Texas Court Case on the Constitutionality of the ACA
Implications for Children’s Health

Background on case

On Dec. 18, 2019, the Fifth Circuit Court of Appeals ruled that the Affordable Care Act’s (ACA) individual mandate is unconstitutional, but sent the remainder of the pending lawsuit, Texas v. U.S., back to the lower court for further review and analysis. In its 2-1 decision, the Court of Appeals agreed with a Dec. 14, 2018 finding by Texas Federal District Court Judge Reed O’Connor that the 2017 congressional repeal of the tax penalty related to the individual mandate renders the individual mandate unconstitutional. However, the appeals court did not take a position on O’Connor’s further finding that, as a result of the unconstitutionality of the mandate, the entire law is unconstitutional. O’Connor had reasoned that both the individual mandate and the tax penalty are integral to the ACA and not severable from the remainder of the law.

In January 2020, the Supreme Court denied a request by 21 Democratic state attorneys general and the U.S. House of Representatives for an expedited review of the appeals court decision. The request was made in hopes that the Supreme Court would settle the uncertainty about the law before the 2020 presidential election and the 2021 ACA open-enrollment period. In March 2020, the U.S. Supreme Court agreed to review the case on its regular schedule and will hear oral arguments in the case on Nov. 10–after the start of the 2021 open enrollment period and one week following the elections. A decision from the Supreme Court will likely not be announced until Spring 2021.

ACA provisions impacting children that could be overturned – Overview

The following provides a high-level overview of those ACA provisions with implications for children’s health and health care that could be affected by a court ruling that finds the entire law unconstitutional.¹

Medicaid and the Children’s Health Insurance Program (CHIP)

- **Expanded Medicaid eligibility** – All children under age 18 in families with income up to 133 percent of the federal poverty level (FPL) are eligible for Medicaid.
- **Medicaid and CHIP maintenance of effort (MOE)** – States must maintain the Medicaid and CHIP eligibility standards under Medicaid and CHIP, which were in effect as of March 23, 2010. Congress has since extended the CHIP MOE for children in families with income up to 300 percent of the FPL until fiscal year (FY) 2027.
- **Enhanced federal funding for CHIP** – States receive additional federal matching funds for CHIP. Congress has since acted to phase out these funds as of FY 2021.

¹ In the event that the Texas Court ruling is upheld, any actions that have been taken by Congress to amend or fund provisions of PPACA, as well as administrative actions to implement the law, would also be nullified because the case would overturn the underlying statute.

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Private insurance coverage through the Exchanges

- **Coverage of essential health benefits (EHBs)** – Commercial plans in the individual and small group markets must cover 10 categories of benefits, including pediatric services (including oral and vision care); rehabilitative and habilitative services and devices; mental health and substance use disorder services; and prescription drugs.

Reforms of the overall private insurance market

- **No exclusions or increased costs for pre-existing conditions** – Children with an ongoing health condition cannot be denied coverage or charged more because of that condition.
- **No annual or lifetime benefit caps** – Children who have high medical costs are assured their private coverage won’t end because their benefit is capped at a certain dollar amount.
- **Preventive services are covered without cost-sharing** – Children can receive well-baby and well-child preventive screenings and scheduled immunizations at no cost to their families.
- **Cap on out-of-pocket expenses** – Establishes an overall annual limit on out-of-pocket expenses, including deductibles and other cost-sharing, related to a child’s care.
- **Dependent coverage up to age 26** – Young adults can remain on their parent(s)’ plan until age 26.

Hospice for children – States must cover curative/life-prolonging services for Medicaid and CHIP-eligible children with serious illness who also receive hospice benefits under these programs.

Delivery system reforms – New models of care are being advanced through the Center for Medicare and Medicaid Innovation (CMMI), including a state option that provides coverage to individuals with chronic conditions through a “health home” and other initiatives.

340B Drug Pricing Program – Self-governing children’s hospitals are listed as covered entities within the Public Health Service Act to insure their permanent eligibility to fully participate in the 340B Drug Pricing Program and to be subject to its program integrity requirements.

Disproportionate Share Hospital Payments (DSH) – The ACA includes provisions to cut Medicaid DSH funding by $18 billion between FY 2014 and 2020. Congress has amended the DSH cut provisions more than six times. Most recently, Congress eliminated the cuts for FY 2020, and reduced the cuts in FY 2021 from $8 billion to $4 billion. The onset of any FY 2021 cuts is delayed from Oct. 1, 2020 to Dec. 1, 2020.
ACA provisions impacting children that could be overturned – Detailed summary

The following detailed list includes all provisions of the ACA with implications for children’s health and children’s hospitals. The list does not include any provisions that have expired, but does include those that have not been implemented, to date. It also includes those provisions that have been modified, extended or otherwise continued through congressional action.2

