

(E) such sect or division thereof has been in existence at all times since December 31, 1950.

An exemption may not be granted to any individual if any benefit or other payment referred to in subparagraph (B) became payable (or, but for section 203 or 222(b) of the Social Security Act, would have become payable) at or before the time of the filing of such waiver.

Appropriations and Fund Transfers in the Patient Protection and Affordable Care Act (PPACA)

C. Stephen Redhead
Specialist in Health Policy

October 28, 2010

Congressional Research Service
7-5700
www.crs.gov
R41301

CRS Report for Congress
Prepared for Members and Committees of Congress

Summary

On March 23, 2010, President Obama signed into law a comprehensive health care reform bill, the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148). The following week, on March 30, 2010, the President signed the Health Care and Education Reconciliation Act of 2010 (HCERA; P.L. 111-152), which amended various health care and revenue provisions in PPACA.

Among its many provisions, PPACA (as amended by HCERA) restructures the private health insurance market, sets minimum standards for health coverage, creates a mandate for most U.S. residents to obtain health insurance, and provides for the establishment by 2014 of insurance exchanges through which certain individuals and families will be able to receive federal subsidies to reduce the cost of purchasing that coverage. The new law expands eligibility for Medicaid; amends the Medicare program in ways that are intended to reduce the growth in Medicare spending that had been projected under preexisting law; imposes an excise tax on insurance plans found to have high premiums; and makes other changes to the tax code, Medicare, Medicaid, and numerous other federal programs.

In some instances, PPACA mandates appropriations or requires the Secretary to transfer from the Medicare Part A and Part B trust funds billions of dollars to support new or existing grant programs and other activities. This report summarizes those mandated appropriations and fund transfers. They include funding for a temporary insurance program for individuals who have been uninsured for several months and have a preexisting condition, as well as funding for states to plan and establish exchanges. PPACA also provides funding for various Medicare and Medicaid demonstration programs, for the creation of a Center for Medicare and Medicaid Innovation to test and implement innovative payment and service delivery models, and for an independent board to provide Congress with proposals for reducing Medicare cost growth and improving quality of care for Medicare beneficiaries.

Among other provisions, the new health reform law appropriates funding for health workforce and maternal and child health programs, and establishes three multi-billion dollar funds. The first fund will provide a total of $11 billion over five years in supplementary funding for community health centers and the National Health Service Corps. (A separate appropriation provides $1.5 billion for health center construction and renovation.) The second fund will support comparative effectiveness research through FY2019 with a mixture of appropriations and fund transfers. The third fund, which is funded in perpetuity, is to support prevention, wellness, and other public health-related programs and activities authorized under the Public Health Service Act (PHSA).

In addition to the mandated appropriations and fund transfers discussed in this report, PPACA authorizes new funding for numerous existing discretionary grant and other programs and activities, primarily ones authorized under the PHSA. It also creates a number of new discretionary grant programs and activities and provides for each an authorization of appropriations. Funding for all of these discretionary programs and activities is subject to action by congressional appropriators. A companion product, CRS Report R41390, *Discretionary Funding in the Patient Protection and Affordable Care Act (PPACA)*, coordinated by C. Stephen Redhead, summarizes all the provisions in PPACA for which appropriations are authorized.

Contents

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Contacts

Introduction

On March 23, 2010, President Obama signed into law a comprehensive health care reform bill, the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148).[1] The following week, on March 30, 2010, the President signed the Health Care and Education Reconciliation Act of 2010 (HCERA; P.L. 111-152), which amended various health care and revenue provisions in PPACA.[2]

Among its many provisions, PPACA (as amended by HCERA) restructures the private health insurance market, sets minimum standards for health coverage, creates a mandate for most U.S. residents to obtain health insurance, and provides for the establishment by 2014 of insurance exchanges through which certain individuals and families will be able to receive federal subsidies to reduce the cost of purchasing that coverage. The new law expands eligibility for Medicaid; amends the Medicare program in ways that are intended to reduce the growth in Medicare spending that had been projected under preexisting law; imposes an excise tax on insurance plans found to have high premiums; and makes other changes to the tax code, Medicare, Medicaid, and numerous other federal programs.

Mandated Appropriations and Fund Transfers

In some instances, PPACA (as amended by HCERA) mandates appropriations or requires the Secretary to transfer from the Medicare Part A and Part B trust funds billions of dollars to support new or existing grant programs and other activities. **Table 1** summarizes all such appropriations and fund transfers, which are grouped under the following headings: (1) Private Health Insurance Reforms; (2) Medicaid and the Children's Health Insurance Program (CHIP); (3) Medicare; (4) Fraud and Abuse; (5) Health Centers and the National Health Service Corps (NHSC); (6) Health Workforce; (7) Community-Based Prevention and Wellness; (8) Maternal and Child Health; (9) Long-Term Care; (10) Comparative Effectiveness Research; (11) Biomedical Research; and (12) PPACA Implementation.

Each table entry includes the following information: (1) the PPACA section number; (2) an indication of whether the provision modifies the Public Health Service Act or another law either by amending an existing section or by adding a new one, or whether the provision creates new stand-alone statutory authority; (3) a brief description of the program or activity; and (4) details of the appropriation or transfer of funds. In most cases, the language specifies funding levels (or transfer amounts) for one or more fiscal years. Two provisions appropriate "such sums as may be necessary" (SSAN) to carry out a program. The table also includes web links to PPACA grant opportunity announcements and grant awards. Unless otherwise stated, references in the table to the Secretary refer to the Secretary of Health and Human Services (HHS).

The following laws are referred to in the table by their acronyms:

- Public Health Service Act (PHSA)

[1] The full text of the Patient Protection and Affordable Care Act, as enacted, is at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590enr.txt.pdf.

[2] The full text of the Health Care and Education Reconciliation Act of 2010, as enacted, is at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h4872enr.txt.pdf.

- Social Security Act (SSA)
- Internal Revenue Code (IRC)
- Older Americans Act (OAA)
- Deficit Reduction Act of 2005 (DRA)[3]
- Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)[4]

Discretionary Funding

In addition to the mandated appropriations and fund transfers discussed in this report, PPACA (as amended by HCERA) authorizes new funding for numerous existing discretionary grant and other programs and activities. It also creates a number of new discretionary grant programs and activities and provides for each an authorization of appropriations. Funding for all of these discretionary programs and activities is subject to action by congressional appropriators. A companion product, CRS Report R41390, *Discretionary Funding in the Patient Protection and Affordable Care Act (PPACA)*, summarizes all the provisions in PPACA for which appropriations are authorized.

CRS Products

More information on the PPACA provisions summarized in **Table 1** may be found in the following CRS products:

- CRS Report R40942, *Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (PPACA)*, by Hinda Chaikind, Bernadette Fernandez, and Mark Newsom
- CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in PPACA: Summary and Timeline*, coordinated by Julie Stone
- CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*, coordinated by Patricia A. Davis
- CRS Report R41278, *Public Health, Workforce, Quality, and Related Provisions in PPACA: Summary and Timeline*, coordinated by C. Stephen Redhead and Erin D. Williams

[3] P.L. 109-171.

[4] P.L. 110-275.

2-11

2-12

Table 1. Appropriations and Fund Transfers in the Health Reform Law

Patient Protection and Affordable Care Act (PPACA; P.L. 111-148, as amended by P.L. 111-152)

PPACA Section	New/Existing Authority	Program Summary	Appropriation/Transfer
Private Health Insurance			
1002	New PHSA Sec. 2793	**Health insurance consumer information.** Requires the Secretary to award grants to states to enable them (or the exchanges operating in such states) to establish, expand, or provide support for offices of health insurance consumer assistance, or health insurance ombudsman programs. These independent entities will assist consumers with filing complaints and appeals, educate consumers on their rights and responsibilities, and collect, track, and quantify consumer problems and inquiries.	Appropriates $30 million for the first fiscal year of the program, to remain available without fiscal year limitation. [Note: the section also authorizes to be appropriated SSAN for each fiscal year thereafter.] [Grant awards: http://www.hhs.gov/news/press/2010pres/10/20101019a.html]
1003	New PHSA Sec. 2794	**Review of health insurance premium rates.** Requires the Secretary, in conjunction with the states, to establish a process for the annual review of unreasonable increases in health insurance premiums beginning in the 2010 plan year. Health insurance issuers must submit a justification for a premium increase judged to be unreasonable prior to its implementation. Instructs the Secretary to award grants to states during the five-year period FY2010 through FY2014 for carrying out the premium review. State grantees are required to provide the Secretary with information about trends in premium increases, including recommendations as to whether particular issuers should be excluded from participation in the exchange due to a pattern of excessive or unjustified premium increases.	Appropriates $250 million for the grant program. Funds remaining unobligated at the end of FY2014 shall remain available for grants to states for planning and implementing PPACA's individual and group market reforms. [Initial grant awards: http://www.hhs.gov/news/press/2010pres/08/20100816a.html]
1101	New authority	**High-risk pools for individuals with preexisting conditions.** Requires the Secretary, within 90 days of enactment, to establish a temporary high-risk pool program to provide health insurance coverage for eligible individuals who have been uninsured for six months and have a preexisting condition. The program, which terminates on January 1, 2014, permits premium rates to vary on the basis of age by a factor of up to 4:1 and places limits on out-of-pocket costs.	Appropriates $5 billion, to remain available without fiscal year limitation, to pay claims against (and administrative costs of) the high-risk pool that are in excess of premiums collected from enrollees. [Fact sheet with potential state-by-state allocations: http://www.hhs.gov/ociio/initiative/hi_risk_pool_facts.html]

PPACA Section	New/Existing Authority	Program Summary	Appropriation/Transfer
1102	New authority	**Reinsurance for early retirees.** Requires the Secretary, within 90 days of enactment, to establish a temporary reinsurance program to provide reimbursement to participating employer-based plans for part of the cost of providing health benefits to early retirees age 55-64 and their families. The program reimburses participating plans for 80% of the costs of benefits provided per enrollee in excess of $15,000 and below $90,000. Funds must be used to lower costs for the plan; for example, the funds could be used to reduce premium costs or lower out-of-pocket costs for beneficiaries.	Appropriates $5 billion, to remain available without fiscal year limitation, to carry out the reinsurance program. [Participating employers, state-by-state: http://www.hhs.gov/news/press/2010pres/10/20101004a.html]
1311	New authority	**Health insurance exchanges.** Requires the Secretary, within one year of enactment, to award grants to states to plan and establish exchanges. By January 1, 2014, each state must have an exchange to facilitate access to insurers' qualified health plans. The grants can be renewed to states making progress in establishing an exchange, implementing PPACA's private health insurance market reforms, and meeting other benchmarks. However, no grant may be awarded after January 1, 2015. Exchanges will have to be self-sustaining by then, using assessments on insurers or some other way to generate funds to support their operations.	Appropriates amounts necessary for the Secretary to award state grants. For each fiscal year, the Secretary must determine the total amount that will be made available to each state. [Initial grant awards: http://www.hhs.gov/news/press/2010pres/07/20100729a.html]
1322	New authority	**Health insurance cooperatives.** Requires the Secretary to establish the Consumer Operated and Oriented Plan (CO-OP) program to provide funding until July 1, 2013, for the creation of nonprofit member-run health insurance issuers that offer qualified health plans in the individual and small group markets. Funds are to be provided as loans for start-up costs and as grants for meeting solvency requirements. Loans must be repaid within 5 years; grants must be repaid within 15 years. Prohibits health insurance issuers that existed on July 16, 2009, or governmental organizations from participating in the CO-OP program.	Appropriates $6 billion to carry out the CO-OP program.
1323	New authority	**Funding for territories.** Provides funds for U.S. territories that elect to establish a health insurance exchange. Funds must be used to provide premium and cost-sharing assistance to territory residents who obtain health insurance coverage through the exchange.	Appropriates $1 billion, to be available during the period 2014 through 2019. Of that total amount, $925 million is for Puerto Rico, and the remaining $75 million is for the other U.S. territories in amounts as specified by the Secretary.

PPACA Section	New/Existing Authority	Program Summary	Appropriation/Transfer
Medicaid and Children's Health Insurance Program (CHIP)			
2701	New SSA Sec. 1139B	**Medicaid adult health quality measures.** Requires the Secretary to develop and, not later than January 1, 2012, publish an initial core set of quality measures for Medicaid-eligible adults. Not later than January 1, 2013, requires the Secretary to develop a standardized format for states to report information about the quality of Medicaid care for adults based on those measures. The Secretary and the states must report on the development of and improvements to the quality measurement program on a regular basis.	Appropriates $60 million for each of FY2010 through FY2014. (Total amount = $300 million.)
2707	New authority	**Medicaid emergency psychiatric demonstration program.** Directs the Secretary to establish a three-year Medicaid demonstration in which eligible states are required to reimburse certain institutions for mental disease (IMDs) for services provided to Medicaid beneficiaries aged 21 through 64 who are in need of medical assistance to stabilize an emergency psychiatric condition.	Appropriates $75 million for FY2011, to remain available for obligation through December 31, 2015.
2801	Amends SSA Sec. 1900	**Medicaid and CHIP Payment and Access Commission (MACPAC).** Clarifies and expands MACPAC's duties; for example, to include a review and assessment of payment policies under Medicaid and CHIP and how factors affecting expenditures and payment methodologies enable beneficiaries to obtain services, affect provider supply, and affect providers that serve a disproportionate share of low-income and other vulnerable populations. Additional duties include reviewing and assessing policies related to eligibility, enrollment and retention, benefits and coverage, quality of care, and interactions between Medicaid and Medicare and how those interactions affect access to services, payments, and dual eligibles. MACPAC is also required to report to Congress on any Medicaid and CHIP regulations that affect access, quality, and efficiency of health care.	Appropriates $9 million, and transfers from CHIP funding an additional $2 million for FY2010 for MACPAC activities. Funds are to remain available until expended. (Total amount = $11 million.)
4108	New authority	**Medicaid prevention and wellness incentives.** Requires the Secretary to award state grants to provide incentives for Medicaid beneficiaries to participate in evidence-based healthy lifestyle programs to prevent or help manage chronic disease.	Appropriates $100 million for the five-year period beginning January 1, 2011, to remain available until expended.
4306	Amends SSA Sec. 1139A(e)	**CHIP childhood obesity demonstration program.** Appropriates funding for a program authorized by the Children's Health Insurance Program Reauthorization Act (CHIPRA; P.L. 111-3), which requires the Secretary to conduct a demonstration project to develop a model for reducing childhood obesity.	Appropriates $25 million for the period FY2010 through FY2014.

PPACA Section	New/Existing Authority	Program Summary	Appropriation/Transfer
10203	Amends SSA Secs. 2104 & 2113	**CHIP annual appropriations, and outreach and enrollment grants.** Appropriates funding for the CHIP program for FY2014 and FY2015 (the program previously had been funded through FY2013). Also, extends the time period for CHIP outreach and enrollment grants through FY2015 and increases the existing appropriation for such grants from $100 million to $140 million.	Appropriates $19.147 billion for FY2014, and a total of $21.061 billion for FY2015 for the CHIP program. Appropriates an additional $40 million for the CHIP outreach and enrollment grants.
Medicare			
3014	Amends SSA Sec. 1890(b). New SSA Sec. 1890A	**Medicare quality measures.** Expands the duties of the consensus-based entity under contract with CMS pursuant to SSA Sec. 1890 (currently the National Quality Forum). Requires the entity to convene multi-stakeholder groups to provide input on the national priorities for health care quality improvement (developed under PPACA). In addition, the multi-stakeholder groups are required to provide input on the selection of quality measures for use in various specified Medicare payment systems for hospitals and other providers, as well as in other health care programs, and for use in reporting performance information to the public. Establishes a multi-step pre-rulemaking process and timeline for the adoption, dissemination, and review of measures by the Secretary.	Requires the Secretary to transfer from the Medicare Part A and Part B trust funds $20 million for each of FY2010 through FY2014, to remain available until expended.[a] (Total amount = $100 million.)
3021	New SSA Sec. 1115A	**Center for Medicare and Medicaid Innovation (CMI).** Requires the Secretary, no later than January 1, 2011, to establish the CMI within the Centers for Medicare and Medicaid Services (CMS). The purpose of CMI is to test and evaluate innovative payment and service delivery models to reduce program expenditures under Medicare, Medicaid, and CHIP while preserving or enhancing the quality of care furnished under these programs. In selecting the models, the Secretary is also required to give preference to those that improve the coordination, quality, and efficiency of health care services.	Appropriates (1) $5 million for FY2010 for the selection, testing, and evaluation of new payment and service delivery models; and (2) $10 billion for the period FY2011 through FY2019, plus $10 billion for each subsequent 10-fiscal year period, to continue such activities and for the expansion and nationwide implementation of successful models.[b] Amounts are to remain available until expended.
3024	New SSA Sec. 1866D	**Medicare independence at home demonstration program.** Requires the Secretary to conduct a three-year Medicare demonstration program, beginning no later than January 1, 2012, to test a payment incentive and service delivery model aimed at reducing expenditures and improving health outcomes that uses physician- and nurse practitioner-directed primary care teams to provide home-based services to chronically ill patients. The Secretary must submit a plan, no later than January 1, 2016, for expanding the program if it is determined that such expansion would improve the quality of care and reduce spending.	Requires the Secretary to transfer from the Medicare Part A and Part B trust funds $5 million for each of FY2010 through FY2015 for administering and carrying out the demonstration, to remain available until expended.[a] (Total amount = $30 million.)

PPACA Section	New/Existing Authority	Program Summary	Appropriation/Transfer
3026	New authority	**Community-based care transitions program.** Requires the Secretary to establish a five-year program, beginning January 1, 2011, to provide funding to eligible hospitals and community-based organizations that provide evidence-based transition services to Medicare beneficiaries with multiple chronic conditions who are at high risk for hospital readmission.	Requires the Secretary to transfer from the Medicare Part A and Part B trust funds $500 million for the period FY2011 through FY2015, to remain available until expended.[a]
3027	Amends DRA Sec. 5007	**Medicare gainsharing demonstration program.** Under DRA Sec. 5007, CMS is supporting two gainsharing projects to test and evaluate arrangements between hospitals and physicians that are intended to improve the quality and efficiency of care provided to beneficiaries. The demonstration allows hospitals to provide gainsharing payments to physicians that represent a share of the savings incurred as a result of collaborative efforts to improve overall quality and efficiency.	Appropriates $1.6 million for FY2010, to remain available through FY2014 or until expended, for carrying out the demonstration.
3306	Amends MIPPA Sec. 119	**Outreach and assistance for Medicare low-income programs.** Provides additional funding for beneficiary outreach and education activities for Medicare low-income programs through the following entities: (1) State Health Insurance Counseling and Assistance Programs (SHIPs); (2) Area Agencies on Aging (AAAs); (3) Aging and Disability Resource Centers (ADRCs); and (4) the National Center for Benefits and Outreach Enrollment (NCBOE).	Appropriates a total of $45 million for the period FY2010 through FY2012, to remain available until expended, as follows: (1) $15 million for SHIPs; (2) $15 million for AAAs; (3) $10 million for ADRCs; and (4) $5 million for the NCBOE. [Grant awards: http://www.hhs.gov/news/press/2010pres/09/20100927a.html]

PPACA Section	New/Existing Authority	Program Summary	Appropriation/Transfer
3403	New SSA Sec. 1899A	**Independent Payment Advisory Board.** Creates an independent, 15-member Payment Advisory Board tasked with presenting Congress with comprehensive proposals to reduce excess cost growth and improve quality of care for Medicare beneficiaries. In years when Medicare costs are projected to exceed a target growth rate, the board's proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings. Congress would be allowed to consider an alternative provision on a fast-track basis. The board would be prohibited from making proposals that ration care, raise taxes, or increase Part B premiums, or change Medicare benefit, eligibility, or cost-sharing standards. Requires the board to make biannual recommendations to the President, Congress, and private entities on actions they can take to improve quality and constrain the rate of cost growth in the private sector. Requires the board to make non-binding Medicare recommendations to Congress in years in which Medicare growth is below the targeted growth rate. Beginning in 2019, limits the board's binding recommendations to Congress to every other year if the growth in overall health spending exceeds growth in Medicare spending; such recommendations would focus on slowing overall health spending while maintaining or enhancing beneficiary access to quality care under Medicare.	Appropriates $15 million for FY2012 to support the board's activities. For each subsequent fiscal year, appropriates the amount from the previous fiscal year adjusted for inflation. Sixty percent of the appropriation is to be derived by transfer from the Medicare Part A trust fund, and 40% is to be derived by transfer from the Medicare Part B trust fund.
4202(b)	New authority	**Medicare prevention and wellness evaluation.** Requires the Secretary to conduct an evaluation of community-based prevention and wellness programs and, based on the findings, develop a plan to promote healthy lifestyles and chronic disease self-management among Medicare beneficiaries.	Requires the Secretary to transfer $50 million from the Medicare Part A and Part B trust funds to fund the evaluation.[a]
4204(e)	New authority	**Medicare vaccine coverage.** Requires the GAO to study and report to Congress on the impact of Medicare Part D vaccine coverage on access to those vaccines among beneficiaries.	Appropriates $1 million for FY2010 for the GAO study.
10323	New SSA Secs. 1881A & 2009	**Environmental health hazards.** Provides Medicare coverage and medical screening services to certain individuals exposed to environmental health hazards. Also, requires the Secretary to award grants to state and local government agencies, health care facilities, and other entities to (1) provide screening for specified lung diseases and other environmental health conditions to at-risk individuals; and (2) disseminate public information about the availability of screening, the detection and treatment of environmental health conditions, and the availability of Medicare benefits to certain individuals diagnosed with such conditions.	Appropriates $23 million for the period FY2010 through FY2014, and $20 million for each five-fiscal year period thereafter, to carry out the screening and public information dissemination program.

