



## What the 2074 Page Senate Health Reform Bill Means for Maternal and Child Health, In 22 Bullets!

*On November 18th, 2009 the U.S. Senate introduced H.R. 3590, the "Patient Protection and Affordable Care Act." Following is a brief AMCHP overview highlighting some important MCH-related provisions. Please note this is neither comprehensive nor final as the Senate still has to pass this bill and then a Congressional Conference Committee will need to merge this bill with the House health reform bill. Then each body will need to vote again on final passage before it can be sent to the President to be signed into law. This document provides some MCH highlights at a glance. In each case the page number the provisions begin on is provided, and the full bill text is available [here](#).*

### PREVENTION AND PUBLIC HEALTH

- 1. Prevention and Public Health fund** to provide for an expanded and sustained national investment in prevention and public health programs (over the FY 2008 level). The Fund will support programs authorized by the Public Health Service Act, for prevention wellness and public health activities including prevention research and health screenings, such as the Community Transformation grant program, the Education and Outreach Campaign for Preventive Benefits, and immunization programs. Funding levels: FY 2010 - \$500 million; FY 2011- \$750 million; FY 2012 - \$1 billion; FY 2013 - \$1.25 billion; FY 2014 - \$1.5 billion; FY 2015 and each fiscal year thereafter- \$2 billion. (Page 1141)
- 2. National Prevention, Health Promotion & Public Health Council** to provide coordination and leadership at the Federal level, and among Federal departments and agencies, with respect to prevention, wellness and health promotion practices, the public health system and integrative health care in the U.S. Tasks the Council with creating a national strategy to: set goals and objectives for improving health through federally-supported prevention, health promotion and public health programs; establish measurable actions and timelines to carry out the strategy; and make recommendations to improve Federal prevention, health promotion, public health and integrative health care practices. (Page 1134)
- 3. Prevention and Health Promotion Outreach and Education Campaign** to provide for the planning and implementation of a national public private partnership for a prevention and health promotion outreach and education campaign to raise public awareness of health improvement across the lifespan. Directs the Secretary to provide guidance and relevant information to States and health care providers regarding preventive and obesity-related services that are available to Medicaid enrollees, including obesity screening and counseling for children and adults. States shall design a public awareness campaign to educate Medicaid enrollees regarding availability and coverage of such services. The Secretary shall report on the status and effectiveness of these efforts. (Page 1150)

4. **Childhood Obesity Demonstration Project.** Appropriates \$25 million to carry out Childhood Obesity Demonstration Project authorized under CHIPRA. (Page 1265)
5. **Oral Healthcare Prevention and Education.** Establishes a 5-year national public health education campaign focused on oral healthcare prevention and education. Establishes demonstration grants to show the effectiveness of research-based dental caries disease management. Includes various oral health improvement provisions relating to school-based sealant programs, oral health infrastructure, and surveillance. (Page 1167)
6. **Community Transformation Grants.** Authorizes CDC to award competitive grants to State and local governmental agencies and community-based organizations for the implementation, evaluation, and dissemination of evidence-based community preventive health activities in order to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming. (Page 1203)
7. **Maternal, infant, and early childhood home visiting programs.** Creates a new section in Title V to provide \$1.5 billion over five years to States, tribes, and territories to develop and implement one or more evidence-based Maternal, Infant, and Early Childhood Visitation model(s). Model options would be targeted at reducing infant and maternal mortality and its related causes by producing improvements in prenatal, maternal, and newborn health, child health and development, parenting skills, school readiness, juvenile delinquency, and family economic self-sufficiency. (Page 568)
8. **Personal responsibility education.** Provides \$75 million per year through FY2014 for Personal Responsibility Education grants to States for programs to educate adolescents on both abstinence and contraception for prevention of teenage pregnancy and sexually transmitted infections, including HIV/AIDS. Funding is also available for 1) innovative teen pregnancy prevention strategies and services to high-risk, vulnerable, and culturally under-represented populations, 2) allotments to Indian tribes and tribal organizations, and 3) research and evaluation, training, and technical assistance.
9. **Restoration of funding for abstinence education.** Appropriates \$50 million per year through FY 2014 for abstinence education.