Provisions Affecting Children’s Coverage

Medicaid and CHIP Coverage

• Creates a new mandatory Medicaid eligibility category that includes all individuals with family income up to 133 percent of the FPL3 who are not eligible under an existing mandatory eligibility category.
  o Includes expanding the mandatory Medicaid income eligibility level for children ages six to 19 from 100 percent of the FPL to 133 percent.
  o Results in the addition of childless adults and some parents to Medicaid
  o Provides enhanced federal matching funds to states that opt in to the Medicaid expansion for newly eligible populations.
  o Requires parents that become eligible for Medicaid through the Medicaid expansion to first enroll their child in Medicaid or other health coverage.
  o Allows states to provide Medicaid coverage to all non-elderly individuals above 133 percent of FPL through a State plan amendment.

• Requires states to use modified adjusted gross income (MAGI) to determine eligibility for Medicaid and CHIP; states may not use income disregards except for a 5 percent income disregard that is allowed for all applicants. MAGI does not apply to individuals who qualify for Medicaid based on age (over 65), disability (including medically needy), or eligibility for other federal or state aid (such as supplemental security income benefits or foster care).
  o Prohibits states from using asset tests in determining Medicaid eligibility.
  o Requires states to deem children eligible for CHIP if they lose Medicaid eligibility due to the elimination of income disregards.
  o Requires the secretary to ensure that the change to MAGI does not cause children who would have been Medicaid-eligible as of enactment of the legislation to lose coverage.
  o Requires states to establish income thresholds using MAGI that are no less than the effective income eligibility levels on the date of enactment of the legislation.

• Establishes MOE requirements that ensure states’ Medicaid and CHIP coverage standards meet historical norms.4
  o Requires states to maintain the eligibility levels for children in Medicaid and CHIP as of March 23, 2010 through Sept. 30, 2019.
  o Prevents states from setting new enrollment caps or freezes in CHIP or from enacting more restrictive methodologies or procedures for enrollment.

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2 This summary does not include administrative actions related to the implementation of any of these provisions.
3 With the 5 percent income disregard, the effective income eligibility rate is 138 percent of the FPL.
4 Congress has extended the MOE through FY 2023 for children in families with income up to 300 percent of the federal poverty level.
• Requires a state that runs out of its CHIP allotment to screen CHIP-eligible children for Medicaid eligibility and to establish procedures to ensure that children not eligible for Medicaid are enrolled in a qualified health plan that has been certified by the secretary.
• Requires states to provide Medicaid coverage to individuals who were in foster care, but aged out, up to age 26.
• Gives hospitals the option to provide Medicaid services during a period of presumptive eligibility to members of all Medicaid eligibility categories.
• Requires states to offer premium assistance to individuals who qualify for Medicaid but have access to employer-sponsored insurance.
• Allows children of employees of state agencies to enroll in CHIP, under certain circumstances.
• Reauthorizes and funds CHIP through Sept. 30, 2015. After that date, allows states to enroll CHIP-eligible children in qualified health plans that have been certified by the secretary.  
  o Provides states with a 23 percentage point increase in their enhanced CHIP federal matching rate (e-FMAP).  
• Requires states to allow children covered by Medicaid or CHIP who qualify for hospice care to get both curative treatment services and hospice care.
• Requires states that recognize freestanding birth centers to provide Medicaid coverage and payment for prenatal, labor, and delivery or postpartum care services provided by those centers, including services by non-licensed practitioners (such as lactation consultants).

Enrollment simplification and health information technology
• Requires the Department of Health and Human Services (HHS) to develop interoperable and secure standards and protocols that facilitate electronic enrollment of individuals in federal and state health and human services programs.
  o Require the standards to allow for electronic data matching and documentation.
  o Allows the secretary to require states or other entities to adopt the standards as a condition of receiving Federal health information technology funds.

Overall Commercial Market
• Prohibits individual and group health plans from placing annual or lifetime limits on the dollar value of coverage. In the case of large group plans this prohibition applies to the coverage of EHBs only.
• Prohibits pre-existing exclusions.
• Requires plans to cover preventive services and immunizations without cost-sharing. Applies to services recommended by the U.S. Preventive Services Task Force and the Centers for Disease Control and Prevention (CDC) for infants, children, adolescents; evidence-informed preventive care; and screenings provided for in the guidelines supported by the Health Resources and Services Administration (HRSA).
• Prohibits plans from rescinding coverage, except in instances of fraud.
• Requires plans to cover dependent coverage until the child turns 26.
• Requires plans to comply with maximum out-of-pocket limits on the cost of care, as set by the secretary. In the case of large group plans, the out-of-pocket limit applies to the coverage of EHBs only.