PPACA Section	New/Existing Authority	Program Summary	Appropriation/Transfer
Fraud and Abuse			
6402(i)	Amends SSA Sec. 1817(k)	**Health Care Fraud and Abuse Control (HCFAC) Account.** Permanently applies an inflation adjustment to the annual appropriation (provided under SSA Sec. 1817(k)) for the HCFAC Account, which finances investigative and enforcement activities undertaken by the HHS Office of the Inspector General, the Department of Justice, and the Federal Bureau of Investigation, as well as Medicare Integrity Program activities undertaken by CMS contractors. In addition, provides supplemental funds through FY2020 for the HCFAC Account.	Appropriates $10 million for each of FY2011 through FY2020; plus an additional $95 million for FY2011, $55 million for FY2012, $30 million for each of FY2013 and FY2014, and $20 million for each of FY2015 and FY2016. Funds are to remain available until expended. (Total amount = $350 million.)
Health Centers and the National Health Service Corps (NHSC)			
4101(a)	New authority	**School-based health centers.** Requires the Secretary to create a grant program for the establishment of school-based health centers. Funds may be used for facility construction, expansion, and equipment.	Appropriates $50 million for each of FY2010 through FY2013, to remain available until expended. (Total amount = $200 million.) [FY2010/FY2011 grant opportunity announcement: http://www.hrsa.gov/about/news/pressreleases/101004schoolbasedhealthcenters.html]
10503(b)	New authority	**Community Health Center Fund (CHCF).** Establishes a CHCF and appropriates a total of $11 billion over the five-year period FY2011 through FY2015 to the fund, to be transferred by the Secretary to HHS accounts to increase funding, over the FY2008 level, for (1) community health center operations; and (2) NHSC operations, scholarships, and loan repayments.	Transfers from the CHCF to the Secretary the following amounts, to remain available until expended. (1) For health center operations: FY2011 = $1 billion; FY2012 = $1.2 billion; FY2013 = $1.5 billion; FY2014 = $2.2 billion; and FY2015 = $3.6 billion. (Total amount = $9.5 billion.) (2) For NHSC: FY2011 = $290 million; FY2012 = $295 million; FY2013 = $300 million; FY2014 = $305 million; and FY2015 = $310 million. (Total amount = $1.5 billion.) [FY2011 grant opportunity announcements: (1) http://www.hhs.gov/news/press/2010pres/08/20100809a.html; (2) http://www.hhs.gov/news/press/2010pres/10/20101026a.html]
10503(c)	New authority	**Health center construction and renovation.** Provides funding for health center construction and renovation.	Appropriates $1.5 billion, to be available for the period FY2011 through FY2015, and to remain available until expended. [Initial grant awards: http://www.hhs.gov/news/press/2010pres/10/20101008c.html]

PPACA Section	New/Existing Authority	Program Summary	Appropriation/Transfer
Health Workforce			
5507(a)	New SSA Sec. 2008	**Health workforce demonstration programs.** Requires the Secretary to establish two demonstration projects. The first is to award health profession opportunity grants to states, Indian tribes, institutions of higher education, and local workforce investment boards to help low-income individuals obtain education and training in health care jobs that pay well and are in high demand; funds may be used to provide financial aid and other supportive services. The second is to provide states with grants to develop core training competencies and certification programs for personal and home care aides.	Appropriates $85 million for each of FY2010 through FY2014, of which $5 million in each of FY2010 through FY2012 is to be used for the second project. (Total amount = $425 million.) [FY2010 grant awards: http://www.hhs.gov/news/press/2010pres/09/20100927e.html]
5507(b)	Amends SSA Sec. 501(c)	**Family-to-family health information centers.** Provides funding for the family-to-family information centers, which assist families of children with disabilities or special health care needs and the professionals who serve them.	Appropriates $5 million for each of FY2010 through FY2012, to remain available until expended. (Total amount = $15 million.) [FY2011 grant opportunity announcement: http://www.hhs.gov/news/press/2010pres/10/20101026f.html]
5508(c)	New PHSA Sec. 340H	**Teaching health centers.** Requires the Secretary to make payments for direct and indirect graduate medical education costs to qualified teaching health centers for the expansion of existing, or establishment of new approved medical residency training programs.	Appropriates SSAN, not to exceed $230 million, for the period FY2011 through FY2015.
5509	New authority	**Medicare graduate nurse education demonstration program.** Requires the Secretary to establish a Medicare demonstration program under which up to five eligible hospitals will receive reimbursement for providing advanced practice nurses with clinical training in primary care, preventive care, transitional care, and chronic care management.	Appropriates $50 million for each of FY2012 through FY2015, to remain available until expended. (Total amount = $200 million.)
10502	New authority	**Health care facility construction.** Provides funding for debt service on, or construction or renovation of, a hospital affiliated with a state's sole public medical and dental school.	Appropriates $100 million for FY2010, to remain available for obligation until September 30, 2011.

PPACA Section	New/Existing Authority	Program Summary	Appropriation/Transfer
Community-Based Prevention and Wellness			
4002	New authority	**Prevention and Public Health Fund (PPHF).** Establishes a PPHF and appropriates amounts to the fund in perpetuity. Requires the Secretary to transfer amounts from the fund to HHS accounts to increase funding, over the FY2008 level, for PHSA-authorized prevention, wellness, and public health activities, including prevention research and health screenings. Authorizes House and Senate appropriators to transfer monies from the PPHF to eligible activities.	Appropriates the following amounts to the PPHF: FY2010 = $500 million; FY2011 = $750 million; FY2012 = $1 billion; FY2013 = $1.25 billion; FY2014 = $1.5 billion; FY2015 and each fiscal year thereafter = $2 billion. [Grant opportunity announcements and awards for the FY2010 funds: (1) http://www.hhs.gov/news/press/2010pres/09/20100927e.html (primary care workforce grant awards: $253 million total); (2) http://www.hhs.gov/news/press/2010pres/06/20100618g.html (grant opportunity announcements for community/clinical prevention initiatives, and public health infrastructure, systems, research, & training: approx. $250 million total)[c]]
Maternal and Child Health			
2951	New SSA Sec. 511	**Maternal, infant, and early childhood home visitation programs.** Requires the Secretary to award grants to states, U.S. territories, and Indian tribes to develop and implement early childhood home visiting programs that adhere to evidence-based models of service delivery. Programs must establish benchmarks to measure improvements for the participating families in prenatal, maternal, and newborn health; child health and development; parenting skills; school readiness; juvenile delinquency; and family economic self-sufficiency.	Appropriates the following amounts for the home visitation program: FY2010 = $100 million; FY2011 = $250 million, FY2012 = $350 million; FY2013 = $400 million; FY2014 = $400 million. (Total amount = $1.5 billion.) [FY2010 grant awards: (1) http://www.hhs.gov/news/press/2010pres/07/20100721a.html (states, territories); (2) http://www.acf.hhs.gov/news/press/2010/hrsa_award_3m.html (Indian tribes, tribal organizations)]
2953	New SSA Sec. 513	**Personal responsibility education programs.** Establishes a state formula grant program to support evidence-based Personal Responsibility Education Programs designed to educate adolescents about abstinence, contraception, and adult preparation, including healthy life skills, educational and career success, and financial literacy. Also, requires the Secretary to award grants to implement innovative youth pregnancy prevention strategies and to target services at high-risk populations.	Appropriates $75 million for each of FY2010 through FY2014, of which $10 million each year is to be reserved for the youth pregnancy prevention grants. (Total amount = $375 million.) [FY2010 grant awards: http://www.hhs.gov/news/press/2010pres/09/20100930a.html]
2954	Amends SSA Sec. 510	**Abstinence education grants.** Renews funding for the state formula grant program, authorized under SSA Sec. 510, to support abstinence education programs. Funds are awarded to states based on the proportion of low-income children in each state compared to the national total, and may only be used for teaching abstinence.	Appropriates $50 million for each of FY2010 through FY2014. (Total amount = $250 million.) [FY2010 grant awards: http://www.hhs.gov/news/press/2010pres/09/teenpregnancy_abstinencegrants.html]

PPACA Section	New/Existing Authority	Program Summary	Appropriation/Transfer
10211-10214	New authority	**Pregnancy assistance grants.** In collaboration with the Secretary of Education, requires the Secretary to establish a Pregnancy Assistance Fund for the purpose of awarding grants to states to assist pregnant and parenting teens and women. State grantees have the flexibility to make funds available to institutions of higher education, high schools and community service centers, and to the state attorneys general to improve services for pregnant women who are victims of domestic violence, sexual assault, or stalking.	Appropriates $25 million for each of FY2010 through FY2019. (Total amount = $250 million.) [FY2010 grant awards: http://www.hhs.gov/news/press/2010pres/09/20100928d.html]
Long-Term Care			
2403	Amends DRA Sec. 6071	**Medicaid Money Follows the Person (MFP) demonstration program.** Appropriates funding through FY2016 for the MFP demonstration, which authorizes the Secretary to award competitive grants to states to reduce their reliance on institutional care for people needing long-term care, and expand options for elderly people and individuals with disabilities to receive home and community-based long-term care services.	Appropriates $450 million for each of FY2011 through FY2016, to remain available through FY2016. (Total amount = $2.7 billion.) [FY2010 grant awards: http://www.hhs.gov/news/press/2010pres/09/20100927a.html]
2405	New authority	**State Aging and Disability Resource Centers (ADRCs).** Provides funding for ADRCs (authorized under Sec. 202 of the OAA), which serve as a single, coordinated resource for consumer information on the range of long-term care options in community and institutional settings. Some ADRCs also serve as the entry point to publicly administered long-term care programs (e.g., Medicaid, OAA services, state assistance programs). As of 2009, ADRC funding had expanded to include at least one site in each state, DC, and 3 U.S. territories (Guam, Puerto Rico, and Northern Mariana), with more than 200 sites nationwide.	Appropriates $10 million for each of FY2010 through FY2014. (Total amount = $50 million.) [FY2010 grant awards: http://www.hhs.gov/news/press/2010pres/09/20100927a.html]
6201	New authority	**Background checks of long-term care providers.** Requires the Secretary to establish a nationwide program for background checks on direct patient access employees of long-term care facilities or providers, and to provide federal matching funds to states to conduct these activities.	Requires the Treasury Secretary to transfer to HHS an amount, not to exceed $160 million, that is specified by the HHS Secretary as necessary to carry out the program for the period FY2010 through FY2012. Funds are to remain available until expended. [Initial grant awards: http://aging.senate.gov/record.cfm?id=328161]

PPACA Section	New/Existing Authority	Program Summary	Appropriation/Transfer
Comparative Effectiveness Research			
6301(d)-(e)	New IRC Secs. 9511, 4375, & 4376. New SSA Sec. 1183	**Patient-Centered Outcomes Research Trust Fund (PCORTF).** Establishes a PCORTF to fund the new Patient-Centered Outcomes Research Institute and its comparative effectiveness research activities. The fund is to receive the following amounts: (1) specified annual appropriations for each of FY2010 through FY2019 (see amounts in the right-hand column); (2) additional annual appropriations for each of FY2013 through FY2019 equal to the net revenue from a new fee levied on health insurance policies and self-insured plans;[d] and (3) transfers from the Medicare trust funds for each of FY2013 through FY2019.[e]	Appropriates $10 million for FY2010, $50 million for FY2011, and $150 million for each of FY2012 through FY2019, for a total of $1.26 billion over that 10-year period. For each of FY2013 through FY2019, the PCORTF is to receive additional appropriations based on the revenue from the health insurance policy/plan fee, as well as Medicare trust fund transfers.
Biomedical Research			
9023(e)	New IRC Sec. 48D	**Therapeutic research and development tax credits and grants.** Creates a two-year temporary tax credit program, subject to an overall cap of $1 billion, for small companies (250 or fewer employees) that invest in new therapies to prevent, diagnose, and treat cancer and other diseases. Companies may apply for one or more tax credits, each covering up to 50% of the cost of qualifying research investments made in 2009 and 2010. However, the total amount of tax credits any one company receives for the two years may not exceed $5 million. Companies may elect to receive one or more grants in lieu of tax credits, subject to the same restrictions (i.e., grants may cover up to 50% of the cost of qualifying investments made in 2009 and 2010; the total amount of grants any one company receives for the two years may not exceed $5 million).	Appropriates SSAN to carry out the grant program.
PPACA Implementation			
HCERA Sec. 1005	New authority	**Health Insurance Reform Implementation Fund (HIRIF).** Establishes an HIRIF for federal administrative expenses to carry out PPACA and HCERA.	Appropriates $1 billion to the HIRIF.

Source: Table prepared by the Congressional Research Service based on the text of the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA; P.L. 111-152).

a. Transfers from the two trust funds are in such proportion as the Secretary determines appropriate.

b. Of the amounts appropriated for the period FY2011 through FY2019 and for each subsequent 10-fiscal year period, at least $25 million must be made available each fiscal year for the selection, testing, and evaluation of new payment and service delivery models.

c. Of the approx. $250 million for community/clinical prevention initiatives and public health infrastructure, systems, research, & training, HHS has announced grant awards totaling $42.5 million to state, tribal, local and territorial health departments to improve their ability to provide public health services (http://www.hhs.gov/news/press/2010pres/09/20100920a.html).

d. The health insurance fee is to equal $2 multiplied by the average number of covered lives in a policy/plan year ($1 in the case of a policy/plan year ending during FY2013), updated annually by the rate of medical inflation.

e. The trust fund transfers are to equal $2 multiplied by the average number of individuals entitled to benefits under Part A or enrolled under Part B in a given fiscal year ($1 in FY2013), updated annually by the rate of medical inflation.

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Acknowledgments

Kirsten Colello, Patricia Davis, Gary Guenther, Elayne Heisler, Lisa Herz, Sarah Lister, Amanda Sarata, Pam Smith, Carmen Solomon-Fears, Emilie Stoltzfus, Julie Stone, and Susan Thaul provided comments on this report.

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Congressional Research Service

Discretionary Funding in the Patient Protection and Affordable Care Act (PPACA)

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December 21, 2010

Congressional Research Service
7-5700
www.crs.gov
R41390

CRS Report for Congress
Prepared for Members and Committees of Congress

c11173006

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Summary

The Patient Protection and Affordable Care Act (PPACA; P.L. 111-148), as amended by the Health Care and Education Reconciliation Act (HCERA; P.L. 111-152), authorizes new funding for numerous existing discretionary grant and other programs and activities. PPACA, as amended, also creates a number of new discretionary grant programs and activities and provides for each an authorization of appropriations. Funding for all of these programs and activities is subject to action by congressional appropriators. This report summarizes all the discretionary provisions in PPACA for which appropriations are authorized. A companion product, CRS Report R41301, *Appropriations and Fund Transfers in the Patient Protection and Affordable Care Act (PPACA)*, summarizes all the mandated appropriations and Medicare trust fund transfers in the new law.

Among the provisions that are intended to strengthen the nation's health care safety net and improve access to care, PPACA permanently reauthorizes the federal health centers program and the National Health Service Corps (NHSC). The NHSC provides scholarships and student loan repayments to individuals who agree to a period of service as a primary care provider in a federally designated Health Professional Shortage Area. In addition, the new law seeks to address concerns about the current size, specialty mix, and geographic distribution of the health care workforce. It reauthorizes and expands existing health workforce education and training programs under Titles VII and VIII of the Public Health Service Act (PHSA). Title VII supports the education and training of physicians, dentists, physician assistants, and public health workers through grants, scholarships, and loan repayment. PPACA creates several new programs to increase training experiences in primary care, in rural areas, and in community-based settings, and provides training opportunities to increase the supply of pediatric subspecialists and geriatricians. It also expands the nursing workforce development programs authorized under PHSA Title VIII to bolster undergraduate and graduate nursing education and training.

As part of a comprehensive framework for federal community-based (i.e., public health) prevention activities, including a national strategy and a national education and outreach campaign, PPACA authorizes several new grant programs with a focus on preventable or modifiable risk factors for disease (e.g., sedentary lifestyle, tobacco use). The new law also leverages a number of mechanisms to improve the quality of health care, including new requirements for quality measure development, collection, analysis, and public reporting; programs to develop and disseminate innovative strategies for improving the quality of health care delivery; and support for care coordination programs such as medical homes, patient navigators, and the co-location of primary health care and mental health services.

Additionally, PPACA authorizes funding for programs to prevent elder abuse, neglect, and exploitation; grants to expand trauma care services and improve regional coordination of emergency services; and demonstration projects to implement alternatives to current tort litigation for resolving medical malpractice claims, among other provisions.

The new law also reauthorizes the Indian Health Care Improvement Act (IHCIA), which sets out the national policy for Indian health care and authorizes programs and services provided by the Indian Health Service. For more information on PPACA' s Indian health provisions, which are not discussed in this report, see CRS Report R41152, *Indian Health Care Improvement Act Provisions in the Patient Protection and Affordable Care Act (PPACA)*.

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Introduction

On March 23, 2010, President Obama signed into law a comprehensive health care bill, the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148). The following week, on March 30, 2010, the President signed the Health Care and Education Reconciliation Act of 2010 (HCERA; P.L. 111-152), which amended various health care and revenue provisions in PPACA.[1] Among its many provisions, PPACA, as amended, creates a mandate for most U.S. residents to obtain health insurance and provides for the establishment of insurance exchanges through which certain individuals and families will be able to receive federal subsidies to reduce the cost of purchasing that coverage. The new law also expands eligibility for Medicaid; amends the Medicare program in ways that are intended to reduce the growth in Medicare spending that had been projected under preexisting law; and imposes an excise tax on insurance plans determined to have high premiums.

Discretionary Funding

In addition, PPACA amends and authorizes new funding for numerous *existing* discretionary grant and other programs and activities, primarily ones authorized under the Public Health Service Act (PHSA). While the authorization of appropriations for most of these programs expired prior to PPACA's enactment, many of them continued to receive an annual appropriation. PPACA also authorizes a number of *new* discretionary programs and activities and provides for each an authorization of appropriations. Funding for all of these discretionary programs and activities is subject to action by congressional appropriators. However, it is often the case that new programs and activities face more of a challenge in securing funding than do existing ones with an established appropriations history.

This report summarizes all the discretionary provisions in PPACA for which appropriations are authorized. The provisions are grouped by general topic in a series of tables. Each table entry includes the following information: (1) the PPACA section number; (2) an indication of whether the provision modifies the PHSA or another law either by amending an existing section or subsection or by adding a new one, or whether it creates new stand-alone statutory authority, as well as the name (if known) of the administering agency or office; (3) a brief description of the program or activity, including the FY2010 appropriation amount for existing programs and activities that received such funding;[2] (4) where applicable, the types of entities and/or individuals eligible for funding;[3] and (5) details of the authorization of appropriations. Some authorizations of appropriations specify funding levels for one or more fiscal years, while others authorize the appropriation of "such sums as may be necessary" (SSAN) to carry out the program or activity. In some instances, the authorization of SSAN does not specify any fiscal years. Unless otherwise stated, references in the tables to the Secretary refer to the Secretary of Health and Human Services (HHS).

[1] A consolidated version of PPACA, incorporating the changes made by the health-related provisions in HCERA, is available at http://docs.house.gov/energycommerce/ppacacon.pdf.

[2] The FY2010 appropriation amounts that appear in the tables in this report are taken from the HHS agency FY2011 budget justification documents, available at http://dhhs.gov/asfr/ob/docbudget/, and H.Rept. 111-366, conference report to accompany H.R. 3288, Consolidated Appropriations Act, 2010, available at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_reports&docid=f:hr366.111.pdf.

[3] Not applicable if the funding is to support programs and activities carried out by a federal agency.

The following laws and HHS agencies and offices are referred to in the tables by their acronym:

- Agency for Healthcare Research and Quality (AHRQ)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare and Medicaid Services (CMS)
- Food and Drug Administration (FDA)
- Federal Food, Drug, and Cosmetic Act (FFDCA)
- Health Resources and Services Administration (HRSA)
- Indian Health Service (IHS)
- National Institutes of Health (NIH)
- Office of Personnel Management (OPM)
- Office of the Secretary (OS)
- Public Health Service Act (PHSA)
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- Social Security Act (SSA)

Mandated Appropriations and Fund Transfers

Separate from the discretionary funding authorities discussed in this report, PPACA includes a number of provisions that mandate appropriations or require the Secretary to transfer amounts from the Medicare Part A and Part B trust funds to support new or existing grant programs and other activities. Those provisions are summarized in a companion product, CRS Report R41301, *Appropriations and Fund Transfers in the Patient Protection and Affordable Care Act (PPACA)*.

CRS Products and Resources

More information on the PPACA provisions summarized in the tables in this report may be found in the following CRS products:

- CRS Report R40942, *Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (PPACA)*.
- CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in PPACA: Summary and Timeline*.
- CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*.
- CRS Report R41278, *Public Health, Workforce, Quality, and Related Provisions in PPACA: Summary and Timeline*.

A list of CRS experts on the topics covered in each of the tables, including contact information, appears at the end of the report.