#### **COVERAGE and BENEFITS**

10. **Medicaid Expansion.** Creates a new mandatory Medicaid eligibility category for all individuals with income at or below 133 percent of the Federal Poverty Level (FPL) beginning January 1, 2014. Prescription drugs and mental health services would be added to the list of services that must be covered at actuarial equivalence. From 2014 through 2016, the Federal government will pay 100 percent of the cost of covering newly-eligible individuals. In 2017 and 2018, States that initially covered less of the newly-eligible population (called "Other States") would receive more assistance than those States that covered at least some non-elderly, non-pregnant individuals ("Expansion States"). (Page 396)
11. **CHIP.** Upon enactment, States would be required to maintain income eligibility levels for CHIP through September 30, 2019. From fiscal year 2014 to 2019, States would receive a 23 percentage

point increase in the CHIP match rate, subject to a cap of 100 percent. CHIP-eligible children who cannot enroll in CHIP due to Federal allotment caps would be eligible for tax credits in the State Exchange. (Page 436)

- 12. State Health Insurance Exchange.** The bill sets up a state health insurance exchange to offer basic health programs. States would have option to offer a community health insurance plan, similar to state plan and be able to offer a waiver to plans showing innovation around care management, care coordination and incentives for using preventive services. States could offer premium tax credits and cost-sharing reduction assistance. Individuals would be required to maintain minimum essential coverage or face a penalty and there would be automatic enrollment for employees of large an employer requirement to inform employees of coverage options and employers would face a penalty if they do not offer coverage. (Page 128)
- 13. Insurance Reforms.** This bill includes several insurance market reforms including no lifetime or unreasonable annual limits, prohibits discriminatory premium rates (page 80), and provides for guaranteed availability of coverage. Reforms include prohibition of preexisting condition exclusions or other discrimination based on health status (pg 78, 83). The bill also eliminates co-pays for services recommended by the United States Preventive Services Task Force, immunizations recommended by CDC, and with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the HRSA (Bright Futures). (Page 17)
- 14. Essential Health Benefits.** Qualified health plans will include the following essential health benefits: 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. (page 102). Also requires the coverage of comprehensive tobacco cessation services for pregnant women in Medicaid and a state option to cover family planning services.

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- 15. Health Homes in Medicaid.** Creates a state option to provide health homes for Medicaid enrollees with chronic conditions. The Secretary may award \$25,000,000 in planning grants to states to develop a state plan amendment to provide health homes. Health homes are provided by a designated provider (physician, clinical group practice, rural clinic, community health center, community mental health center, pediatricians, gynecologists, obstetricians) or team (include physicians and other professionals such as nurse care coordinator, social worker, behavioral health) and must provide comprehensive case management, care coordination and health promotion, transitional care, patient and family support, referral to community services, and the use of HIT as appropriate. (Page 528)
- 16. Pediatric Accountable Care Organization Demonstration Project -** Authorizes participating states to recognize pediatric medical providers as an accountable care organization (ACO) for purposes of receiving incentive payments (states and the Secretary will establish an annual minimum savings

level to be achieved by the ACO for services covered under Medicaid or CHIP in order to receive savings). Demonstration project established with the ACO should last three years. (Page 544)

**17. CMS Center for Medicare and Medicaid Innovation (CMI)** to test innovative payment and service delivery models for Medicare, Medicaid, and CHIP programs. Models should promote payment and practice reform in primary care, including patient-centered medical home models for high-need individuals and medical homes that address women's unique health care needs. Additional factors for consideration include whether the model places the individual, including family members and other informal caregivers, at the center of the care team and provides for the maintenance of a close relationship between care coordinators, primary care, specialists, and community-based organizations. (Page 723)

**18. State Grants to Promote Community Health Teams** that support the Patient-Centered Medical Home. Community-based interdisciplinary teams will provide support services to primary care practices, including OBGYN practices. The team may include specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral/mental health providers, and physicians' assistants. Health teams should collaborate with local primary care and health providers; coordinate disease prevention and management, coordinate transition between health care providers and settings; provide case management for patients, including children; incorporate patients and caregivers in program design and oversight; provide quality-driven, cost-effective, culturally appropriate, and patient- and family-centered health care; establish a coordinated system of early identification and referral for children at risk for developmental or behavioral problems; and should provide support for transitional health care needs from adolescence to adulthood. (Page 1067)

**19. Federal Qualified Health Centers.** Increased authorization for federally qualified health centers (FQHCs), starting with nearly \$3 billion in 2010 and ramping up to nearly \$8.5 billion in 2015. For fiscal year 2016, and each subsequent fiscal year, the amount appropriated for the preceding fiscal year will be adjusted based on costs per patient served and number of patients served. (Page 1508)

**20. School Based Health Clinics.** Authorizes \$50 million over 4 years to establish a new grant program to support school-based health clinics that provide health services to children and adolescents. (Page 1156)

**21. EMSC Program.** Reauthorizes The Wakefield Emergency Medical Services for Children Program at \$25 million for fiscal year 2010 going up to \$30.8 million for fiscal year 2014. (Page 1514)

## **FAMILY TO FAMILY HEALTH INFORMATION CENTERS**

**22. Family to Family Health Information Centers.** Would extend Family-to-Family Health Information Centers through FY2012 at current funding level. (Page 1485)

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