5 Congress extended CHIP funding through FY 2027 through an amendment to the Social Security Act.
6 Congress amended the Social Security Act to reduce the extra percentage point increase in the e-FMAP from 23 to 11.5 percentage points for FY 2020. In FY 2021 and beyond, the matching rate returns to each state’s regular e-FMAP.
• Requires insurers to accept every employer and individual in the state that applies for coverage and/or seeks to renew coverage.
• Prohibits any health plan eligibility rules (such as waiting periods) that are based on health status, medical condition (both physical and mental illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other health status-related factor determined appropriate by the secretary.
• Requires plans to cover emergency department services without prior authorization requirements, regardless of whether the provider is in-network.
• Requires the secretary to develop standards for health plan summaries of benefits and coverage (SBC) and requires insurers to provide an SBC to all plan applicants and enrollees.
• Requires insurers to allow pediatricians to be designated as the primary care provider (PCP) for a child enrollee when the insurer requires enrollees to designate a PCP.
• Prohibits insurers from discriminating against any health care provider acting within the scope of the provider’s professional license and state laws.

**Individual and Small Group Commercial Markets**
• Requires issuers that offer health insurance coverage in the individual or small group market to provide coverage that includes the EHBs and to cover at least 60 percent of the actuarial value of covered benefits.
• Requires the EHB package to include pediatric items and services (including oral and vision care); rehabilitative and habilitative services and devices; and mental health and substance use disorder services, including behavioral health treatment. The other EHBs that plans must cover are: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, prescription drugs, laboratory services, and prevention and wellness services and chronic disease management.
• Requires the secretary to define, and periodically update, the EHB package, which must be equal in scope to those benefits provided under a typical employer plan.
• Allows states to require coverage of additional benefits, as long as the state covers the costs of those benefits.
• Limits premium rate charges in the individual and small group markets to vary only with respect to: family structure, premium rating area, age (limited to 3:1), and tobacco use (limited to 1.5:1).

**Health Insurance Exchanges**
• Requires states to establish a health insurance Exchange, including a web site, to assist individuals to identify affordable health insurance coverage options, including insurance, Medicaid or Medicare, high-risk pools, and coverage within the small market.
• Requires state Exchanges to inform individuals of eligibility for Medicaid, CHIP or any other applicable local or state program, and enroll and reenroll them in that coverage (“No Wrong Door”) without any additional eligibility determinations.
  • Requires that individuals who are found to be ineligible for Medicaid or CHIP are screened for eligibility for an Exchange plan and, if eligible, enrolled.
• Requires the secretary to establish standards for states to operate an Exchange and criteria for state Exchanges to use to certify health plans as qualified health plans (QHPs).
  • Exchange standards must address: certification process for QHPs; the operation of a toll-free consumer hotline; the maintenance of the web site, which must include standardized comparative information on
health plans; ratings of each QHP; and the establishment of an actuarial value calculator to determine the actual cost of coverage after subsidies.

- QHP certification criteria must include, at a minimum: marketing requirements that ensure they do not discourage individuals with significant health needs from enrolling; inclusions of a sufficient choice of providers consistent with applicable network adequacy requirements; the provision of information to current and prospective enrollees on in-network and out-of-network providers; inclusion of essential community providers that serve predominately low-income, medically-underserved individuals, including children’s hospitals, in the plan network; and the utilization of a uniform enrollment form.
- Requires the secretary to establish and operate an Exchange in states that choose not to do so themselves.
- Establishes four coverage levels, based on their actuarial value, that qualified health plans may offer – Bronze (60 percent), Silver (70 percent), Gold (80 percent) and Platinum (90 percent).
- Requires insurers that offer a QHP to also offer a child-only plan with the same level of coverage.
- Requires insurers to submit justification of premium rate increases to the secretary.
- Requires all plans to provide a rebate to enrollees if the medical loss ratio (MLR) exceeds 85 percent for the large group market and 80 percent for the small group market. Defines the MLR as the ratio of premium revenue used for clinical services and activities to improve health care quality over total premium revenue.
- Allows QHPs to provide coverage through a direct primary care medical home plan per requirements established by the secretary.
- Prohibits QHPs from contracting with hospitals with greater than 50 beds that do not utilize a patient safety evaluation system and ensure that patients receive a comprehensive program for hospital discharge.
- Requires QHPs to implement a quality improvement strategy.
- Allows states to create a basic health plan (BHP) for uninsured individuals with income between 133 and 200 percent of the FPL as an alternative to private coverage through the Exchange. Specifies the criteria for BHP approval and its funding stream.
- Allows states to obtain a five-year (Section 1332) waiver of the Exchange-related provisions of the ACA if the state can demonstrate that it provides health coverage to all residents that is at least as comprehensive as the coverage required under an exchange plan and does not increase the federal budget deficit.