PPACA reauthorizes the Indian Health Care Improvement Act (IHCIA), which sets out the national policy for Indian health care and authorizes programs and services provided by the Indian Health Service. It also extends indefinitely the authorization of appropriations for IHCIA programs. For more information on PPACA' s Indian health provisions, which are not discussed in this report, see CRS Report R41152, *Indian Health Care Improvement Act Provisions in the Patient Protection and Affordable Care Act (PPACA)*.

Table 1. PPACA Discretionary Funding: Health Centers and Clinics

Subject to Appropriations

PPACA Section	New/Existing Authority (Agency)	Description/Purpose	Eligibility	Authorization of Appropriations
5601	Permanently reauthorizes PHSA Sec. 330 (HRSA)	**Health centers program.** Provides grants to health centers serving federally designated medically underserved populations and furnishing comprehensive primary care services, referrals, and other services needed to facilitate access to such care, regardless of ability to pay. ***FY2010 appropriation = $2.19 billion.***	Community, migrant, public housing, and homeless health centers that meet the statutory requirements of PHSA Sec. 330.	$3.0 billion for FY2010, $3.9 billion for FY2011, $5.0 billion for FY2012, $6.5 billion for FY2013, $7.3 billion for FY2014, and $8.3 billion for FY2015; amounts in subsequent years based on previous year's funding, subject to adjustment.
4101(b)	New PHSA Sec. 399Z-1 (HRSA)	**School-based health centers (SBHCs).** Requires the Secretary to award grants to fund the management and operation of SBHCs that provide comprehensive physical and behavioral health services to children and adolescents, subject to parental consent.	SBHCs that meet certain specified criteria and match 20% of the grant amount with non-federal funds (unless waived). Preference may be given to SBHCs serving children and adolescents who have limited access to or difficulty accessing health care.	SSAN for each of FY2010 through FY2014.
5208	New PHSA Sec. 330A-1 (HRSA)	**Nurse-managed health clinics (NMHCs).** Requires the Secretary to award grants to fund the operation of NMHCs—associated with schools, colleges, federally qualified health centers (FQHCs), or nonprofit health/social services agencies—that provide comprehensive primary health care and wellness services to vulnerable or underserved populations.	NMHCs that provide care regardless of income or insurance status and in which nurses provide the majority of the services. At least one advanced practice nurse must hold an executive management position in the NMHC.	$50 million for FY2010, and SSAN for each of FY2011 through FY2014.
10504	New authority (HRSA)	**Access to affordable care demonstration program.** Within six months of enactment (i.e., Sept. 23, 2010), requires the Secretary to establish a three-year demonstration project in up to 10 states—each state may receive up to $2 million—to provide access to comprehensive health care services to the uninsured.	State-based, nonprofit, public-private partnerships that provide access to comprehensive health care services to the uninsured at reduced fees.	SSAN (no years specified).

Source: Table prepared by the Congressional Research Service based on the text of the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA; P.L. 111-152).

Table 2. PPACA Discretionary Funding: Health Care Workforce

Subject to Appropriations

PPACA Section	New/Existing Authority (Agency)	Description/Purpose	Eligibility	Authorization of Appropriations
National Health Service Corps (NHSC)				
5207	Permanently reauthorizes PHSA Title III, Part D, Subpart III (HRSA)	**NHSC scholarships and loan repayments.** In exchange for a commitment to work in a federally designated Health Professional Shortage Area (HPSA), provides (1) scholarships to students training in a primary care discipline to cover tuition, fees, other educational costs, and a stipend; and (2) student loan repayments of up to $50,000 a year to primary care and mental health clinicians. ***FY2010 appropriation = $142 million.***	(1) Scholarships: students accepted to or enrolled in a training program for medicine, dentistry, family nurse practitioner, nurse midwife, or physician assistant who agree to two to four years of service in an NHSC-approved site in a HPSA. (2) Loan repayments: primary care, dental, and mental health clinicians who agree to at least two years of service in an NHSC-approved site in a HPSA.	$320 million for FY2010, $414 million for FY2011, $535 million for FY2012, $691 million for FY2013, $893 million for FY2014, and $1.155 billion for FY2015; amounts in subsequent years based on previous year's funding, subject to adjustment.
Physicians				
5301	Amends and reauthorizes PHSA Sec. 747 (HRSA)	**Primary care training programs.** (1) Authorizes five-year grants to support training programs in primary care. Funds are to be used to plan, develop and operate accredited training programs, including residency and internship programs, in family medicine, general internal medicine, and general pediatrics and to provide financial assistance (e.g., traineeships). (2) Authorizes five-year grants for primary care capacity building. Funds are to be used to create academic units or programs that improve clinical teaching in the primary care fields, and (in a separate authorization) to integrate academic units to enhance interdisciplinary recruitment, training, and faculty development. ***FY2010 appropriation = $39 million.***	(1) Training grants: public and nonprofit private hospitals, medical schools, academically affiliated physician assistant training programs, and other public and nonprofit private entities. (2) Capacity building grants: medical schools; priority given to entities proposing innovative approaches to primary care training and with a record of training primary care providers, among other things.	For both grant programs, $125 million for FY2010, and SSAN for each of FY2011 through FY2014. A separate authorization of $750,000 for each of FY2010 through FY2014 is provided for capacity building grants to integrate academic units.
5203	New PHSA Sec. 775 (HRSA)	**Pediatric specialist loan repayment program.** Requires the Secretary to implement a loan repayment program that pays up to $35,000 for each year of service (for a maximum of three years) to eligible individuals in exchange for a commitment to work in a pediatric medical specialty, in pediatric surgery, or in child and adolescent mental and behavioral health care in a medically underserved area.	Practicing or in-training pediatric specialists and surgeons, and child and adolescent mental health specialists, who agree to at least 2 years of full-time service in a HPSA.	$30 million for each of FY2010 through FY2014 for loan repayments to pediatric specialists and surgeons; $20 million for each of FY2010 through FY2013 for loan repayments to mental health professionals.

PPACA Section	New/Existing Authority (Agency)	Description/Purpose	Eligibility	Authorization of Appropriations
5508(a)	New PHSA Sec. 749A (HRSA)	**Teaching health centers development grants.** Authorizes three-year grants of up to $500,000 to community-based, ambulatory care centers that establish or expand a primary care residency training program.	FQHCs, rural health clinics, Indian health centers, and entities receiving PHSA Title X (family planning) funds.	$25 million for FY2010, $50 million for each of FY2011 and FY2012, and SSAN for each fiscal year thereafter.
10501(l)	New PHSA Sec. 749B (HRSA)	**Rural physician training grants.** Requires the Secretary to (1) award grants for recruiting medical students most likely to practice in underserved rural communities and for providing rural-focused training and experience; and (2) within 60 days of enactment (i.e., May 20, 2010), by regulation, define underserved rural communities.	Medical schools; priority given to entities that train students to practice in rural communities, that have established partnerships with rural community health centers, or who submit a long-term plan for tracking where graduates practice.	$4 million for each of FY2010 through FY2013.
Dentistry				
5303	New PHSA Sec. 748 (HRSA)	**General, pediatric, and public health dentistry training.** Authorizes grants or contracts for dental training activities including faculty development, financial assistance, faculty loan repayment programs, technical assistance for pediatric dental programs, and pre- and post-doctoral training programs in dental primary care. Gives priority to entities that train individuals from disadvantaged backgrounds, who have a record of placing graduates in facilities that provide care to the underserved, or whose programs focus on providing care to the underserved through demonstrated partnerships with FQHCs, rural health clinics, or through having programs focused on specific topics, such as HIV/AIDs. ***FY2010 appropriation = $15 million.***	Dental or dental hygiene schools; approved residency or advanced education programs in general, pediatric, or public health dentistry. Eligible entities may partner with schools of public health so that dental residents and dental hygiene students may receive masters-level training in public health.	$30 million for FY2010, and SSAN for each of FY2011 through FY2015; permits grantees to carry over funds for up to three fiscal years.
5304	New PHSA Sec. 340G-1 (HRSA)	**Alternative dental health care provider demonstration program.** Authorizes the Secretary to award 15 five-year grants of not less than $4 million to train or employ alternative dental health care providers (e.g., community dental health coordinators, dental health aides) to increase access to dental health care services in rural and other underserved communities.	Institutions of higher education; public-private entities; FQHCs; facilities operated by the Indian Health Service (IHS) or by Indian tribes or organizations; state or county public health clinics; public hospitals or health systems; or accredited dental education programs.	SSAN (no years specified).

PPACA Section	New/Existing Authority (Agency)	Description/Purpose	Eligibility	Authorization of Appropriations
Nursing				
5309(a)	Amends and reauthorizes PHSA Sec. 831 (HRSA)	**Nurse education, practice, and quality grants.** Authorizes grants or contracts for activities related to expanding the nursing workforce such as programs to retain nurses, programs to train new nurses, and programs to enhance the patient care provided by nurses.	Schools of nursing, health care facilities, or partnerships of the two.	SSAN for each of FY2010 through FY2014. See also PPACA Sec. 5312 below.
5309(b)	New PHSA Sec. 831A (HRSA)	**Nurse retention grants.** Authorizes funding for nurse retention and promotion ("career ladder") programs, and for the enhancement of patient care that is directly related to nursing activities. Preference given to new grantees, and to entities that address other high-priority areas as determined by the Secretary.	Schools of nursing, health care facilities, or partnerships of the two.	SSAN for each of FY2010 through FY2012. See also PPACA Sec. 5312 below.
5311(a)	Amends and reauthorizes PHSA Sec. 846A (HRSA)	**Nursing faculty loan program.** Authorizes loans to nursing school students pursuing advanced degrees to become qualified nursing faculty. Sets the annual loan limit at $35,500 for FY2010 and FY2011; for subsequent fiscal years, the loan limit is subject to a cost-of-attendance adjustment. Students who go on to serve as nursing school faculty may have up to 85% of their loan repayment cancelled. ***FY2010 appropriation = $25 million.***	Accredited schools of nursing may operate the student loan programs.	SSAN for each of FY2010 through FY2014.
5311(b)	New PHSA Sec. 847 (HRSA)	**Nursing faculty loan repayment program.** Authorizes a loan repayment program for qualified nursing students or graduates who agree to serve as nursing faculty for four to six years. Sets the annual loan limit for FY2010 and FY2011 at $10,000 for individuals with a master's or equivalent degree in nursing ($20,000 for those with a doctorate or equivalent degree in nursing), and an aggregate loan limit of $40,000 for individuals with a master's or equivalent degree in nursing ($80,000 for those with a doctorate or equivalent degree in nursing). Thereafter, the annual and aggregate loan limits are subject to a cost-of-attendance adjustment.	U.S. citizens, nationals, or lawful permanent residents who are registered nurses and have either already completed a master's or doctorate nursing program at an accredited school of nursing or are currently enrolled on a full-time or part-time basis in such a program.	SSAN for each of FY2010 through FY2014.

PPACA Section	New/Existing Authority (Agency)	Description/Purpose	Eligibility	Authorization of Appropriations
5312	Amends and reauthorizes PHSA Sec. 871; previously Sec. 841 (HRSA)	**Authorization of appropriations.** Authorizes funding for the following PHSA Title VIII programs: Sec. 811 (grants for the support of advanced education nurses, i.e., nurse practitioners); Sec. 821 (grants for nursing workforce diversity); Sec. 831 (nurse education, practice, and quality grants); and new Sec. 831A (nurse retention grants). ***Total FY2010 appropriation = $120 million (Sec. 811 = $64 million, Sec. 821 = $16 million, and Sec. 831 = $40 million).***	(1) Sec. 811: accredited programs for advanced nurse education including combined registered nurse masters degree programs, authorized nurse practitioner programs, accredited nurse midwifery programs, accredited nurse anesthesia programs, and other programs approved by the Secretary. (2) Sec. 821: schools of nursing, nursing centers, academic health centers, state or local governments, and other appropriate public or private nonprofit entities as determined appropriate by the Secretary. (3) Secs. 831 and 831A: schools of nursing, health care facilities, or partnerships of the two.	$338 million for FY2010, and SSAN for each of FY2011 through FY2016.
5316	New authority	**Family nurse practitioner demonstration program.** Requires the Secretary to award three-year demonstration grants, not to exceed $600,000 a year, for programs to train nurse practitioners as primary care providers in FQHCs and NMHCs (as defined in PPACA Sec. 5208). Preference given to bilingual individuals.	FQHCs, NMHCs.	SSAN for each of FY2011 through FY2014.
Geriatrics and Long-Term Care (LTC)				
5302	New PHSA Sec. 747A (HRSA)	**Direct care worker training.** Requires the Secretary to establish a grant program to provide new training opportunities, such as tuition and fee assistance, for direct care workers employed in LTC settings. Individuals who receive assistance are required to work in the field of geriatrics, disability services, LTC services and supports, or chronic care management for a minimum of two years.	Accredited institutions of higher education that have established a partnership with a long-term care setting (e.g., nursing home, home and community based service provider), as specified.	$10 million for the period FY2011 through FY2013.

PPACA Section	New/Existing Authority (Agency)	Description/Purpose	Eligibility	Authorization of Appropriations
5305(a)	Amends PHSA Sec. 753 by adding new subsections (d) & (e) (HRSA)	**Geriatric workforce development; geriatric career incentive awards.** (1) Requires the Secretary to award no more than 24 grants or contracts for $150,000 to eligible entities that operate geriatric education centers to support short-term intensive courses on geriatrics and LTC, and support training for family caregivers and direct care workers. (2) Requires the Secretary to award grants or contracts to eligible individuals pursuing an advanced degree in geriatrics or a related field, in return for agreeing to teach or practice in the field of geriatrics, LTC, or chronic care management for a minimum of five years upon completion of the degree.	(1) Accredited schools of allied health, medicine, nursing, dentistry, osteopathic medicine, optometry, podiatric medicine, veterinary medicine, public health, or chiropractic care; accredited graduate programs in clinical psychology, clinical social work, health administration, marriage and family therapy, and counseling; and physician assistant programs. (2) Advanced practice nurse, clinical social worker, pharmacist, or psychology student.	(1) $10.8 million for the period FY2011 through FY2014. (2) $10 million for the period FY2011 through FY2013.
5305(c)	Amends and reauthorizes PHSA Sec. 865; previously Sec. 855 (HRSA)	**Geriatric nursing education and training.** Provides traineeships for individuals preparing for advanced degrees in geriatric nursing or other nursing areas that specialize in elder care. ***FY2010 appropriation = $5 million.***	A school of nursing, a health care facility, a program leading to certification as a certified nurse assistant, or a partnership of a health care facility and one of the other two entities.	SSAN for each of FY2010 through FY2014.
Pain Care				
4305(c)	New PHSA Sec. 759 (HRSA)	**Education and training in pain care.** Authorizes a grant program to train health professionals in pain care. [See also **Table 14.**]	Health professions schools, hospices, and other public and private entities. Applicants must agree to include training and education on recognizing the signs and symptoms of pain; applicable laws and policies on controlled substances; interdisciplinary approaches to pain care delivery; barriers to care in underserved populations; and recent developments in pain care.	SSAN for each of FY2010 through FY2012, to remain available until expended.
Public Health				
5204	New PHSA Sec. 776 (HRSA)	**Public health workforce loan repayment program.** Requires the Secretary to establish a student loan repayment program that pays up to $35,000 a year, or one-third of total debt, whichever is less, to increase the supply of public health professionals.	Public health or health professionals who agree to work for at least three years in a public health agency or related training fellowship.	$195 million for FY2010, and SSAN for each of FY2011 through FY2015.

PPACA Section	New/Existing Authority (Agency)	Description/Purpose	Eligibility	Authorization of Appropriations
5206(b)	New PHSA Sec. 777 (HRSA)	**Public health and allied health scholarship program.** Authorizes grants to eligible educational entities to award scholarships for the training of mid-career professionals in public health and allied health. Available grant funds are to be divided 50:50 between supporting public health and allied health professionals.	Accredited institutions that offer training programs in public health and allied health.	$60 million for FY2010, and SSAN for each of FY2011 through FY2015.
5313	New PHSA Sec. 399V (CDC)	**Community health worker (CHW) program.** Requires CDC to award grants to promote healthy behaviors and outcomes for populations in medically underserved communities through programs of training and supervision of CHWs.	States and subdivisions, health departments, free clinics, hospitals, and FQHCs; priority given to applicants that target areas with a high proportion of uninsured or underinsured individuals, or with high rates of chronic illness or infant mortality.	SSAN for each of FY2010 through FY2014.
5314	New PHSA Sec. 778 (CDC)	**CDC training fellowships.** Authorizes the Secretary to expand existing CDC training fellowships in epidemiology, laboratory science, and informatics; the Epidemic Intelligence Service (EIS); and other training programs that meet similar objectives.	Participants may be placed in state and local health agencies, and states can receive federal assistance for loan repayment programs for such participants.	$39.5 million for each of FY2010 through FY2013 ($24.5 million for EIS, and $5 million each for epidemiology, laboratory science, and informatics).
5315	New PHSA Title II, Part D – Secs. 271-274 (U.S. Surgeon General)	**United States Public Health Sciences Track.** Authorizes the establishment of a science track at academic sites selected by the Secretary to award degrees that emphasize team-based service, public health, epidemiology, and emergency preparedness and response.	Assistance to academic institutions for program development; tuition and stipends for students who meet a service obligation, including in the United States Public Health Service (USPHS) Commissioned Corps. Preference to students from rural communities, and minorities.	Requires the Secretary to transfer SSAN from the Public Health and Social Services Emergency Fund for FY2010 and each fiscal year thereafter. (See note at end of table.)
10501(m)(2)	Amends PHSA Sec. 770 (HRSA)	**Public health workforce programs.** Authorizes new funding for existing public health workforce programs (PHSA Secs. 765-769). They 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. Several programs mention preference for underserved communities or underrepresented minorities. ***FY2010 appropriation = $10 million.***	Eligible entities for each program are stipulated and generally include accredited academic institutions, but may also include state, local and tribal public health departments and/or other private nonprofit entities.	$43 million for FY2011, and SSAN for each of FY2012 through FY2015.

PPACA Section	New/Existing Authority (Agency)	Description/Purpose	Eligibility	Authorization of Appropriations
5210	Amends PHSA Sec. 203 (U.S. Surgeon General)	**USPHS Commissioned Corps.** Establishes a Ready Reserve Corps of officers who are subject to involuntary call to active duty (including for training) by the Surgeon General, in order to bolster the available workforce for both routine and emergency public health missions.	Not applicable.	$17.5 million for each of FY2010 through FY2014 ($5 million for recruitment and training, $12.5 million for the Ready Reserve Corps).
Workforce Diversity/Health Disparities				
5307(a)	Amends and reauthorizes PHSA Sec. 741 (HRSA)	**Cultural competency, prevention, public health, disparities, and individuals with disability training.** Authorizes grants, contracts, or cooperative agreements under PHSA Title VII (Health Professions Education) for the development and evaluation of research, demonstration projects, and model curricula that provide training in cultural competency, prevention, public health proficiency, reducing health disparities, and aptitude for working with individuals with disabilities.	Health professions schools, academic health centers, state or local governments, or other appropriate public or private nonprofit entities (or consortia of such entities).	SSAN for each of FY2010 through FY2015.
5307(b)	Amends and reauthorizes PHSA Sec. 807 (HRSA)	**Cultural competency, prevention, public health, disparities, and individuals with disability training.** Authorizes grants, contracts, or cooperative agreements under PHSA Title VIII (Nursing Workforce Development) for the development and evaluation of research, demonstration projects, and model curricula that provide training in cultural competency, prevention, public health proficiency, reducing health disparities, and aptitude for working with individuals with disabilities. The Secretary is required to coordinate this program with the one authorized under PHSA Sec. 741.	Nursing schools, academic health centers, state or local governments, or other appropriate public or private nonprofit entities.	SSAN for each of FY2010 through FY2015.
5401	Amends and reauthorizes PHSA Sec. 736 (HRSA)	**Centers of excellence (COE).** Requires the Secretary to fund COE, that is, centers that sponsor programs related to the recruitment, training and retention of underrepresented minorities in the health professions. ***FY2010 appropriation = $25 million.***	Health professions schools that recruit, enroll, and graduate underrepresented minorities or who have increased the recruitment of underrepresented minorities serving in faculty or administrative positions.	$50 million for each of FY2010 through FY2015, and SSAN for each subsequent fiscal year.

PPACA Section	New/Existing Authority (Agency)	Description/Purpose	Eligibility	Authorization of Appropriations
5402	Amends and reauthorizes PHSA Sec. 740 (HRSA)	**Authorization of appropriations for diversity programs.** Authorizes appropriations for the following programs: Sec. 737 (scholarships for disadvantaged students); Sec. 738 (faculty loan repayments and fellowships); and Sec. 739 (educational assistance for individuals from disadvantaged backgrounds). ***FY2010 appropriations = $49 million for Sec. 737, $1 million for Sec. 738, and $22 million for Sec. 739.***	Sec. 737: health professions schools. Sec. 738: individuals from disadvantaged backgrounds who are in their final year of study or have a degree from an accredited health professions school. Sec. 739: health professions schools.	For Sec. 737, $51 million for FY2010, and SSAN for each of FY2011 through FY2014. For Sec. 738, $5 million for each of FY2010 through FY2014. For Sec. 739, $60 million for FY2010, and SSAN for each of FY2011 through FY2014.
5403(a)	Amends and reauthorizes PHSA Sec. 751 (HRSA)	**Area Health Education Centers (AHECs).** Requires the Secretary to award grants (with a matching requirement) of at least $250,000 to (1) plan, develop, and operate AHEC programs; and (2) to maintain and improve the effectiveness of existing AHEC programs. AHECs recruit, train, and prepare individuals from minority populations or from disadvantaged or rural backgrounds to work in medically underserved areas. ***FY2010 appropriation = $33 million.***	Medical and nursing schools.	$125 million for each of FY2010 through FY2014; funds may be carried over for up to three fiscal years.
5403(b)	New PHSA Sec. 752 (HRSA)	**Continuing educational support for health professionals serving in underserved communities.** Requires the Secretary to award grants to enhance education through distance learning, continuing education, collaborative conferences, and telehealth, with a focus on primary care.	Health professions schools, academic health centers, state or local governments, or other public or nonprofit entities participating in training activities.	$5 million for each of FY2010 through FY2014, and SSAN for each subsequent fiscal year.
Mental and Behavioral Health				
5306	Redesignates PHSA Sec. 756 as Sec. 757, and adds a new Sec. 756 (HRSA)	**Mental and behavioral health education and training grants.** Authorizes grants for the recruitment and education of students in social work, interdisciplinary psychology training, and internships or other field placement programs related to child and adolescent mental health. Priority for social work grants given to schools of social work meeting certain criteria such as recruiting from and placing graduates into areas with a high-need and high-demand population. Priority for psychology grants given to institutions that focus on the needs of specified vulnerable groups. Priority for grants to train professional and paraprofessional child and adolescent mental health workers given to applicants that can, among other things, assess workforce needs and that have programs designed to increase the number of child and adolescent mental health workers serving high-priority populations.	Historically black colleges and universities (HBCUs) or other minority-serving institutions. Institutions of higher education that have knowledge, understanding and participation of individuals and groups from different racial, ethnic, cultural, geographic, religious, linguistic, and class backgrounds, and different genders and sexual orientations; and that have internship or other field placement programs that prioritize cultural and linguistic competency. State-licensed mental health organizations to train paraprofessional child and adolescent mental health workers.	$35 million for the period of FY2010 through FY2013 ($8 million for training in social work, $12 million for training in graduate psychology, $10 million for training in professional child and adolescent mental health, and $5 million for training in paraprofessional child and adolescent mental health).

PPACA Section	New/Existing Authority (Agency)	Description/Purpose	Eligibility	Authorization of Appropriations
Policy and Planning				
5101	New authority	**National Health Care Workforce Commission.** Establishes a 15-member commission focused on evaluating and meeting the need for health care workers in the United States. The commission is required to conduct studies, produce annual reports beginning in 2011, and make recommendations on high-priority topics related to the health care workforce.	Not applicable.	SSAN (no years specified).
5102	New authority (HRSA)	**State health care workforce development grants.** Establishes a matching grants program for state partnerships to plan and implement activities leading to coherent and comprehensive health care workforce development strategies at the state and local levels. Planning grants of up to $150,000 are for up to one year and require a 15% match. Implementation grants are for up to two years (with up to one additional year of funding) and require a 25% match.	A state workforce investment board that includes certain specified members.	For planning grants, $8 million for FY2010, and SSAN for each subsequent fiscal year. For implementation grants, $150 million for FY2010, and SSAN for each subsequent fiscal year.
5103	Amends and reauthorizes PHSA Sec. 761 (HRSA)	**Health care workforce program assessment.** Requires the Secretary to establish a National Center for Health Care Workforce Analysis, award grants to support state and regional centers for health workforce analysis, and increase funding for longitudinal evaluations of specified individuals who have received education, training, or financial assistance from programs under PHSA Title VII. ***FY2010 appropriation = $3 million; includes funding for Sec. 792 (health professions data) and Sec. 806 (nursing grant program data).***	State and regional centers for health workforce analysis: states, state workforce investment boards, public health or health professions schools, academic health centers, or appropriate public or private nonprofit entities.	For the National Center, $7.5 million for each of FY2010 through FY2014; for state and regional centers, $4.5 million for each of FY2010 through FY2014; and for longitudinal evaluations, SSAN for FY2010 through FY2014.

Source: Table prepared by the Congressional Research Service based on the text of the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA; P.L. 111-152).

Note: Regarding funding for the U.S. Public Health Sciences Track (PPACA Sec. 5315), the Public Health and Social Services Emergency Fund (PHSSEF) is an HHS account administered by the Secretary. Congress has historically used the PHSSEF to provide one-time funding for non-routine activities. Each fiscal year, Congress appropriates amounts to the PHSSEF for specified purposes. PPACA does not authorize or appropriate funds to the PHSSEF.

Table 3. PPACA Discretionary Funding: Prevention and Wellness

Subject to Appropriations

PPACA Section	New/Existing Authority (Agency)	Description/Purpose	Eligibility	Authorization of Appropriations
Community-Based Prevention				
3509/3511	New PHSA Secs. 229 (OS), 310A (CDC), 925 (AHRQ); new SSA Sec. 713 (HRSA); and new FFDCA Sec. 1011 (FDA). Reauthorizes PHSA Secs. 486(a) (NIH) and 501(f) (SAMHSA).	**Offices of Women's Health.** Establishes or reauthorizes offices of women's health in OS, CDC, AHRQ, HRSA, FDA, NIH, and SAMHSA. Grants, agreements, or contracts may be awarded for activities of the OS office to establish an information center and coordinating committee. Activities of other offices include recommendations regarding grant-making through other agency accounts, not direct grant-making. ***FY2010 appropriations = $43 million for NIH's Office of Research on Women's Health, and $34 million for the OS Office on Women's Health.***	OS grants, agreements, and contracts may be awarded to public and private entities, agencies, and organizations.	For most offices, SSAN for each of FY2010 through FY2014. For NIH and SAMHSA offices, SSAN (no years specified).
4003	Amends PHSA Sec. 915(a) (AHRQ). New PHSA Sec. 399U (CDC).	**Clinical and community preventive services task forces.** Reauthorizes and expands the authority for the U.S. Preventive Services Task Force (USPSTF) to review and recommend effective clinical preventive services. Provides explicit statutory authority for the existing Task Force on Community Preventive Services (TFCPS) to review and recommend effective community-based interventions. ***FY2010 appropriations = $2.7 million for USPSTF, and $1.8 million for TFCPS.***	Not applicable.	SSAN for each fiscal year to carry out the activities of the USPSTF and the TFCPS.
4004	New authority	**Education and outreach regarding prevention.** Requires the Secretary to carry out various specified communications activities regarding health promotion and disease prevention, for common and serious chronic health problems. They include establishing, within one year of enactment, a national media campaign on health promotion and disease prevention.	Mentions awarding contracts, but does not specify eligibility criteria.	SSAN for each fiscal year; no more than $500 million total.
4102(a)	New PHSA Secs. 399LL, 399LL-1, and 399LL-2 (CDC)	**Oral health activities.** Requires CDC, subject to appropriations, to fund a five-year national oral health education campaign, and award grants for dental caries disease management programs, among other things. ***FY2010 appropriation for CDC oral health = $15 million.***	Community-based providers of dental services, including public or private entities.	SSAN (no years specified).

PPACA Section	New/Existing Authority (Agency)	Description/Purpose	Eligibility	Authorization of Appropriations
4102(b)	Amends PHSA Sec. 317M(c) (CDC, HRSA)	**School-based dental sealant program.** Amends the existing school-based dental sealant grant program, which was discretionary, by requiring the Secretary to award grants to the 50 states and to Indian tribes for school-based dental sealant programs.	Grants must be awarded to each of the 50 states and territories, and to Indians, Indian tribes, tribal organizations, and urban Indian organizations. Preference given to urban districts with high participation rates in school meals programs, and rural districts with high poverty levels (as defined).	Authority expired at end of FY2005; PPACA does not authorize new funding.
4102(c)	Amends PHSA Sec. 317M by adding a new subsection (d) (CDC)	**Oral health infrastructure.** Requires the Secretary to enter into cooperative agreements to establish oral health leadership and programs to improve oral health.	States, territories, and tribal entities.	SSAN for FY2010 through FY2014.
4102(d)	New authority (CDC, AHRQ)	**Oral health surveillance.** Requires the Secretary to expand the following surveillance systems to include more information on oral health: Pregnancy Risk Assessment Monitoring System (PRAMS); National Health and Nutrition Examination Survey (NHANES); National Oral Health Surveillance System (NOHSS); and Medical Expenditure Panel Survey (MEPS).	Not applicable.	SSAN (no years specified) for PRAMS; SSAN for each of FY2010 through FY2014 for NOHSS; no explicit authorization of appropriations for NHANES/MEPS expansion.
4201	New authority (CDC)	**Community transformation grants.** Requires CDC to fund competitive grants for the implementation, evaluation, and dissemination of evidence-based community preventive health activities.	State or local government agencies or nonprofit organizations, networks of community-based organizations, and Indian tribes.	SSAN for each of FY2010 through FY2014.
4202(a)	New authority (CDC)	**Community wellness pilot program.** Requires CDC to award grants for five-year pilot programs to provide community prevention interventions, screenings, and clinical referrals for individuals between 55 and 64 years of age.	State or local health departments, and Indian tribes.	SSAN for each of FY2010 through FY2014.
4204	Amends PHSA Sec. 317 (CDC)	**Immunization programs.** Provides explicit authority for states to purchase vaccines at prices negotiated by Secretary. Reauthorizes state immunization grants. Requires new immunization demonstration grants. ***FY2010 appropriation for Sec. 317 vaccination program = $559 million.***	States, political subdivisions, and other public entities.	SSAN for each of FY2010 through FY2014 for demonstration grants; SSAN (no years specified) for other authorities.

PPACA Section	New/Existing Authority (Agency)	Description/Purpose	Eligibility	Authorization of Appropriations
4206	Amends PHSA Sec. 330 by adding a new subsection (s)	**Individualized wellness plan demonstration program.** Requires the Secretary to establish a pilot program in not more than 10 community health centers to test the impact of providing at-risk individuals who use the centers with individualized wellness plans.	Community health centers.	SSAN (no years specified).
4304	New PHSA Sec. 2821 (CDC)	**Epidemiology and laboratory capacity grants.** Codifies existing grant program to strengthen national epidemiology, laboratory, and information management capacity for the response to infectious diseases and other conditions of public health importance.	State, local, or tribal health departments, tribal jurisdictions, or academic centers that meet CDC-specified criteria.	$190 million for each of FY2010 through FY2013 (at least $95 million for epidemiology, $60 million for information management, and $32 million for laboratories).
10334	Amends PHSA Sec. 1707 (OS) and PHSA Title IV (NIH)	**Offices of Minority Health.** Elevates the existing OS Office of Minority Health and NIH National Center on Minority Health and Health Disparities (NCMHD); requires award of grants, contracts, and agreements by the OS office; and gives the new NIH National Institute on Minority Health and Health Disparities (NIMHD) responsibility for minority health disparities research and other health disparities research at NIH. ***FY2010 appropriations = $212 million for NIH's NCMHD, and $56 million for the OS Office of Minority Health.***	For OS office: public and nonprofit private entities, federal agencies, and organizations that are indigenous human resource providers in communities of color. For the NIH Institute, grantee eligibility criteria are not stipulated.	SSAN for each of FY2011 through FY2016 for OS office.
10407	New authority (CDC)	**Diabetes activities.** Requires CDC to conduct several diabetes prevention activities including state assessments, vital statistics, physician education, and funding of an Institute of Medicine (IOM) report.	Not applicable.	SSAN (no years specified).
10411	New PHSA Secs. 399V-2 (CDC) and 425 (NIH)	**Congenital heart disease programs.** Authorizes CDC to establish a National Congenital Heart Disease Surveillance System (NCHDSS), or to award one grant to establish such a system. Authorizes NIH to expand and coordinate research on congenital heart disease.	NCHDSS grantee must be a public or private nonprofit entity with experience in congenital heart disease. NIH must consider the application of research to minority and medically underserved populations.	SSAN for each of FY2011 through FY2015 for both the surveillance system and the expanded research program.
10412	Reauthorizes PHSA Sec. 312 (HRSA)	**Public access defibrillation programs.** Reauthorizes a program of grants for public access defibrillation programs, including equipment purchase and training.	States and political subdivisions, Indian tribes, and tribal organizations.	$25 million for each of FY2003 through FY2014.

PPACA Section	New/Existing Authority (Agency)	Description/Purpose	Eligibility	Authorization of Appropriations
10413	New PHSA Sec. 399NN (OS, CDC)	**Young women's breast health awareness.** Among other things, requires CDC to conduct an education campaign and award grants for a media campaign regarding breast health in young women, and to conduct prevention research; requires the Secretary to award grants to provide education and assistance to young women diagnosed with breast disease.	Media campaign grants; not stated. Assistance grants; organizations and institutions, priority to those that deal specifically with breast cancer and pre-neoplastic breast disease in young women.	$9 million for each of FY2010 through FY2014.
10501(g)	New PHSA Sec. 399V-3 (CDC)	**National diabetes prevention program.** Among other things, requires the Secretary to award grants for community-based diabetes prevention program model sites.	State or local health departments, tribal organizations, national networks of community-based nonprofits, academic institutions, or other entities as determined by the Secretary.	SSAN for each of FY2010 through 2014.
Workplace Wellness				
10408	New authority	**Workplace wellness program grants.** Requires the Secretary to award grants to eligible employers to provide employees with access to comprehensive workplace wellness programs.	Employers of fewer than 100 employees (who work 25 or more hours per week) that do not already provide a wellness program.	$200 million for the period of FY2011 through FY2015.

Source: Table prepared by the Congressional Research Service based on the text of the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA; P.L. 111-152).

Table 4. PPACA Discretionary Funding: Maternal and Child Health

Subject to Appropriations

PPACA Section	New/Existing Authority (Agency)	Description/Purpose	Eligibility	Authorization of Appropriations
2952(b)	New SSA Sec. 512 (HRSA)	**Services to individuals with a postpartum condition.** Authorizes grants to establish, operate and coordinate effective and cost-efficient systems for the delivery of essential services to individuals with, or at risk of, postpartum depression and their families.	Public or nonprofit private entities, state or local government public-private partnerships, recipients of Healthy Start grants, public or nonprofit private hospitals, community-based organizations, hospices, ambulatory care facilities, community health centers, migrant health centers, public housing, primary care centers, and homeless health centers.	$3 million for FY2010, and SSAN for each of FY2011 and FY2012.

Source: Table prepared by the Congressional Research Service based on the text of the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA; P.L. 111-152).

Table 5. PPACA Discretionary Funding: Health Care Quality

Subject to Appropriations

PPACA Section	New/Existing Authority (Agency)	Description/Purpose	Eligibility	Authorization of Appropriations
Quality Measure Development, Analysis, and Public Reporting				
3013(a)&(c)	New PHSA 931 (AHRQ)	**Quality measure development.** Requires the Secretary, in consultation with AHRQ and CMS, to (1) identify gaps where no quality measures exist or where existing measures need improvement, updating or expansion consistent with the National Strategy for Quality Improvement; and (2) fund or enter into agreements with eligible entities for purposes of developing, improving, updating, or expanding quality measures in areas identified as gap areas.	Entities with demonstrated expertise in measure development and evaluation, which have adopted processes that incorporate the views of measure users, as well as those assessed by the measures, into the development process.	$75 million for each of FY2010 through FY2014, to remain available until expended. At least 50% of the amounts appropriated must be used pursuant to SSA Sec. 1890A(e), as added by PPACA Sec. 3013(b). See below.
3013(b)	Amends new SSA Sec. 1890A, as added by PPACA Sec. 3014(b), by adding a new subsection (e) (CMS)	**Quality and efficiency measures development.** Requires CMS, in consultation with AHRQ, through contracts, to develop quality and efficiency measures as determined appropriate for use under the SSA.	Not specified.	See PPACA Sec. 3013(a)&(c) above.
3015	New PHSA Sec. 399II	**Collection and analysis of data for quality and resource use measures.** Requires the Secretary to establish and implement an overall strategic framework to carry out the public reporting of performance information. Requires the Secretary to collect and aggregate consistent data on quality and resource use measures, and authorizes the Secretary to award grants or contracts for this purpose. Authorizes the Secretary to award grants or contracts to eligible entities to support new, or improve existing, efforts to collect and aggregate quality and resource use measures.	Multi-stakeholder entities that coordinate methods and plans for the consistent reporting of summary quality and cost information and that are capable of submitting such summary data for a particular population and providers. Awards may only be made to entities that enable summary data that can be integrated and compared across multiple sources.	SSAN for each of FY2010 through FY2014.
3015	New PHSA Sec. 399JJ	**Public reporting of performance information.** Requires the Secretary to make available to the public, through standardized websites, performance information summarizing data on quality measures. The information must include clinical conditions to the extent such data is available and, where appropriate, be provider-specific and sufficiently disaggregated and specific to meet the needs of patients with different clinical conditions.	Not applicable.	SSAN for each of FY2010 through FY2014.

PPACA Section	New/Existing Authority (Agency)	Description/Purpose	Eligibility	Authorization of Appropriations
Quality Improvement Research, Training, and Implementation				
3501	New PHSA Sec. 933 (AHRQ)	**Health care delivery system research.** Requires AHRQ to (1) identify, develop, evaluate, and disseminate innovative strategies for quality improvement practices in the delivery of health care services that represent best practice; (2) support research on health care delivery improvement and facilitate adoption of best practices; and (3) make the research findings available to the public; among other specified functions.	Not specified.	$20 million for FY2010 through FY2014.
3501/3511	New PHSA Sec. 934 (AHRQ)	**Quality improvement technical assistance and implementation.** Requires AHRQ to award technical assistance grants (with a matching requirement) to entities that deliver health care to help them understand, adapt, and implement the models and practices identified by the research conducted by the agency.	May be a health care provider, professional society, health care worker organization, Indian health organization, quality improvement organization, patient safety organization, local quality improvement collaborative, the Joint Commission, academic health center, university, physician-based research network, primary care extension program, or an Indian Health Service program; and must have demonstrated expertise in providing information and technical support and assistance to health care providers regarding quality improvement.	SSAN (no years specified).
3508/3511	New authority	**Quality and patient safety training.** Authorizes the Secretary to award demonstration grants (with a matching requirement) to eligible entities or consortia to develop and implement academic curricula that integrate quality improvement and patient safety into clinical education of health professionals.	Health professional schools; schools of public health, social work, nursing, pharmacy or health care administration; institutions with a graduate medical education program.	SSAN (no years specified).

PPACA Section	New/Existing Authority (Agency)	Description/Purpose	Eligibility	Authorization of Appropriations
Health Care Coordination				
3502/3511	New authority	**Community health team grants to support medical homes.** Requires the Secretary to award grants to or enter into contracts with eligible entities to support community-based interdisciplinary, interprofessional health teams in assisting primary care practices. Funding must be used to establish the health teams and to provide capitated payments to the providers.	States or state-designated entities; Indian tribes or tribal organizations.	SSAN (no years specified).
3503/3511	New PHSA Sec. 935 (AHRQ)	**Medication therapy management (MTM) grants.** Requires the Secretary, not later than May 1, 2010, to provide grants to support MTM services provided by licensed pharmacists that are targeted at patients who take four or more prescribed medications, take high-risk medications, have two or more chronic diseases, or have undergone a transition of care or other factors that are likely to create a high risk for medication-related problems.	Entities that provide a setting appropriate for MTM services and that submit a plan for achieving long-term financial sustainability.	SSAN (no years specified).
3506	New PHSA Sec. 936 (AHRQ)	**Program to facilitate shared decisionmaking.** Requires the Secretary, through a contract, to develop and identify standards for patient decision aids, to review patient decision aids, and develop a certification process for determining whether patient decision aids meet those standards. Further requires the Secretary to (1) award grants or contracts to develop, update, and produce patient decision aids, to test such materials to ensure they are balanced and evidence-based, and to educate providers on their use; and (2) to award grants for establishing Shared Decision Making Resource Centers to develop and disseminate best practices to speed adoption and effective use of patient decision aids and shared decision making. Also requires the Secretary to award grants to providers for the development and implementation of shared decision-making techniques.	The standards and certification contract is to be awarded to the entity that holds the contract under SSA Sec. 1890 (currently the National Quality Forum). Eligible grantees are not specified.	SSAN for FY2010 and each subsequent fiscal year.
3510	Amends and reauthorizes PHSA Sec. 340A	**Patient navigator program.** Prohibits the Secretary from awarding a grant to an entity under this section unless the entity provides assurances that patient navigators recruited, assigned, trained, or employed using these grant funds meet certain minimum core proficiencies. ***FY2010 appropriation = $5 million.***	A public or nonprofit private health center (including an FQHC), Indian Health Service facility, hospital, cancer center, rural health clinic, academic health center, or a nonprofit entity that partners or coordinates referrals with such a facility to provide patient navigator services.	$3.5 million for FY2010, and SSAN for each of FY2011 through FY2015.

PPACA Section	New/Existing Authority (Agency)	Description/Purpose	Eligibility	Authorization of Appropriations
5405	New PHSA Sec. 399V-1 (AHRQ)	**Primary care extension program.** Requires the Secretary to establish a Primary Care Extension Program to award competitive grants to states to create Primary Care Extension Program State Hubs, consisting of the state health department and other specified entities. State hubs must contract with and provide grant funds to county and local entities to serve as Primary Care Extension Agencies that assist primary care providers in implementing patient-centered medical homes and develop and support primary care learning communities, among other functions.	States or multistate entities.	$120 million for each of FY2011 and FY2012, and SSAN for each of FY2013 and FY2014.
5604	New PHSA Sec. 520K (SAMHSA)	**Co-locating primary and specialty care in community-based mental health settings.** Requires the Secretary to fund demonstration projects for providing coordinated and integrated services to individuals with mental illness and co-occurring chronic diseases through the co-location of primary and specialty care services in community-based mental and behavioral health settings.	Qualified community mental health programs.	$50 million for FY2010, and SSAN for each of FY2011 through FY2014.
10333	New PHSA Sec. 340H	**Community-based collaborative care network program.** Authorizes the Secretary to award grants to eligible entities to support community-based collaborative care networks (CCN).	An eligible CCN is a consortium of health care providers with a joint governance structure that provides comprehensive coordinated and integrated health care services (as defined by the Secretary) for low-income populations. CCNs must include a safety net hospital and all FQHCs in the community, as specified.	SSAN for each of FY2011 through FY2015.
10410	New PHSA Sec. 520B (SAMHSA)	**Centers of excellence for depression.** Requires SAMHSA to award five-year grants (with a matching requirement) on a competitive basis to eligible entities to establish national centers of excellence for depression. One grantee is to be designated as the coordinating center and required to establish and maintain a national database. Centers of excellence may receive a grant of up to $5 million; the coordinating center may receive a grant of up to $10 million.	Institutions of higher education; public or private nonprofit research institutions.	$100 million for each of FY2011 through FY2015, and $150 million for each of FY2016 through FY2020.

Source: Table prepared by the Congressional Research Service based on the text of the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA; P.L. 111-152).

Table 6. PPACA Discretionary Funding: Nursing Homes

Subject to Appropriations

PPACA Section	New/Existing Authority (Agency)	Description/Purpose	Eligibility	Authorization of Appropriations
6112	New authority	**National independent monitor demonstration program.** Requires the Secretary, within one year of enactment, to implement a two-year demonstration to develop, test, and implement an independent monitoring program to oversee interstate and large intrastate chains of skilled nursing facilities (SNFs) and nursing facilities (NFs).	Duties of the independent monitor are stipulated, but eligibility criteria are not.	SSAN (no years specified); a monitored chain must contribute a portion of costs of the demonstration, as determined by the Secretary.
6114	New authority	**Culture change and information technology demonstration programs.** Requires the Secretary, within one year of enactment, to award one or more competitive grants to support each of the following two three-year demonstration projects for SNFs and NFs: (1) develop best practices for culture change (i.e., patient-centric models of care); and (2) develop best practices for the use of health information technology.	Facility-based settings.	SSAN (no years specified).

Source: Table prepared by the Congressional Research Service based on the text of the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA; P.L. 111-152).

Table 7. PPACA Discretionary Funding: Health Data Collection

Subject to Appropriations

PPACA Section	New/Existing Authority (Agency)	Description/Purpose	Eligibility	Authorization of Appropriations
4302(a)	New PHSA Sec. 3101	**Health disparities data collection and analysis.** Not later than two years after enactment, requires federally conducted and supported health programs and surveys, to the extent practicable, to collect health disparities data. Requires the Secretary to adopt standards for the measurement and collection of such data. Requires the Secretary to analyze the data collected on health disparities; provide for the public reporting and dissemination of the data and analyses; and safeguard the privacy of the information.	Not applicable.	SSAN for each of FY2010 through FY2014; however, data may not be collected unless funds are directly appropriated for such purpose.
5605	New authority	**Key national indicators.** Establishes a Commission on Key National Indicators composed of eight members appointed by Congress. Requires the commission to contract with the National Academy of Sciences to review available public and private sector research on key national indicator set selection and determine how best to establish a key national indicator system, among other things. Mandates a Government Accountability Office (GAO) study of previous efforts by public, private, or foreign entities to develop best practices for a key national indicator system.	National Academy of Sciences.	$10 million for FY2010, and $7.5 million for each of FY2011 through FY2018, with amounts appropriated to remain available until expended.

Source: Table prepared by the Congressional Research Service based on the text of the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA; P.L. 111-152).

Table 8. PPACA Discretionary Funding: Emergency Care

Subject to Appropriations

PPACA Section	New/Existing Authority (Agency)	Description/Purpose	Eligibility	Authorization of Appropriations
3504(a)	New PHSA Sec. 1204 (OS)	**Regional systems for emergency care.** Requires the Assistant Secretary for Preparedness and Response to award at least four multi-year contracts or grants (with matching requirement) for pilot projects to improve regional coordination of emergency services.	States (or a partnership of one or more states and one or more localities) and Indian tribes (or a partnership of one or more tribes). Priority given to entities that serve a medically underserved population.	$24 million for each of FY2010 through FY2014 for PHSA Title XII Parts A and B (i.e., Secs. 1201-1222).
3504(b)	New PHSA Sec. 498D (NIH, AHRQ, HRSA, CDC)	**Emergency medicine research.** Requires the Secretary to expand and accelerate basic, translational, and service delivery research on emergency medical care systems and emergency medicine, including pediatric emergency medical care. Also requires the Secretary to support research on the economic impact of coordinated emergency care systems.	Not specified.	SSAN for each of FY2010 through FY2014.
3505(a)	Amends and reauthorizes PHSA Secs. 1241-1245 (HRSA)	**Trauma care centers.** Requires the Secretary to establish separate grant programs for trauma care centers to (1) help defray substantial uncompensated care costs, (2) further the core missions of trauma care centers, and (3) provide emergency relief to ensure the continued availability of trauma services.	Qualified public nonprofit IHS, Indian tribal, and urban Indian trauma centers.	$100 million for FY2009, and SSAN for each of FY2010 through FY2015.
3505(b)	New PHSA Secs. 1281-1282 (HRSA)	**Trauma service availability grants.** Requires the Secretary to award grants to states for the purpose of supporting trauma-related physician specialties and broadening access to and availability of trauma care services.	Grants are awarded to states to fund (1) a public or nonprofit trauma center, (2) a safety net public or nonprofit trauma center, or (3) a hospital in an underserved area (as defined by the state) that seeks to establish new trauma services. States must use at least 40% of the amount awarded in a fiscal year for grants to safety net trauma centers.	$100 million for each of FY2010 through FY2015.
5603	Amends and reauthorizes PHSA Sec. 1910 (HRSA)	**Children's emergency medical services demonstration grants.** Expands emergency services for children who need treatment for trauma or critical care by lengthening the period for demonstration grants to four years (with an optional fifth year). ***FY2010 appropriation = $21.5 million.***	States or accredited schools of medicine.	$25 million for FY2010, $26.3 million for FY2011, $27.6 million for FY2012, $28.9 million for FY2013, and $30.4 million for FY2014.

Source: Table prepared by the Congressional Research Service based on the text of the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA; P.L. 111-152).

Table 9. PPACA Discretionary Funding: Elder Justice

Subject to Appropriations

PPACA Section	New/Existing Authority (Agency)	Description/Purpose	Eligibility	Authorization of Appropriations
6703(a)	New SSA Sec. 2021 (OS)	**Elder Justice Coordinating Council.** Establishes an Elder Justice Coordinating Council to include the Secretary as chair and the U.S. Attorney General, as well as the head of each federal department or agency, identified by the chair, as having administrative responsibility or administering programs related to elder abuse, neglect, and exploitation.	Not applicable.	SSAN (no years specified). See also new SSA Sec. 2024 below.
6703(a)	New SSA Sec. 2022	**Advisory Board on Elder Abuse, Neglect, and Exploitation.** Establishes an advisory board to create a short- and long-term multidisciplinary plan for development of the field of elder justice and to make recommendations to the Elder Justice Coordinating Council.	Not applicable.	SSAN (no years specified). See also new SSA Sec. 2024 below.
6703(a)	New SSA Sec. 2024	**Authorization of appropriations.** Authorizes funding for new SSA Secs. 2021 (Coordinating Council), 2022 (Advisory Board), and 2023 (human subject protection guidelines for researchers).	Not applicable.	$6.5 million for FY2011, and $7.0 million for each of FY2012 through FY2014.
6703(a)	New SSA Sec. 2031	**Forensic centers and expertise.** Requires the Secretary to award grants to eligible entities to establish and operate stationary and mobile forensic centers and to develop forensic expertise pertaining to elder abuse, neglect, and exploitation.	(1) Stationary forensic centers: four of the grants to institutions of higher education with demonstrated expertise in forensics or commitment to preventing or treating elder abuse. (2) Mobile forensic centers: six of the grants to appropriate entities.	$4 million for FY2011, $6 million for FY2012, and $8 million for each of FY2013 and FY2014.
6703(a)	New SSA Sec. 2041(a)	**Incentives for LTC staffing.** Requires the Secretary to award grants to carry out activities for individuals to train for, seek, and maintain employment providing direct care in LTC; and to award grants to conduct programs that offer direct care employees continuing training and varying levels of certification.	LTC facilities or community-based LTC entities as defined by the Secretary.	For new SSA Sec. 2041: $20 million for FY2011, $17.5 million for FY2012, and $15 million for each of FY2013 and FY2014.
6703(a)	New SSA Sec. 2041(b)	**Certified EHR technology grant program.** Authorizes grants to LTC facilities for specified activities that would assist such entities in offsetting costs related to purchasing, leasing, developing, and implementing certified electronic health record technology.	LTC facilities.	See above authorization of appropriations for SSA Sec. 2041.
6703(a)	New SSA Sec. 2041(c)	**Standards for transactions involving clinical data by LTC facilities.** Requires the Secretary to adopt electronic standards for the exchange of clinical data by LTC facilities and, within 10 years, to have in place procedures to accept the optional electronic submission of clinical data by LTC facilities pursuant to such standards.	Not applicable.	See above authorization of appropriations for SSA Sec. 2041.

PPACA Section	New/Existing Authority (Agency)	Description/Purpose	Eligibility	Authorization of Appropriations
6703(a)	New SSA Sec. 2042(a)	**Adult protective service functions.** Requires the Secretary to undertake various activities with respect to adult protective services, including providing funding, collecting and disseminating data on elder abuse, disseminating information on best practices and training, conducting research, and providing technical assistance to states and other entities.	Not applicable.	$3 million for FY2011, and $4 million for each of FY2012 through FY2014.
6703(a)	New SSA Sec. 2042(b)	**Grants to enhance provision of adult protective services.** Requires the Secretary to award formula grants to enhance adult protective services programs provided by states and local governments.	States and U.S. territories.	$100 million for each of FY2011 through FY2014.
6703(a)	New SSA Sec. 2042(c)	**Adult protective services demonstration grants.** Requires the Secretary to fund state demonstration programs for adult protective services that test methods to prevent and detect elder abuse.	States.	$25 million for each of FY2011 through FY2014.
6703(a)	New SSA Sec. 2043(a)	**Long-term care ombudsman program grants.** Requires the Secretary to award grants to improve the capacity of state LTC ombudsman programs to address abuse and neglect complaints, conduct pilot programs, and provide support for such programs.	Eligible entities with relevant expertise and experience in abuse and neglect in LTC facilities, or state LTC ombudsman programs.	$5 million for FY2011, $7.5 million for FY2012, and $10 million for each of FY2013 and FY2014.
6703(a)	New SSA Sec. 2043(b)	**Ombudsman training programs.** Requires the Secretary to establish programs to provide and improve ombudsman training with respect to elder abuse, neglect, and exploitation for national organizations and state LTC ombudsman programs.	Not specified.	$10 million for each of FY2011 through FY2014.
6703(b)	New authority	**National Training Institute for Surveyors.** Requires that the Secretary enter into a contract with an entity to establish and operate a National Training Institute for Federal and State Surveyors to provide and improve training of surveyors investigating allegations of abuse in programs and LTC facilities that receive payments under Medicare or Medicaid.	Not specified.	$12 million for the period of FY2011 through FY2014.
6703(b)	New authority	**Grants to state survey agencies.** Requires the Secretary to award grants to state survey agencies that perform surveys of Medicare or Medicaid participating nursing facilities to design and implement complaint investigation systems.	State agencies that perform surveys of nursing facilities.	$5 million for each of FY2011 through FY2014.
6703(c)	New authority	**National nurse aide registry study and report.** Requires the Secretary, in consultation with appropriate government agencies and private sector organizations, to conduct a study on establishing a national nurse aide registry and report on its findings.	Not applicable.	SSAN (no years specified) to carry out these activities, with funding not to exceed $500,000.

Source: Table prepared by the Congressional Research Service based on the text of the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA; P.L. 111-152).

Table 10. PPACA Discretionary Funding: Biomedical Research

Subject to Appropriations

PPACA Section	New/Existing Authority (Agency)	Description/Purpose	Eligibility	Authorization of Appropriations
10409	Amends PHSA Secs. 402(b) and 499(c); new PHSA Sec. 402C (NIH)	**Cures Acceleration Network (CAN).** Establishes a CAN program within the Office of the NIH Director to award grants, contracts, or cooperative agreements to support the development of treatments for diseases or conditions that are rare, or for which market incentives are inadequate.	Public or private entity, which may include a private or public research institution, an institution of higher education, a medical center, a biotechnology company, a pharmaceutical company, a disease advocacy organization, a patient advocacy organization, or an academic research institution.	$500 million for FY2010, and SSAN for subsequent fiscal years. Other funds appropriated under the PHSA may not be allocated to CAN.

Source: Table prepared by the Congressional Research Service based on the text of the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA; P.L. 111-152).

Table 11. PPACA Discretionary Funding: Biologics

Subject to Appropriations

PPACA Section	New/Existing Authority (Agency)	Description/Purpose	Eligibility	Authorization of Appropriations
7002	Amends PHSA Sec. 351 (FDA)	**FDA approval of follow-on biologics.** Creates a regulatory pathway for approving biosimilar or interchangeable biological drugs. Provides for the collection of user fees, subject to congressional authorization, to cover regulatory costs beginning in FY2013.	Not applicable.	SSAN for each of FY2010 through FY2012.

Source: Table prepared by the Congressional Research Service based on the text of the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA; P.L. 111-152).

Table 12. PPACA Discretionary Funding: 340B Drug Pricing

Subject to Appropriations

PPACA Section	New/Existing Authority (Agency)	Description/Purpose	Eligibility	Authorization of Appropriations
7102	Amends PHSA Sec. 340B(d) (HRSA)	**Improvements to 340B program integrity.** Requires the Secretary to develop systems to improve compliance and program integrity to (1) increase transparency and strengthen monitoring, oversight, and investigation of the prices that manufacturers charge covered entities; and (2) ensure covered entities do not divert drugs or obtain multiple discounts. Further requires the Secretary to establish a new administrative dispute resolution process to mediate and resolve covered entity overpayment claims and manufacturer claims against covered entities for drug diversion or multiple discounts. ***FY2010 appropriation = $2.2 million.***	Not applicable.	SSAN for FY2010 and each succeeding fiscal year.

Source: Table prepared by the Congressional Research Service based on the text of the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA; P.L. 111-152).

Table 13. PPACA Discretionary Funding: Medical Malpractice

Subject to Appropriations

PPACA Section	New/Existing Authority (Agent)	Description/Purpose	Eligibility	Authorization of Appropriations
10607	New PHSA Sec. 399V-4	**Liability reform demonstration program.** Authorizes five-year demonstration grants to states for the implementation and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or organizations. Planning grants of up to $500,000 may be awarded to states for the development of demonstration project applications.	To receive a grant, a state must develop an alternative system that allows for the resolution of disputes caused by health care providers or organizations, and reduces medical errors by encouraging the collection and analysis of patient safety data related to the resolved disputes.	$50 million for the period FY2011 through FY2015.

Source: Table prepared by the Congressional Research Service based on the text of the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA; P.L. 111-152).

Table 14. PPACA Discretionary Funding: Pain Care Management

Subject to Appropriations

PPACA Section	New/Existing Authority (Agency)	Description/Purpose	Eligibility	Authorization of Appropriations
4305(a)	New authority	**Conference on pain.** Requires the Secretary, within one year of appropriating funds, to seek to enter into an agreement with the IOM to convene a Conference on Pain for the purpose of increasing the recognition of pain as a significant public health problem in the United States, among other purposes.	IOM or another appropriate entity if the IOM declines.	SSAN for each of FY2010 and FY2011.

Source: Table prepared by the Congressional Research Service based on the text of the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA; P.L. 111-152).

Table 15. PPACA Discretionary Funding: Medicaid Demonstrations

Subject to Appropriations

PPACA Section	New/Existing Authority (Agency)	Description/Purpose	Eligibility	Authorization of Appropriations
2705	New authority (CMS)	**Global payment system demonstration program.** Requires the Secretary, in coordination with the Center for Medicare and Medicaid Innovation, to fund up to five demonstration projects during the period FY2010 through FY2012 under which a participating state will adjust payments made to an eligible hospital system or network from a fee-for-service payment structure to a global capitated payment model.	Large safety net hospital systems or networks.	SSAN (no years specified).
2706	New authority (CMS)	**Pediatric accountable care organization demonstration program.** Requires the Secretary to conduct a five-year demonstration (Jan. 1, 2012 through Dec. 31, 2016) under which a participating state is allowed to recognize pediatric providers as an accountable care organization for the purpose of receiving incentive payments.	Eligible pediatric providers must meet certain performance guidelines established by the Secretary to be recognized as an accountable care organization, and must achieve a specified minimum level of savings in Medicaid expenditures in order to receive an incentive payment.	SSAN (no years specified).

Source: Table prepared by the Congressional Research Service based on the text of the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA; P.L. 111-152).

Table 16. PPACA Discretionary Funding: Medicare

Subject to Appropriations

PPACA Section	New/Existing Authority (Agency)	Description/Purpose	Eligibility	Authorization of Appropriations
3129	Amends and reauthorizes SSA Sec. 1820 (HRSA)	**Rural hospital flexibility grant program.** Extends authorization of appropriations for the rural hospital flexibility (FLEX) grants that support a range of performance and quality improvement activities at small rural hospitals. Permits the funding to be used to help rural hospitals participate in delivery system reform programs authorized under PPACA. ***FY2010 appropriation = $41.2 million.***	States; small rural hospitals.	SSAN for each of FY2011 and FY2012, to remain available until expended.

Source: Table prepared by the Congressional Research Service based on the text of the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA; P.L. 111-152).

Table 17. PPACA Discretionary Funding: Private Health Insurance

Subject to Appropriations

PPACA Section	New/Existing Authority (Agency)	Description/Purpose	Eligibility	Authorization of Appropriations
1334	New authority (OPM)	**Multi-state health plans.** Requires OPM to contract with health insurers to offer at least two multi-state health plans (at least one nonprofit) through exchanges in each state. Authorizes OPM to prohibit multi-state plans that do not meet standards for medical loss ratios, profit margins, and premiums. Requires multi-state plans to cover essential health benefits and meet all the requirements of a qualified health plan.	Health insurance issuers that agree to offer multi-state qualified health plans and meet other specified requirements.	SSAN (no years specified).

Source: Table prepared by the Congressional Research Service based on the text of the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA; P.L. 111-152).

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Acknowledgments

Pamela W. Smith, Analyst in Biomedical Policy, provided extensive comments on this report.

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Georgetown University Health Policy Institute
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Holding the Line on Medicaid and CHIP: Key Questions and Answers About Health Care Reform's Maintenance-of-Effort Requirements

Background

The Patient Protection and Affordable Care Act (PPACA; Public Law 111-148), signed into law on March 23, 2010, requires that states maintain their current eligibility standards for Medicaid and the Children's Health Insurance Program (CHIP). These maintenance-of-effort (MOE) requirements apply to adults until the major components of health reform go into effect on January 1, 2014, and to children until September 30, 2019. During the MOE periods, states also are barred from imposing new paperwork and other barriers that would make it harder for people to enroll in Medicaid or CHIP. These MOE requirements are designed to assure that people do not lose coverage in the months and years ahead as health reform is being implemented. In the absence of such provisions, some states might have scaled back Medicaid or CHIP coverage in response to current fiscal problems or in anticipation of health reform, even as changes are being made to move the country forward in providing families with affordable coverage options.

Detailed Questions and Answers

This set of question and answers reviews how the MOEs are structured in the PPACA. As noted, some areas are open to interpretation. Until the Centers for Medicare and Medicaid Services (CMS) issues guidance that answers these questions definitively, it is important to treat all of these answers as educated guesses.

1. In general, what are the new maintenance-of-effort (MOE) requirements included in health reform?

The PPACA requires states to maintain eligibility standards for adults in Medicaid until January 1, 2014, when the new health exchanges are operational, and for children in Medicaid and CHIP until October 1, 2019. The statutory language says that a state shall not have in effect eligibility standards, methodologies, or procedures under its Medicaid or CHIP state plan (or under a Medicaid or CHIP waiver) "that are more restrictive than the eligibility standards, methodologies, or procedures" in effect on the date of enactment of the PPACA. This language is explored in more detail under Question 4, but, in effect, it means states cannot adopt changes in eligibility rules and procedures that would make someone ineligible for Medicaid or CHIP coverage, who would have been eligible for Medicaid or CHIP on March 23, 2010. Examples of changes that are likely to be precluded by the MOE language include:

- Scaling back income eligibility or eliminating coverage for an entire eligibility category in Medicaid;
- Eliminating CHIP or scaling back eligibility for children in CHIP;
- Dropping lawfully-residing immigrants from coverage in Medicaid or CHIP;
- Reducing or eliminating an income or asset disregard, such as an earnings disregard;
- Imposing a new paperwork requirement, such as a face-to-face interview or a more frequent renewal period.

One exception, discussed in more detail in Question 8, is that the handful of states that cover adults with incomes above 133 percent of the federal poverty line (FPL) can scale back coverage for this population beginning in January 2011, if they are facing a budget deficit.

2. **Can states still expand coverage or simplify enrollment?**
Yes, the purpose of the MOEs is to prevent people from losing coverage while the major components of health reform are being implemented. It is not to stop states from covering more people. States still have full flexibility to further expand eligibility or simplify enrollment in Medicaid and CHIP, such as by exercising the options made available to them under the Children's Health Insurance Program Reauthorization Act (CHIPRA), which was signed into law by President Obama in February 2009.

3. **When do the MOE requirements for Medicaid and CHIP go into effect?**
The MOE requirements became effective when President Obama signed the PPACA on March 23, 2010. This means that states cannot roll back the Medicaid and CHIP eligibility standards and methods and procedures for determining eligibility that they had in place on March 23, 2010.

4. **What constitutes a policy that is "in effect" for purposes of the MOEs?**
States cannot scale back the coverage that they had "in effect" on March 23, 2010. CMS guidance on the MOE included in the American Recovery and Reinvestment Act (ARRA) passed last year, which includes similar language, clarifies that "in effect" means the "actual standards, methodologies, or procedures that States were utilizing...to determine or redetermine eligibility for Medicaid under the State plan or through a waiver program, and which are consistent with Federal statute and regulations." Thus, cuts passed by state legislatures early in 2010 that have not been implemented as of March 23, 2010 are likely to be considered an MOE violation if implemented in the future. For example, Arizona passed legislation in the week before health reform passed to eliminate its CHIP program in June 2010, but it had not implemented the cut, and it had not updated its state plan to reflect the planned cut as of March 23, 2010. CMS already has informed Arizona policymakers that they will be in violation of the health care reform MOE requirements if they proceed with eliminating CHIP.

5. **When do the MOE requirements for Medicaid and CHIP end?**
The Medicaid MOE remains in place for adults until January 1, 2014. (More precisely, the Medicaid MOE for adults continues until the new exchanges are fully operational, which must be accomplished by January 1, 2014). At that time all adults with incomes up to 133 percent of the FPL will be eligible for Medicaid and uninsured adults with incomes above that level will be able to get subsidized coverage in the exchanges. The CHIP MOE and Medicaid MOE for children up to age 19 (or such higher age as a state may have elected) continue until September 30, 2019.

6. **What happens if a state violates the Medicaid or CHIP MOE?**
If a state violates the Medicaid or CHIP MOE, it would forgo all of its federal Medicaid funding, including funding for children, parents, pregnant women, seniors, people with disabilities, and administrative costs. In light of these severe consequences, states have an enormous incentive to comply with the MOE requirements.

7. **How do the health reform MOE requirements relate to ARRA?**
States already must comply with a Medicaid MOE requirement based on the policies that they had in effect on July 1, 2008 to secure the Medicaid fiscal relief provided in ARRA. The ARRA Medicaid MOE is slated to expire on December 31, 2010, along with the Medicaid fiscal relief. (Congress, however, is widely expected to extend these provisions until June 30, 2011.) While there is considerable overlap, the new health reform MOE requirements differ from the ARRA rules in some key respects. Most notably, the health reform MOEs 1) apply to CHIP (not just

Medicaid), 2) apply for a significantly longer period of time, and 3) eliminate all federal Medicaid funding for violations, not just the extra Medicaid fiscal relief included in ARRA.

8. **What is the exception to the Medicaid MOE for states facing budget deficits in 2011?** Staring next year (January 1, 2011), a state that provides Medicaid coverage to adults with incomes above 133 percent of the FPL can scale back eligibility for adults (unless pregnant or disabled) if the state is facing, or projects it will face, a budget deficit. However, if the six-month extension of ARRA is enacted as expected, it will likely include a separate MOE requirement that would keep states from scaling back eligibility for these adults until June 30, 2011, when the six-month extension expires.

9. **Can states still make other kinds of cuts to their Medicaid and CHIP programs?** The MOE requirements do not stop states from cutting Medicaid and CHIP in other ways, such as by reducing provider reimbursement rates or eliminating optional benefits. The experience with the ARRA Medicaid MOE suggests that states may actually turn more heavily to such cuts when they are prevented from scaling back eligibility.

10. **What are the unique issues raised by the CHIP MOE?**
While states have some experience with an MOE requirement in Medicaid because of ARRA (see question 7), the PPACA for the first time creates an MOE requirement for CHIP. CHIP allows states to expand coverage to uninsured children through a Medicaid expansion or a separate state program. Under a separate state program, states historically have had the flexibility to cap or freeze enrollment, and CMS will need to issue guidance as to how the CHIP MOE affects such policies. The statutory language creating the CHIP MOE specifically says that states are not precluded from setting up enrollment caps if they run out of federal CHIP funding, suggesting that Congress was not envisioning other scenarios under which states would be allowed to put caps into effect.

    One key issue CMS will need to consider is how to treat states that have language in their CHIP state plans authorizing an enrollment freeze or cap if they run out of state appropriations, but, on the date of PPACA's enactment did not actually have such a freeze or cap in place. Currently, it is unclear whether CMS will treat these states as having a cap or freeze "in effect."

    As of March 23, 2010, only one state (Arizona) had an enrollment freeze in place. Even if Arizona is allowed to continue with this policy, CMS will need to decide whether the state is expected to maintain its enrollment at March 23, 2010 levels over time. In the absence of such a requirement, Arizona's CHIP program will shrink as children leave due to a change in family income or for a variety of other reasons. While CMS has not previously addressed such a situation in the context of CHIP, it did decide in the context of the ARRA MOE that capped home and community-based waiver programs in Medicaid need to maintain their capacity to serve people over time. Specifically, CMS determined that states could not reduce the number of people served by these waivers below the higher of 1) the number of slots actually being used by people, or 2) the number of slots funded on the effective date of the MOE requirement.

    We will provide additional information on the MOE requirements as CMS guidance becomes available. In the meantime, if you would like to discuss any of these issues, please contact Judy Solomon at 202-408-1080 or Tricia Brooks at 202-365-9148.

FOCUS on Health Reform

THE HENRY J. KAISER FAMILY FOUNDATION

AUGUST 2010

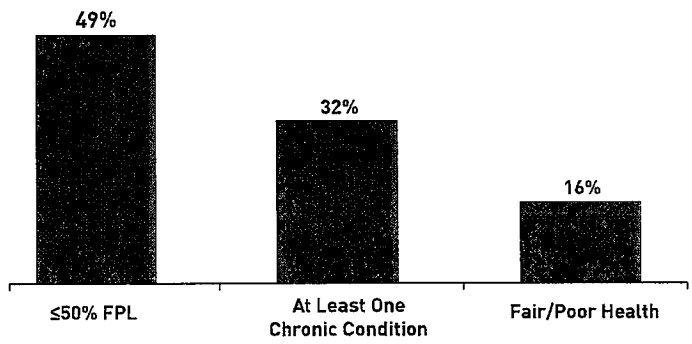
EXPLAINING HEALTH REFORM:
Benefits and Cost-Sharing for Adult Medicaid Beneficiaries

Under the Patient Protection and Affordable Care Act (PPACA; Public Law 111-148), signed into law on March 23, 2010, Medicaid plays a major role in covering more uninsured people. On January 1, 2014, the program will be expanded to provide eligibility to nearly all people under age 65 with income below 133 percent of the federal poverty level (FPL).[1] As a result, millions of low-income adults without children who currently cannot qualify for coverage (except in a handful of states with waivers), as well as many low-income parents and, in some instances, children now covered through the Children's Health Insurance Program (CHIP), will become eligible for Medicaid. In addition, the health reform law is expected to result in more people who already are eligible for Medicaid under current rules learning about and signing up for coverage. In total, Medicaid, along with its smaller companion program, CHIP, is expected to cover an additional 16 million people by 2019.[2]

Many of the people who will be enrolled in Medicaid are very low-income and a substantial number face significant health problems (Figure 1). Half of all uninsured adults below 133 percent FPL have income below 50 percent FPL. When it comes to their health status, about one-third have a diagnosed chronic condition, such as hypertension or depression, and about 1 in 6 are in fair or poor health. The majority of uninsured adults below 133 percent FPL – 69 percent – are adults without dependent children, and 31 percent are parents. In light of the characteristics of these newly-eligible adults, a key question is what kind of coverage they will have. This brief provides the details of the benefit and cost-sharing rules that will govern the coverage available to newly-eligible adult Medicaid beneficiaries. The rules for children in Medicaid are distinctly different; federal law requires states to cover all medically necessary services for children and provides stronger cost-sharing protection to them (Appendix).

Figure 1

Uninsured Adults ≤133% FPL, by Income and Health Characteristics



Note: 100% of the HHS federal poverty level (FPL) was $10,400 for an individual in 2008.
SOURCE: KCMU/Urban Institute analysis of 2009 ASEC Supplement to the CPS (income data). KFF analysis of 2007 Medical Expenditure Panel Survey (health data).

Background

As of January 1, 2014, states are required to provide Medicaid to nearly all people under age 65 with income below 133 percent FPL (about $14,400 for an individual in 2010). From 2014 through 2016, the federal government will finance 100 percent of the cost of those who become eligible for Medicaid due to the expansion. In subsequent years, the federal matching rate will decline somewhat, but it will eventually settle at 90 percent, well above the regular Medicaid matching rates for states. States are required to provide most people who become newly eligible for coverage under the Medicaid expansion with "benchmark" benefits. As discussed below, states also have authority to provide benchmark benefits to certain other groups of Medicaid beneficiaries who qualify under existing rules (i.e., "already-eligible" Medicaid beneficiaries).

Set forth in the Deficit Reduction Act of 2005 (DRA), the concept of benchmark benefits is relatively new to Medicaid. Prior to the DRA, states were required to cover a federally-specified set of services for adult Medicaid enrollees and they had the option to cover additional services. For example, under the traditional rules, adult beneficiaries must be provided with hospital care, physician services, lab and x-ray services, nursing home

care, and family planning services. But states also can cover prescription drugs (which all of them do) and other additional services, such as dental care and vision care, and personal care and other community-based services for people with disabilities.

In the DRA, Congress gave states the option to provide certain groups of Medicaid enrollees with an alternative benefit package (i.e., "benchmark" or "benchmark-equivalent" coverage) based on one of three commercial insurance products or determined to be appropriate by the Secretary of Health and Human Services ("Secretary-approved coverage"). With respect to groups receiving benchmark or benchmark-equivalent coverage, the DRA gave states flexibility to disregard Medicaid's longstanding requirements for "comparability" (i.e., the same coverage must be provided to all categorically eligible Medicaid beneficiaries and cannot vary based on a person's diagnosis, age, or other factors) and "statewideness" (i.e., the state must provide the same scope of services to Medicaid beneficiaries throughout the state, regardless of where they live). States can also disregard other Medicaid requirements, but only if they are "directly contrary" to the flexibility they need to provide benchmark benefits.[3]

To date, states have used the benchmark benefits option sparingly. Since the option's creation in 2005, just ten states have used benchmark benefits for some of their beneficiaries.[4] In most cases, the option was adopted as a means to provide additional services to certain groups of adults with special conditions, for example, to provide disease management services and enhanced access to nurse help lines to people with selected chronic conditions, such as heart disease and diabetes.

In the health reform law, Congress made some changes to the standards for benchmark benefits. Most notably, it added a requirement that benchmark packages provide all "essential health benefits," which are the benefits that must be provided to people signing up for Exchange plans or coverage in the individual or small group insurance market, beginning in 2014. The HHS Secretary is charged with defining "essential health benefits," and, as a result, it may be some time before it is clear how significant a change in benchmark benefit rules the inclusion of essential health benefits will represent. In addition, the health reform law added new requirements that benchmark benefits include family planning services and, in instances where a state relies on "benchmark-equivalent coverage," mental health services and coverage of prescription drugs.

Federal Standards for Benchmark and Benchmark-Equivalent Benefits

As noted above, the health reform law requires states to provide most newly-eligible adult Medicaid beneficiaries with benchmark or benchmark-equivalent coverage. The major federal rules governing benchmark coverage include:

- **Coverage of essential health benefits.** Benchmark and benchmark-equivalent coverage must include "essential health benefits." These essential health benefits, which will be outlined in more detail by the Secretary of Health and Human Services in the years ahead, also form the basis for the coverage that will be provided to people enrolled in Exchange plans and the individual and small group insurance markets. The specific categories of service that the essential health benefits must include are:
    - Ambulatory patient services;
    - Emergency services;
    - Hospitalization;
    - Maternity and newborn care;
    - Mental health and substance use disorder services, including behavioral health treatment;
    - Prescription drugs;
    - Rehabilitative and habilitative services and devices;
    - Laboratory services;
    - Preventive and wellness services and chronic disease management; and
    - Pediatric services, including oral and vision care.

In providing more detail on these services, the HHS Secretary must ensure that the scope of the essential health benefits is equal to the scope of benefits provided under a typical employer plan. It is not yet clear to what extent the federal rules will address the amount, duration and scope of benefits that must be provided.

- **Coverage must consist of "benchmark" or "benchmark-equivalent" benefits.** In addition to providing essential health benefits, the coverage must be equal to the coverage provided in one of three benchmarks, equivalent in actuarial value to one of the three benchmarks, or a package approved by the Secretary:[5]
  - **Blue Cross/Blue Shield plan.** The standard Blue Cross/Blue Shield preferred provider option plan under the Federal Employee Health Benefits Plan (FEHBP);
  - **State employee plan.** Any state employee plan generally available in a state;
  - **Commercial HMO product.** The HMO plan in a state that has the largest commercial, non-Medicaid enrollment in the state; or
  - **Secretary-approved coverage.** Any plan that the HHS Secretary determines is appropriate for the people who will be covered by it. HHS recently has indicated that it will consider the full Medicaid benefit package to be an appropriate plan under the Secretary-approved coverage option.[6]

States also can provide additional benefits on top of what is included in a benchmark-equivalent plan as long as the services are included in the benchmark plan or could be covered under "regular" Medicaid.[7] For example, a state could decide to provide additional disease management services, care coordination, or therapies.

- **Additional Medicaid requirements.** Benchmark and benchmark-equivalent coverage must meet other Medicaid requirements, including requirements to cover transportation services, family planning services, and care provided by rural health clinics and federally qualified health centers. Also, such coverage, if it is provided through managed care entities, must comply with Medicaid managed care requirements. In addition, states must secure public input prior to filing a proposal with HHS to use benchmark or benchmark-equivalent coverage.[8]

Groups Exempt from Benchmark Coverage

The DRA identified a number of groups of people who cannot be required to enroll in benchmark benefits. In the health reform law, Congress explicitly carried these "exemptions" over, applying them also to those newly eligible for Medicaid due to the expansion to 133 percent FPL. The following groups of beneficiaries – including those eligible under traditional Medicaid rules and those eligible under the new expansion to 133 percent FPL – are exempt from mandatory enrollment in benchmark coverage and, instead, must be offered the traditional, full Medicaid benefit package:[9]

- **People with disabilities.** People who qualify for Medicaid because they are blind or disabled, as well as people who are receiving certain long-term care services.
- **Dual eligibles.** People who are enrolled in both Medicaid and Medicare.
- **Medically frail.** People who are medically frail or who otherwise have special medical needs. HHS' final rule on benchmark benefits clarified that a state's definition of who is medically frail must, at a minimum, include people with "serious and complex medical conditions" and people with "physical and/or mental disabilities that significantly impair their ability to perform one or more activities of daily living." A state, however, also could define medically frail more broadly.[10]
- **Certain low-income parents.** Parents or caretaker relatives whom a state is required to cover under federal minimum Medicaid standards (i.e., "Section 1931 parents"). The federal minimum standard for parent coverage varies across states from a low of 17 percent FPL to a high of more than 133 percent FPL; the median is 64 percent FPL for a working parent.[11]
- **Other special groups.** Others whom states cannot require to enroll in benchmark coverage include pregnant women, women who qualify for Medicaid because of breast or cervical cancer, children in foster care or receiving adoption assistance, the medically needy, and individuals receiving only emergency services.

Given that significant health care conditions are relatively prevalent among the low-income adults who will become eligible for Medicaid under the expansion to 133 percent FPL, a considerable share of this population can be expected to be exempt from mandatory enrollment in benchmark coverage.

Premiums, Deductibles, and Cost-Sharing for Adults

The rules governing how much states can charge newly-eligible adult Medicaid beneficiaries for coverage and services are complex and they vary depending on a beneficiary's income and the service that is being used. In general, though, states are strictly limited in the premiums, deductibles, and cost-sharing amounts that they can charge adult Medicaid beneficiaries, with particularly strong rules for those below 100 percent FPL.[12] For adults in this lowest income range, states cannot charge more than a nominal amount for most services, nor can they impose premiums or any charge for emergency services or family planning services. At state option, adults with more income can face somewhat higher cost-sharing charges – for most services, up to 10 percent of the cost of the service for those with income between 100 percent and 150 percent FPL, and up to 20 percent for those with income above 150 percent FPL. Adults cannot be charged premiums until their income reaches 150 percent FPL. In addition, states must ensure that the total cost of Medicaid premiums, deductibles, and cost-sharing charges for a family in a year does not exceed 5 percent of the family's income.

MEDICAID PREMIUM AND COST-SHARING STANDARDS FOR ADULTS

	≤100% FPL	101%–150% FPL	>150% FPL
Premiums	*Not allowed*	*Not allowed*	*Allowed*
Cost-Sharing (may include deductibles, copayments, or coinsurance) "Nominal" is defined as up to $2.30[1] deductible per month per family, up to $3.40[1] copayment, or up to 5% coinsurance.			
Most services[2]	*Nominal*	*Up to 10% of the cost of the service or a nominal charge*	*Up to 20% of the cost of the service or a nominal charge*
Prescription drugs			
• **Preferred**	*Nominal*	*Nominal*	*Nominal*
• **Non-preferred**	*Nominal*	*Nominal*	*Up to 20% of the cost of the drug*
Non-emergency use of emergency department	*Nominal*	*Up to twice the nominal amount*	*No limit, but 5% family cap applies*
Preventive services	*Nominal*	*Up to 10% of the cost of the service or a nominal charge*	*Up to 20% of the cost of the service or a nominal charge*
Cap on total premiums, deductibles, and cost-sharing charges for all family members	*5% of family income*		
Service may be denied for non-payment of cost-sharing	*No*	*Yes*	*Yes*

NOTE: Some groups of adults are exempt from premiums, deductibles, and most cost-sharing charges described in this table. They include pregnant women (except that those above 150 percent FPL can be charged very modest premiums), terminally ill individuals receiving hospice care, institutionalized spend-down individuals, breast and cervical cancer patients, and Indians who receive services from Indian health care providers. These groups can be charged cost-sharing for non-emergency use of an emergency department and for use of a non-preferred prescription drug.

[1] $2.30 and $3.40 are the "nominal" amounts for federal fiscal year 2009 – the latest available from HHS. They will be adjusted over time to reflect inflation in medical care costs.

[2] Cost-sharing of any kind is prohibited for some services, including emergency services and family planning services.

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Policy Implications

Under the health reform law, states will have considerable flexibility within federal guidelines to design Medicaid benefit packages and cost-sharing rules that are appropriate for newly-eligible adult beneficiaries. The often-extensive health care needs and very low income of the newly-eligible adults are important considerations for states to take into account in making their design choices. The available federal financing is another important factor for states to weigh. The federal government will finance the full cost of care for newly-eligible Medicaid adults for the first three years of reform, and at least 90 percent of the cost thereafter. The matching rate is lower for other, already-eligible populations, but the federal government will still pick up at least 50 percent – and in most cases, more – of the cost of providing them with benefits.[13]

Beyond the question of benefits for the newly-eligible population in particular, the broader issue for states is how to create a coherent Medicaid program that provides the full range of groups served by the program with the benefits that they need when they need them. Many people are likely to experiences changes in their circumstances that move them in and out of "exempt" status. For example, individuals who are mandatorily enrolled in benchmark or benchmark-equivalent coverage could become exempt if they become pregnant, develop a medical condition that causes them to be classified as "medically frail," qualify for Medicare, or experience a drop in income that puts them below pre-reform federal minimum eligibility standards. Given that such changes in income, health status, and other factors are common, coordination and consistency of coverage between groups and over time are key aims. Because individuals may also shift between eligibility for Medicaid and Exchange coverage, identifying ways in which states can promote continuity of care between the two systems is a priority.

As state policymakers decide their direction regarding benefits for newly-eligible Medicaid adults, two major options available to them are:

- **Provide the traditional, full Medicaid package.** While HHS has yet to issue guidance on Medicaid benefits in the context of the health reform law, its recent final rule on benchmark coverage suggests that states will be able to provide newly-eligible adults with the traditional, full Medicaid benefit package.[14] Given the newly-eligible population's low income and health profile, states that have established a Medicaid package for already-eligible adults that is well-designed to meet their needs may decide that they should use the same package for newly-eligible adults. Also, because states must continue to provide full Medicaid benefits to many adults (both already-eligible and newly-eligible) who belong to the groups exempt from mandatory benchmark coverage, this option may be attractive to states seeking to run a streamlined and simplified Medicaid program that does not require them to track beneficiaries in order to capture changes in exempt status.
- **Provide a benchmark benefit package with essential health benefits.** States can elect to use a benchmark benefit package (or benchmark-equivalent package) based on one of three commercial products or an appropriate package under the Secretary-approved coverage option, as long as it covers essential health benefits and complies with other Medicaid requirements. States that rely on a benchmark benefit package (or benchmark-equivalent package) may consider adding services that are tailored to the specific health care needs of low-income adult Medicaid beneficiaries, such as additional mental health services, support for managing chronic conditions, or assistance in care coordination.

Along with making decisions about the benefit package for newly-eligible adults in Medicaid, states will need to explore using delivery systems that are coordinated or even overlapping with those used in Exchange plans while ensuring, at the same time, that beneficiaries retain access to vital, Medicaid-specific services, such as transportation and, in some cases, more extensive help with chronic conditions, serious health issues, and care coordination.

Conclusion

The content of the coverage provided to the millions of low-income adults slated to secure Medicaid coverage under the health reform law will depend, in part, on how the federal government addresses key issues, such as the definition of "essential health benefits." Most importantly, it will depend on the decisions of state policymakers in the months and years ahead. In light of the limited income and often extensive health care needs of newly-eligible adult Medicaid beneficiaries, it will be critical that they be provided with benefits designed to reflect their unique needs if health reform is to work as intended.

APPENDIX: Federal Rules Regarding Benefits for Children in Medicaid

The health reform law is expected to make some children newly-eligible for Medicaid. In particular, children ages 6 to 19 in separate CHIP programs with income between 100 percent and 133 percent FPL will move into Medicaid when the major Medicaid expansion takes place on January 1, 2014.

Like other children in Medicaid, those who become newly eligible for Medicaid must be provided with the "EPSDT" benefit, which federal Medicaid rules have long required for children. EPSDT – Early and Periodic Screening, Diagnosis, and Treatment – is designed to cover all medically necessary care for children, in recognition of their unique developmental needs. Under EPSDT, states must fully cover preventive and primary care, including dental, hearing, and vision care, as well as all acute care needs. Further, the EPSDT benefit extends beyond acute care to address long-term care needs, including therapies, medical equipment and other support services that are particularly important for children with special health care needs.

States can provide children in Medicaid with benchmark benefits, but, if they do so, they must supplement the coverage as needed to ensure the child receives the full EPSDT benefit. Technically, states are required to provide benchmark coverage to children who move from separate CHIP plans into Medicaid following the expansion of Medicaid eligibility to 133 percent FPL. However, as a practical matter, the law appears to give states broad flexibility to decide the best way to ensure that Medicaid children receive the EPSDT benefit. Thus, states can opt to use a benchmark issuer (e.g., a state employee plan) to provide coverage and then supplement it as needed. Alternatively, it appears that states can rely on the same delivery system they use for other children to provide benchmark benefits and any supplemental services needed to reach an EPSDT level of coverage.

MEDICAID PREMIUM AND COST-SHARING STANDARDS FOR CHILDREN

	"Mandatory Children"[1]	Other children ≤150% FPL	Children >150% FPL
Premiums	*Not allowed*	*Not allowed*	*Allowed; may vary by group*
Cost-Sharing (may include deductibles, copayments, or coinsurance) "Nominal" is defined as up to $2.30[2] deductible per month per family, up to $3.40[2] copayment, or up to 5% coinsurance.			
Most services[3]	*Not allowed*	*Up to 10% of the cost of the service*	*Up to 20% of the cost of the service*
Prescription drugs			
• **Preferred**	*Not allowed*	*Not allowed*	*Nominal*
• **Non-preferred**	*Nominal*	*Nominal*	*Up to 20% of the cost of the drug*
Non-emergency use of emergency department	*Nominal*	*Up to twice the nominal amount*	*No limit*
Preventive services	*Not allowed*		
Cap on total premium and cost-sharing charges for all family members	*5% of family income*		
Service may be denied for non-payment of cost-sharing	*No*	*Yes*	*Yes*

Note: Indian children who receive services from Indian health care providers, as well as children in foster care or adoption assistance programs, are exempt from all premiums and cost-sharing charges except those for non-preferred prescription drugs and non-emergency use of the emergency department. Disabled children who qualify for coverage under the Family Opportunity Act option are exempt from cost-sharing charges, but can be charged certain premiums.

[1] "Mandatory children" are those whom the federal government requires states to cover in Medicaid, including children ages 0-5 with family income below 133 percent of FPL and ages 6-18 with family income below 100 percent of FPL. Starting in 2014, under the Affordable Care Act, children of all ages with family income up to 133 percent of FPL will be "mandatory children."

[2] $2.30 and $3.40 are the "nominal" amounts for federal fiscal year 2009 – the latest available from HHS. They will be adjusted over time to reflect inflation in medical care costs.

[3] Cost-sharing of any kind is prohibited for some services, including emergency services and family planning services.

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[1] As under prior law, undocumented immigrants will remain ineligible for Medicaid and CHIP, and only certain legal immigrants can secure coverage.

[2] Congressional Budget Office, "H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation)," March 20, 2010.

[3] Prior to technical corrections included in the Children's Health Insurance Program Reauthorization Act (P.L. 111-3), the DRA could have been read as giving states broader flexibility to disregard even those Medicaid requirements not directly in contravention of benchmark benefits. As a result of the technical corrections, CMS stated in its final rule on benchmark benefits, issued on April 30, 2010 (Federal Register, Vol. 75, No. 83), that states still must comply with any Medicaid requirement not directly contrary to benchmark benefit flexibilities, including Medicaid managed care regulations and the requirement to provide transportation services.

[4] See page 23076, Federal Register, Vol. 75, No. 83, April 30, 2010.

[5] If a state uses a benchmark-equivalent package, it must submit an actuarial report that attests that the coverage has an aggregate actuarial value equivalent to the benchmark. In making such an assessment, the actuary may take into account the state's ability to reduce benefits to reflect the increase in actuarial value created by using Medicaid cost-sharing rules rather than the benchmark's rules. In addition, the benchmark-equivalent package must include coverage for inpatient and outpatient hospital services, physician services, laboratory and x-ray services, well-baby and well-child care (including immunizations), emergency services, other appropriate preventive services, and, as a result of changes included in the health reform law, family planning services, prescription drugs and mental health services. To the extent the benchmark includes vision and hearing services, the equivalent package also must provide these services and ensure they have an actuarial value equal to at least 75 percent of vision and hearing services in the benchmark.

[6] 42 CFR 440.330(d).

[7] Specifically, states can provide additional services if they use the option to provide benchmark-equivalent coverage, as long as the services could be covered under regular Medicaid rules or are included in the benchmark package. See page 23086, Federal Register, Volume 75, Number 83, April 30, 2010 for a discussion of this issue and 42 CFR 440.335 for the regulatory language.

[8] The basis for the application of these additional requirements varies. For example, the DRA requires that beneficiaries continue to have access to federally-qualified health centers and rural health centers (as has long been required under Medicaid law). In light of technical corrections included in Section 611 of CHIPRA (Public Law 111-3), CMS more recently clarified in its final rule on benchmark benefits, published April 30, 2010, that states are required to provide transportation services and to comply with Medicaid managed care regulations. Finally, the requirements to provide family planning services and comply with mental health parity requirements were included in Sections 2001 and Section 2302, respectively, of the Affordable Care Act (Public Law 111-148), although CMS notes that the family planning services would have been required in benchmark-equivalent plans even without the statutory change because of the existing requirement to provide "appropriate preventive services."

[9] At their option, exempt individuals can choose to sign up for benchmark benefits. They must be informed of any differences between the benefits or cost of coverage under the benchmark benefit package (or equivalent) and a state's standard full Medicaid benefit, be given ample time to arrive at an informed choice, and voluntarily and affirmatively choose to enroll in the benchmark package. Once enrolled, an exempt individual can disenroll from benchmark coverage at any time and must be "promptly" moved into the standard full Medicaid benefit. While the disenrollment request is being processed, exempt individuals must be able to secure all standard Medicaid services.

[10] 42 CFR 440.315(f).

[11] Ross et al. *A Foundation for Health Reform: Findings of a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP for Children and Parents During 2009*, Kaiser Commission on Medicaid and the Uninsured, December 2009.

[12] A large body of research indicates that Medicaid beneficiaries otherwise are at high risk of going without needed care. See, for example, Hudman and O'Malley, *Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations*, Kaiser Commission on Medicaid and the Uninsured, March 2003.

[13] Heberlein et al, *Financing New Medicaid Coverage under Health Reform: The Role of the Federal Government and States*, Kaiser Commission on Medicaid and the Uninsured, June 2010.

[14] See 42 CFR Part 440.330(d), which states that "the scope of a Secretary-approved health benefits package will be limited to benefits within the scope of the categories available under a benchmark coverage package or *the standard full Medicaid coverage package under section 1905(a) of the Act*" (emphasis added). In addition 42 CFR Part 440.360 clarifies that states can cover additional services for people enrolled in benchmark or benchmark equivalent plans if the services are within the scope of what is normally allowed under Medicaid. This option also appears to give states the choice to provide a traditional, full Medicaid benefit package.

This brief was prepared by Jocelyn Guyer of Georgetown University's Center for Children and Families and Julia Paradise of the Kaiser Family Foundation's Commission on Medicaid and the Uninsured. The authors wish to thank Judith Solomon of the Center on Budget and Policy Priorities for her review.

This publication (#8092) is available on the Kaiser Family Foundation's website at www.kff.org.

Senate Confirmation Information Summary

Prepared and Submitted by the Office of Governor Sam Brownback

Appointee: Dennis Taylor

Position: Secretary of Administration

Expiration Date: N/A

Term Length: POG

Statutory Authority: K.S.A.75-3702a

Party Affiliation: R

- Statutory geographic representation Requirements (insert any that apply)

Congressional District: 2

County: Shawnee County

Size Requirement (*if any*):

Other, specify:

- Statutory party affiliation requirement: N/A
- Statutory industry or occupation requirements: N/A

Salary: 110,000

Predecessor: Duane Goosen

Board Composition Prior to Confirmation of New Appointee:

Duane Goossen, Secretary of Administration

Carol Foreman, Deputy Secretary of Administration

Patrick Hurley, Chief Attorney

Marilyn Jacobson, Chief Financial Officer

Kent E. Olson, Director of Accounts and Reports

Denise Moore, Director of Information Systems and Communications

Marilyn Jacobson, Director of Facilities Management and Printing

Chris Howe, Director of Purchases

George Vega, Director of Personnel Services

Duane Goossen, Director of the Budget

Senate Ways and Means
Date: 01/31/11
Attachment: 3

DENNIS TAYLOR

3934 S.W. Wanamaker Road, Topeka, Kansas 66610 (785) 478-0881

Professional Experience

STATE GOVERNMENT MANAGEMENT (1983-1999)

New Mexico Department of Children, Youth, and Families, Santa Fe, New Mexico
Juvenile Justice Division Director.

- Directed staff in management and operation of 10 correctional institutions and 33 probation and parole offices.
- Developed division's legislative proposals and worked with interest group coalitions.
- Testified before legislative committees.
- Collaborated with county governments in the development and administration of intergovernmental service agreements.

Kansas Legislature, Topeka, Kansas
Chief of Staff to the President of the Kansas Senate.

- Directed the work of staff providing legislative research, constituent services, scheduling, media relations, legislative session management and special projects in support of a 40- member legislative body composed of members from both political parties.

Kansas Department of Social and Rehabilitation Services, Topeka, Kansas
Cabinet Secretary.

- Directed programs in the areas of foster care, child protective services, mental health, vocational rehabilitation, substance abuse, Medicaid, institutional and community-based long term care, income maintenance, child support enforcement, and employment preparation services.
- Supervised more than 8,000 FTE in 106 offices statewide.
- Developed legislative agenda, in collaboration with the Governor, other cabinet agencies, and non-governmental stakeholders.
- Testified before the relevant legislative committees in support of agency and administration initiatives, and worked with citizens and interest groups to enact positive changes on behalf of those in need of services.

Office of the Governor of Kansas, Topeka, Kansas
Chief of Staff to the Governor.

- Directed the work of the Governor's staff including management of two constituent services field offices, and supervised functions including media relations, constituent services, legislative liaison, appointments, scheduling, legal counsel, and special assistants for health, education, environment, and substance abuse.

Kansas Department of Human Resources (now Department of Labor), Topeka, Kansas
Cabinet Secretary.

- Directed programs including worker's compensation, unemployment insurance, job service, occupational safety and health, disability concerns, and public employee relations matters.
- Supervised 850 FTE in 34 offices statewide.
- Worked closely with organized labor and state chamber of commerce on legislation.

LOCAL GOVERNMENT MANAGEMENT (1979-1997) and (2008-present)

City of Topeka, Kansas
Performance Management Coordinator

- Reports directly to the City Manager
- Coordinates the development of City-wide and departmental strategic plans
- Designs and coordinates implementation of a performance management system
- Promotes organizational change for efficiency and effectiveness
- Coordinates negotiations with seven (7) separate collective bargaining units
- Assists the City Manager with special projects including as interim department dirctor

Topeka-Shawnee County Metropolitan Planning Commission, Topeka, Kansas
Director.

- Directed a joint city-county agency that staffed an intergovernmental planning commission, commission subcommittees, and special task forces on human services, capital improvements, transportation, public transit, economic development, neighborhood revitalization, and down-zoning.
- Conducted public hearings and initiated and monitored implementation of local regulatory framework.

County of Shawnee, Topeka, Kansas
County Auditor and Financial Administrator.

- Directed financial management operations including managrement of investment portfolio and preparation of annual county budget for approval by elected board of county commissioners composed of members of both political parties.

County of Jackson, Kansas City, Missouri
County Manager of Operations (Assistant County Manager).

- Directed the work of 750 FTE in six departments: corrections, parks and recreation, public works, purchasing, environmental health, and planning and economic development (served as county's director of planning and economic development).
- Directed the preparation of strategic plans and budgets, including revenue and expenditure projections.
- Presented information to County Legislature and its various committees.
- Represented management in labor negotiations.

County of Shawnee, Topeka, Kansas
Member, Board of County Commissioners

- Served one four-year term as full-time elected member of three-person board of county commissioners in full-service county without a professional county manager. Chose not to run for re-election.
- Direct reports included directors of departments of corrections, public works, planning, environmental health, refuse, and parks and recreation.
- Initiated successful consolidation of county mental health operations that improved services. Served as vice-chairman of county mental health center board. Awarded Mental Health Center Advocate of the Year, 1982.
- Proposed successful reorganization of operations of jail, juvenile justice center, work release program, and community corrections program under first-ever professional county corrections department.

INTERNATIONAL DEVELOPMENT MANAGEMENT AND CONSULTING (1994-2007)

ICMA International, Washington, D.C.
Director.

- Worked with U.S. ambassadors, USAID officials, World Bank, Asian Development Bank, and others in support of democratic reform throughout the world including creation of policies and implementation of programs to improve the transparency, financial viability and stability, and management of local and regional governments.
- Directed a home office staff of 20 and over 100 worldwide providing consulting and training services to local governments and their officials on behalf of the largest division of ICMA (International City/County Management Association)

Development Alternatives, Inc., Bethesda, Maryland
Principal Development Specialist.

- Collaborated with U.S. embassies and USAID missions in support of American foreign policy objectives in Southeastern Europe.
- Served as Chief of Party (Project Director) for USAID-funded local governance democratic reform project in Romania.
- Served as Acting Deputy Chief of Party (Project Director) for USAID-funded local governance project in Serbia.
- Performed numerous short-term (3 weeks to 5 months) international development assignments primarily in the areas of performance measurement and management, budget and finance, and economic development strategic planning, assisting regional and local governments in Serbia, Macedonia, and Romania.

Chemonics International, Inc., Warsaw, Poland
Chief of Party (Director) of USAID-funded Local Government Partnership Program (LGPP)

- Collaborated with U.S. government representatives and Polish government counterparts in improving the governance capabilities of Polish local and regional governments.

- Directed the delivery of technical assistance and training program in partnership with over 150 cities in Poland.
- Performed institutional and organizational assessments, including review of organizational structure, departmental roles and responsibilities, and staffing.
- Directed staff in the development of strategies and plans (including projected timetables, assignment of responsibilities, and costs) in partnership with municipalities and non-governmental organizations in the areas of financial management (program budgeting, project financial analysis, creditworthiness assessment, and capital investment planning development), strategic planning and management, municipal services management, infrastructure finance, housing, health and human services, economic development, and public participation.
- Developed rigorous financial management certification program that trained Polish professional consultants to assist local governments in financial analysis, revenue and expenditure forecasting, creditworthiness assessment, and capital investment planning.

United States Agency for International Development (USAID), Warsaw, Poland
Regional Public Administration Advisor.

- In cooperation with U.S. Ambassadors in Estonia, Latvia, Lithuania, Hungary, and the Czech Republic developed the Central and Eastern European Public Administration Assistance Program.
- Directed assistance to counterpart governments on a wide range of local government issues including budget and finance, health and human services, planning, and citizen participation.
- Served as Special Assistant to the President Lennart Meri of Estonia.

LAW (1974-1983) and (2001-2003)

Dennis Taylor & Associates, Topeka, Kansas
Principal.

- Provided legal services to individual, non-profit, and state and local governments in the areas of mediation and conflict resolution and employment, administrative, and land use law.
- Serveed as Fact-Finder for the Kansas Public Employee Relations Board as requested by parties to public employment contract disputes.
- Consulted with local, state, and regional governments in the United States and in countries throughout the world in the areas of local government law, organization and management, strategic planning, financial administration, and community planning and development.

Fisher, Patterson, Sayler, and Smith, Topeka, Kansas
Attorney.

- Associate in litigation practice, including personal injury, products liability, medical malpractice, worker's compensation, employment, and administrative law.
- Consulted with local governments' risk management programs as counsel for insurance carriers contracted by insured local governments.
- Presented oral arguments in appellate cases before the Kansas Court of Appeals,

Kansas Supreme Court, and U.S. Court of Appeals.

Supreme Court of Kansas, Topeka, Kansas
Research Attorney.

- Researched and wrote draft Supreme Court opinions for Justices John F. Fontron and Robert H. Miller.

Education

Master of Laws (LL. M.), Urban Affairs, University of Missouri, Kansas City School of Law, Kansas City, Missouri, 1978
Doctor of Jurisprudence (J.D.), Drake University Law School, Des Moines, Iowa, 1974
Master of Public Administration, (M.P.A.), University of Kansas, Lawrence, Kansas, 1982
Certificate of Advanced Study, American Graduate School of International Management (Thunderbird), Glendale, Arizona, 1994
Bachelor of Science, Business Administration, (B.S.B.A.), Drake University, Des Moines, Iowa, 1971

Teaching Experience

Adjunct Instrcutor of Political Science, Washburn University, Topeka, Kansas
Adjunct Assistant Professor of Business Law, Washburn University School of Business, Topeka, Kansas
Adjunct Instructor of Environmental Law, Washburn University School of Law, Topeka, Kansas

Awards

Public Administrator of the Year , Kansas Chapter of the American Society of Public Administration, 1989.
Advocate of the Year, Shawnee Community Mental Health Center, Inc., 1982

Country Experience

Afghanistan, Albania, Bolivia, Bulgaria, Czech Republic, Estonia, Hungary, Indonesia, Latvia, Lithuania, Macedonia, Montenegro, Poland, Romania, Serbia, and South Africa.

Member of the Bar

Iowa, 1974
Kansas, 1974
Missouri, 1983

Kansas
Senate

CONFIRMATION OVERSIGHT COMMITTEE

APPOINTMENT QUESTIONNAIRE

Full Name: Dennis Reed Taylor
(please include title and middle name along with any names previously used)

Home Address: 3934 S.W. Wanamaker Road (Street Address) Topeka, Kansas 66610 (City, State, Zip)

Driver's License Number: [redacted] Social Security Number: [redacted]

Position to which Appointed: Secretary of Administration

Appointing Authority: Governor

* Information on this page will not be made public but is used by the KBI and Department of Revenue.

(for Committee use only)
KBI Check: N/A___ In-Process___ Complete___
DOR Check: N/A___ In-Process___ Complete___

This Questionnaire is to be fully completed by each appointee appearing before the Senate Confirmation Oversight Committee (Committee) and returned to the Committee Chairman's Office. A meeting of the Committee to consider an appointee will not be scheduled until a completed questionnaire and other forms are received by the Chairman. Please answer each question completely to the best of your knowledge. Should a question not be applicable, please so state. Hand-written responses are strongly discouraged. If filling out this form electronically, "☐" should be replaced with "X" by the appropriate response on the form. Please contact your appointing authority if you have questions when completing the form.

Full Name: Mr. Dennis Reed Taylor
(please include title and middle name along with any names previously used)

Position to which Appointed: Secretary of Administration

Appointing Authority: Governor

Home Address: 3934 S.W. Wanamaker Road (Street Address) Topeka, Kansas 66610 (City, State, Zip)

Business Name: City of Topeka

Business Address: 620 S.E Madison (Street Address) Topeka, Kansas 66607 (City, State, Zip)

Position Title: Performance Management Coordinator

Home Phone: (785) 478-0881 Business Phone: (785) 368-1640 Cell Phone: (785) 845-7616

Fax Number: N/A E-Mail Address: poland@mindspring.com

Kansas resident? ☒Yes / ☐No Date of Birth: 09-17-1949 Place of Birth: Topeka, Kansas

Registered Voter? Yes Party Affiliation: Republican

Congressional District: Second Kansas Senate District: 20th Kansas Representative District: 54th

Do you have the legal right to live and work in the United States? ☒Yes / ☐No

Please answer the following questions numbered 1 – 43. Each question MUST BE ANSWERED ON THIS ORIGINAL FORM. If the answers the question are provided on your resume, please state "See Resume" or if you supply additional attachment(s) with answers, please state "See Attachment(s)" on this form.

1. What is your educational background? See Resume

2. Describe your employment experience. Include any expertise related to the position to which you were appointed. See Resume

3. List any professional licenses that you have obtained and include the number for each license.
Missouri 33422 Iowa 5485 Kansas 08459

4. Why do you feel you are a good candidate for the position to which you have been appointed?
1. Education in business, public administration, law. 30 years of public management experience.

5. What do you see as the purpose or mission of the role to which you have been appointed?
To provide leadership of the Department of Administration.

6. **Military Service**: List rank, date and type of discharge from active service.
☒None

7. **Government Experience**: List any experience or association with local, state or federal government (exclusive of elective public office but including advisory, consulting, honorary, appointed or other part-time service or positions) and include dates of service.
☐None See Resume

8. **Elective Public Office**: List all elective public offices sought and/or held with dates of service.
☐None Shawnee County Commissioner, sought 1978 and 1992, elected 1978, served 1979-83

United States Representative, sought 1982

9. **Campaigns**: Have you ever played a role or held a position in a political campaign? If so, please identify the candidate(s), the dates of the campaign and describe your involvement.
☐No ☒Yes
Ron Hein for Congress, 1978, campaign manager

10. **Honors and Awards**: List all scholarships, fellowships, honorary degrees, honorary society memberships and any other special recognition for outstanding service or achievements.
☐None Public Administrator of the year, Kansas Chapter, ASPA, 1990

Advocate of the Year, Shawnee Community Mental Health Center, 1982
Omicron Delta Kappa, 1971, Who's Who Among Students in American Universities, 1970

11. **Organization Affiliations**: List all civic, cultural, educational, charitable, or work-related organizations that you have been associated with in the past ten years. Include any position held in the organization and the dates of service.
☐None United Way, Let's Help, Washburn University, Heartland Visioning, Boy Scout of America, Topeka Community Foundation

12. **Organization Restrictions**: To your knowledge, is any organization listed above restricted on the basis of race, color, religion, sex, national origin, disability, marital status or veteran status? If so, please describe.
☒No ☐Yes

13. **Issues**: Have you ever been publicly identified, in person or by organizational membership, with a particularly controversial national or local issue? If so, please describe.
☒No ☐Yes

14. **Submission of Views**: Have you ever submitted oral or written views to any governmental authority, whether executive or legislative, or to the news media on any particularly controversial issue other than in an official governmental capacity? If so, please describe.
☒No ☐Yes

15. **Associations**: Have you ever had any association with any person, group or business venture that could be used, even unfairly, to impugn or attack your character and qualifications for the position to which you seek to be appointed? If so, please describe.
☒No ☐Yes

16. **Opposition**: Do you know of any person or group who might take overt or covert steps to attack, even unfairly, your appointment? If so, please identify and explain the basis for the potential attack.
☐No ☒Yes Past political adversaries and former employees. Retaliation for electoral successes or terminations of employment

17. **Miscellaneous**: List any factors, other than the information provided above, which particularly qualifies you or is relevant to the position to which you are seeking appointment? Include any special skills.
☒None

18. **Relationship to Governmental Employees**: Are you or your spouse or other close family members related to any state governmental official or employee? If so, please provide details.
☒No ☐Yes

19. **Compensation**: During the past five years, have you or your spouse or other close family members received any compensation or been involved in any financial transaction with the State of Kansas? If so, please explain.
☐No ☒Yes Selected by labor and management to be PERB Fact-Finder in 5 cases between 2002 and 2008. Total compensation assessed to the parties of approximately $4,000 per fact-finding assignment.

20. **Business Relationships**: Describe any business relationship, dealing or financial transaction which you have had during the last five years, whether for yourself, on behalf of a client or acting as an agent, which you believe may constitute an appearance of impropriety or result in a potential conflict of interest in the position to which you want to be appointed. If none, please so state.
☒None

21. **Transactions with Officials**: During the past five years, have you or your spouse or other close family members received any compensation or been involved in any financial transaction with any state government official? If so, please explain.
☒No ☐Yes

22. **Spouse or Other Family Members**: If the nature of employment for your spouse or other close family member is related in any way to the position to which you have been appointed, please indicate the employer, the position and the length of time it has been held. If not, please so state.
☒No ☐Yes

23. **Lobbying Activities**: Describe any lobbying activity during the past ten years in which you and/or your spouse have engaged for the purpose of influencing the passage, defeat or modification of any legislative or administrative action. Lobbying activity includes any activity performed as an individual or agent of another individual, or of any organization that involves direct communication with an official in the executive branch of state government or any official of the legislative branch. If none, please so state.
☒None

24. **Regulated Activities**: Describe any interest that you, your spouse or other close family member may have (whether as an officer, owner, director, trustee, or partner) in any corporation, firm, partnership or other business enterprise and any non-profit organization or other institution that is regulated by or receives direct financial benefits from any department or agency of the State of Kansas. If none, please so state.
☒None

25. **Other**: Please describe any other matter in which you are involved that is or may be incompatible or in conflict with the discharge of the duties of the position to which you have been appointed or which may impair or tend to impair your independence of judgment or action in the performance of the duties of that position. If none, please so state.
☒None

26. **Conflict of Interest**: How would you resolve any potential conflicts of interest that, while maybe unforeseen at this point in time, could arise? By eliminating the potential conflict through divestiture of assets or by recusal from responsibility for decision.

27. **Citations**: Have you ever been cited for a breach of ethics for unprofessional conduct, or been named in a complaint to any court, administrative agency, professional association, disciplinary committee, or other professional group? If so, please provide details.
☒No ☐Yes

28. **Convictions**: Have you ever been convicted of or entered a plea of guilty or nolo contendere or forfeited collateral for any criminal violation other than a traffic infraction? (Please include any offenses of driving under the influence, operating while impaired, reckless driving, or the equivalent offenses in other states.) If so, please explain.
☒No ☐Yes

29. **U.S. Military Convictions**: Have you ever been convicted by any military court? If so, please provide details.
☒No ☐Yes

30. **Imprisonment**: Have you ever been imprisoned, been on probation or been on parole? If so, please provide details.
☒No ☐Yes

31. **Agency Proceedings/Civil Litigation**: Are you presently, or have you ever been, a party in interest in any administrative agency proceeding or civil litigation that is related in any way to the position to which you are seeking appointment? If so, please provide details.
☒No ☐Yes

32. **Agency Proceedings and Civil Litigation of Affiliates and Family**: a.) Is your spouse or other close family member currently, or ever been, a party in interest in any administrative agency proceeding or civil litigation that is related in any way to the position to which you are seeking appointment? If so, please provide details.
☒No ☐Yes

b.) Has any business in which you, your spouse, close family member or business associate are or were an officer, director or partner been a party to any administrative agency proceeding or civil litigation relevant to the position to which you are seeking appointment? If so, please provide details. (With respect to this question, you need only consider proceedings and litigation that occurred while you, your spouse, close family member, or business associate were an officer of that business.)
☒No ☐Yes

33. **Other Litigation**: a.) Other than the litigation described in question 32, have you or any business in which you are or were an officer, director, or partner been a plaintiff or a defendant in a civil lawsuit? If so, please describe.
☒No ☐Yes
b.) Are you aware of any pending or anticipated litigation against you or any business in which you are an officer, director, or partner? If so, please describe.
☒No ☐Yes

34. **Drivers License**: Has your driver's license ever been suspended or revoked? If so, please describe.
☒No ☐Yes

35. **Parking Tickets**: Do you have outstanding parking tickets from any jurisdiction that have remained unpaid for more than 60 days? If so, please explain.
☒No ☐Yes

36. **Security Clearance Denial**: Have you ever been denied a military or other governmental clearance? If so, please explain.
☒No ☐Yes

37. **Firings**: a.) During the past ten years, have you been fired from a job for any reason? If so, please explain.
☒No ☐Yes

b.) During the past ten years, have you quit a job after being told that you would be fired? If so, please explain.
☒No ☐Yes

c.) During the past ten years, did you leave a job by mutual agreement because of specific problems? If so, please explain.
☒No ☐Yes

38. **Alimony and Child Support**: Are you now, or have you ever been, delinquent in the payment of alimony or child support? If so, please explain
☒No ☐Yes

39. **Consumption of Alcohol**: Have you ever or are you currently abusing alcohol? If so, please explain.
☒No ☐Yes

40. **Controlled Substances**: Have you ever or are you currently engaged in the illegal use of a controlled substance or abusing the use of a prescribed controlled substance? If so, please explain.
☒No ☐Yes

41. **Physical Examination**: If you receive a conditional offer of appointment or employment, would you be willing to take a physical examination, which may include a drug test?
☐No ☒Yes

42. **Governmental Delinquencies:** Are you delinquent in the payment of any obligation owed to the federal or state government or any political or taxing subdivision or any instrumentality thereof? (Include delinquencies in the payment of: Income, property, or other taxes; exactions, fees or special assessments; loans, including any defaults, on or under loans which are or were made by, guaranteed, insured or subsidized by any unit of government or instrumentality thereof; overpayment of benefits; required payments into or under governmental programs; payments under a diversion arrangement or other repayment schedule.) If applicable, please state whether such delinquency is under formal appeal.
☒No ☐Yes

43. **Other**: Please provide any additional information, favorable or unfavorable, which you feel should be considered in connection with your appointment. If none, please so state.
☒None

Please include resume and completed Statement of Substantial Interest not more than twelve months old.

REFERENCES

Name: Jonathan P. Small Knows you how?: Fellow attorney and personal friend

Address: 1931 S.W. Indian Woods Lane Topeka, Kansas 66611 (City, State, Zip)

Home Phone: (785) 232-4630 Business Phone: (785) 234-3686

Name: E. Merris Brady Knows you how?: Pastor of my church for many years

Address: 3306 S. W. Belle Topeka, Kansas 66614 (City, State, Zip)

Home Phone: (785) 271-9090 Business Phone: N/A

Name: Linda P. Jeffrey Knows you how?: Attorney and former colleague in county government

Address: 3345 S.W. Mariposa Place Topeka, Kansas 66614 (City, State, Zip)

Home Phone: (785) 273-5604 Business Phone: N/A

Name: Steven E. Lippai Knows you how?: College classmate and friend of 40+ years

Address: 3487 Summit Avenue Highland Park, Illinois 60035 (City, State, Zip)

Home Phone: (847) 432-8185 Business Phone: Unknown

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AUTHORIZATION AND CERTIFICATION:

The facts set forth in my application are true and complete. False statements, answers, or omissions on this application shall be sufficient cause for nonconsideration or for dismissal after appointment or employment. I also recognize that my selection is based on receipt of satisfactory information from former employers and references, and upon my ability to perform the essential elements, with or without reasonable accommodations, for the position for which I am applying. I herein authorize investigation, without liability, of the information supplied by me in this application for employment or appointment including academic, occupational, health, law enforcement, and government records. I also authorize listed employers and references, without liability, to make full response to any inquiries in connection with this application for appointment or employment. I understand and agree that the terms, conditions, compensation, benefits, hours, schedule, and duration of my appointment or employment may be determined, changed, or modified from time to time at the will of the appointing authority or designee without limitation or condition. I FURTHER CERTIFY THAT I HAVE READ THE FOREGOING PARAGRAPH AND KNOWINGLY MAKE THIS AUTHORIZATION BY SETTING FORTH MY SIGNATURE.

I understand that if I am required to be registered, licensed, or certified by federal or state law or regulation for the position I seek, I will notify the appointing authority immediately if any investigation, limitation, or cancellation of my registration, licensure, or certification occurs. If any investigation, probation, limitation, or cancellation occurs, I understand that my failure to notify my appointing authority as described above will result in the termination of my appointment or employment.

Signature D. Ronald Taylor Date November 24, 2010

3-14

Kansas
Senate

CONFIRMATION OVERSIGHT COMMITTEE

Acknowledgment of Release of Tax and Criminal Records Information Form

I, DENNIS R. TAYLOR acknowledge that as part of the
(print name)

Senate Confirmation Oversight Committee process I will:

- be subject to a criminal records background investigation by the Kansas Bureau of Investigation; and
- have my tax records released by the Kansas Department of Revenue.

Such information will not be released to the general public, but will be made available for review at the appropriate time by:

- Myself;
- My appointing authority;
- Chairperson of the Senate Confirmation Oversight Committee; and
- The Vice Chair of the Senate Confirmations Oversight Committee.

By signing the "Authorization and Certification" section (on page 8) of the Senate Confirmation Oversight Committee questionnaire, the Kansas Department of Revenue will be authorized to release my tax information and the Kansas Bureau of Investigation will be authorized to conduct a criminal background investigation on me and provide that information to the appropriate individuals.

Signature Dennis R Taylor Date 11-9-2010

Form 08/08

KANSAS GOVERNMENTAL ETHICS COMMISSION

STATEMENT OF SUBSTANTIAL INTERESTS FORM

REVIEW PAGE

To make changes, click the link next to each section below that you want to update, or click the 'Make Changes' button then use the buttons at the bottom of each page to take you to the section you would like to update.

Next Section Make Changes

STATE OF KANSAS

KANSAS GOVERNMENTAL ETHICS COMMISSION

ELECTRONIC STATEMENT OF SUBSTANTIAL INTERESTS FORM

INSTRUCTIONS: This statement must be completed by individuals who are required to do so by law. Any individual who intentionally fails to file as required by law, or intentionally files a false statement, is subject to prosecution for a class B misdemeanor.

Please read the "Guide" and "Definition" section provided with this form for additional assistance in completing sections "C" through "G". If you have questions or wish assistance, please contact the Commission office at 109 West 9th, Topeka, KS or call 785-296-4219.

A. IDENTIFICATION: Click here to make changes to Section A

Taylor Dennis R

Karen

3934 S.W. Wanamaker Road

Topeka, KS 66610 - 1350

(785) 478-0881 (785) 368-1640

B. THIS FORM IS REQUIRED TO BE FILED BECAUSE YOU ARE: Click here to make changes to Section B

(check one or more of the following)

- ☐ 1. State Elected Official (Governor, Lt. Governor, Attorney General, Commissioner of Insurance, State Treasurer, Secretary of State, State Senator, State Representative, Member of State Board of Education or District Attorney);
- ☐ 2. Appointed Member of a State Board, Council, Commission or Authority;
- ☑ 3. Appointed State Position is Subject to Senate Confirmation;
- ☐ 4. Employee of a State Agency or University;
- ☐ 5. General Counsel for a State Agency;
- ☐ 6. Candidate for State Office.
- ☐ 7. Other (Contractor / Member of Compact)

Department of Administration

Secretary

**** The last four digits of your social security number will aid in identifying you from others with the same name on the computer list. This information is optional. ****

[redacted]

C. OWNERSHIP INTERESTS: Click here to make changes to Section C

List any corporation, partnership, proprietorship, trust, joint venture and every other business interest, including land used for income, and specific stocks, mutual funds or retirement accounts in which either you or your spouse has owned within the preceding 12 months a legal or equitable interest exceeding $5,000 or 5%, whichever is less. If you or your spouse own more than 5% of a business, you must disclose the percentage held. Please insert additional page if necessary to complete this section.

If you have nothing to report in Section "C", check here ☐

	BUSINESS NAME AND ADDRESS	TYPE OF BUSINESS	DESCRIPTION OF INTERESTS HELD	PERCENT OF OWNERSHIP INTERESTS	HELD BY WHOM
1.	TIAA-CREF PO Box 1275, Charlotte, NC 28201	Investment	IRA--Common stocks, Bonds	100%	self
2.	TIAA-CREF PO Box 1275 Charlotte, NC 28201	Investment	IRA--Common Stocks, Bonds	100%	spouse
3.	Nationwide Retirement Solutions PO Box 182797 Columbus OH 43218	Investment	IRA--Common Stocks, Bonds	100%	self
	ING, Kansas Plan Manager		IRA--Common Stocks,		

4.	PO Box 9900067 Hartford, CT 06199	Investment	Bonds	100%	self
5.	ING, City of Topeka PO Box 9900067 Hartford, CT 06199	Investment	IRA--Common Stocks, Bonds	100%	self
6.	Chemonics Int., Inc., 401 (k) Profit-Sharing Plan-095887 1155-20th Street, NW, Washington, D.C. 20036	International Development	IRA--Common Stocks, Bonds	100%	self
7.	Wells Fargo Advisors LLC R4057-016 PO Box 50016 Roanoke, VA 24040-7300	Investment	Brokerage and IRA--Common Stocks, Bonds	100%	self
8.	Wells Fargo Advisors LLC R4057-016 PO Box 50016 Roanoke, VA 24040-7300	Investment	Brokerage and IRA--Common Stocks, Bonds	100%	spouse
9.	Core First Bank and Trust 3035 SW Topeka Blvd., Topeka, KS 66611	Investment	Investment and IRA--Common Stocks, Bonds	100%	self
10.	Euronet, Inc. Kansas City, MO	Financial	Common Stock	1%	spouse
11.	Dennis and Karen Taylor 25350 Perdido Beach Blvd, Orange Beach, AL 36561	Investment rental property	Joint ownerhsip	100%	both
12.	Karen's Gifts 3934 SW Wanamaker Rd., Topeka, KS 66610	Wholesale Crafts and Jewelry	Sole Proprietorship	100%	spouse
13.	Dennis Taylor & Associates 3934 SW Wanamaker Rd., Topeka, KS 66610	Legal and Management Consulting Services	Sole Proprietorship	100%	self

D. GIFTS OR HONORARIA: Click here to make changes to Section D
List any person or business from whom you or your spouse either individually or collectively, have received gifts or honoraria having an aggregate value of $500 or more in the preceding 12 months.

If you have nothing to report in Section "D", check here ☐

	NAME OF PERSON OR BUSINESS FROM WHOM GIFT RECEIVED	ADDRESS	RECEIVED BY
1.	Floyd V. Taylor Irrevocable Trust, in care of Core First Bank and Trust	3035 SW Topeka Blvd., Topeka, KS 66611	self

E. RECEIPT OF COMPENSATION: (Part 1) List all places of employment in the last calendar year, and any other businesses from which you or your spouse received $2,000 or more in compensation (salary, thing of value, or economic benefit conferred on in return for services rendered, or to be rendered), which was reportable as taxable income on your federal income tax returns.

Click here to make changes to Section E1
1. YOUR PLACE(S) OF EMPLOYMENT OR OTHER BUSINESS IN THE PRECEDING CALENDAR YEAR. IF SAME AS SECTION "B", CHECK HERE ☐

If you have nothing to report in Section "E"1, check here ☐

	NAME OF BUSINESS	ADDRESS	TYPE OF BUSINESS
1.	City of Topeka	215 S.E. 7th Street, Topeka, KS 66603	Government
2.	Washburn University	1700 SW College Ave., Topeka, KS 66621	Education

Click here to make changes to Section E2

2. SPOUSE'S PLACE(S) OF EMPLOYMENT OR OTHER BUSINESS IN THE PRECEDING CALENDAR YEAR.

If you have nothing to report in Section "E"2, check here ☐

	NAME OF BUSINESS	ADDRESS	TYPE OF BUSINESS
1.	Let's Help, Inc.	200 S. Kansas Ave., Topeka, Kansas 66603	Charitable

F. OFFICER OR DIRECTOR OF AN ORGANIZATION OR BUSINESS: Click here to make changes to Section F

List any organization or business in which you or your spouse hold a position of officer, director, associate, partner or proprietor at the time of filing, irrespective of the amount of compensation received for holding such position. Please insert additional page if necessary to complete this section.

If you have nothing to report in Section "F", check here ☐

	BUSINESS NAME AND ADDRESS	POSITION HELD	HELD BY WHOM
1.	United Methodist Homes, Inc. 7220 SW Asbury Drive, Topeka, KS 66614	Member, Board of Directors	spouse

G. RECEIPT OF FEES AND COMMISSIONS: Click here to make changes to Section G

List each client or customer who pays fees or commissions to a business or combination of businesses from which fees or commissions you or your spouse received an aggregate of $2,000 or more in the preceding calendar year. The phrase "client or customer" relates only to businesses or combination of businesses. In the case of a partnership, it is the partner's proportionate share of the business, and hence of the fee, which is significant, without regard to expenses of the partnership. An individual who receives a salary as opposed to portions of fees or commissions is generally not required to report under this provision. Please insert additional page if necessary to complete this section.

If you have nothing to report in Section "G", check here ☐

	NAME OF CLIENT / CUSTOMER	ADDRESS	RECEIVED BY
1.	Meyer Real Estate	PO Box 1359, Gulf Shores, AL 36547-1359	both

Back to top, then click 'Next Section' button to finish your filing.