**Premium Tax Credits and Cost-sharing Reductions**

- Creates a refundable premium assistance tax credit for individuals with income up to 400 percent of the FPL for the purchase of coverage through a QHP. Bases the tax credits on the cost of the second lowest-priced silver plan in the individual’s area, and limits individuals’ premium contributions based on a sliding scale.
- Provides eligible individuals with a reduction in cost-sharing for coverage of EHBs, based on a sliding scale.
- Establishes an “affordability” standard to determine eligibility for premium tax credits, which deems premiums for employer-based plans as unaffordable if they exceed 9.5 percent of household income.\(^7\)

**Employer Mandate/Responsibilities**

- Large employers, defined as those with at least 50 full-time employees, must offer employees minimum essential coverage with or without a waiting period of no more than 60 days or pay a penalty.\(^8\)

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\(^7\) An Internal Revenue Service (IRS) interpretation of the law applies the 9.5 percent rule to the cost of premiums for individual plans, rather than family plans, which precludes dependents (in many cases) from accessing premium tax credits.

\(^8\) In 2015, Congress amended PPACA to give states the option to raise the large employer threshold to 100 or more employees.
• Defines “minimum essential coverage” as coverage under Medicare, Medicaid, CHIP, TRICARE, veteran’s health care programs, an employer-sponsored plan, a plan obtained through the individual market, or other coverage recognized by the Secretary.9
• Requires large employers to report to the secretary whether it offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan, the length of any applicable waiting period, the lowest cost option in each of the enrollment categories under the plan, and the employer’s share of the total allowed costs of benefits provided under the plan.
• Requires the cost of employer-sponsored health coverage to be reported on an employee’s W-2.
• Excludes over-the-counter drugs as a permissible, reimbursable expense under Flexible Spending Accounts.

Medicaid Disproportionate Share Hospital Payments (DSH)

• Includes provisions to cut Medicaid DSH funding by $18 billion between FY 2014 and FY 2020.10
• Requires the Secretary to impose the largest cuts on states with the lowest percentage of uninsured individuals and those that do not target their DSH funds to hospitals with high volumes of Medicaid inpatients and uncompensated care.

Medicaid Provider Screening and Enrollment

• Requires the secretary to establish procedures for screening providers and suppliers participating in Medicare, Medicaid, and CHIP that, at a minimum, requires licensure checks of all providers and suppliers.
  o Allows the secretary to impose additional screening measures based on risk, including fingerprinting, criminal background checks, multi-State data base inquiries, and random or unannounced site visits.
• Requires the secretary to issue a regulation mandating that all Medicare, Medicaid, and CHIP providers include their National Provider Identifier on enrollment applications.

Other Medicaid Provisions

• Requires states to implement certain public notice and comment procedures, including public hearings, before submitting an application for a Section 1115 waiver.
• Clarifies that the term “medical assistance” refers to the care and services provided under Medicaid, in addition to payment for those services, re-emphasizing that states must ensure that Medicaid enrollees receive prompt access to services.
• Allows the secretary to award grants to states that establish wellness incentive programs for Medicaid beneficiaries.
• Standardizes and expands data collection on health disparities (race, ethnicity, sex, primary language, and disability status) for HHS–sponsored surveys and programs.

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9 Congress amended PPACA to add qualified CHIP look-alike programs and the Department of Defense’s Health Benefit Program for non-civil service employees to the definition of “minimum essential coverage.”
10 Congress has amended the DSH cut provisions of PPACA more than six times to delay the cuts. Most recently, Congress eliminated the cuts for FY 2020, and reduced the cuts in FY 2021 from $8 billion to $4 billion. The onset of any FY 2021 cuts is delayed from Oct. 1, 2020 to Dec. 1, 2020.
• Expands the Recovery Audit Contractor (RAC) Program to Medicaid and requires states to contract with RACs to identify underpayments and overpayments and recoup overpayments.
  o Requires the secretary to report annually to Congress about the program’s effectiveness.
• Authorizes the secretary to withhold FMAP to a state that does not report enrollee encounter data in a timely manner to the Medicaid Management Information System (MMIS).
• Requires states to make their MMIS methodologies compatible with Medicare’s national correct coding initiative, which promotes correct coding and controls improper coding.

Medicaid and CHIP Payment and Access Commission (MACPAC)

• Broadens the scope of MACPAC from examining children’s access to Medicaid and CHIP-covered items and services to examining all beneficiaries’ access, and to review state, in addition to federal, Medicaid/CHIP policies.
• Expands the policies that MACPAC must review and requires an annual report to Congress on findings and recommendations on those policies, including:
  o Payment policies, including how policies enable beneficiaries to obtain services, affect provider supply, and affect providers that serve a disproportionate share of low-income and other vulnerable populations.
  o Eligibility policies.
  o Enrollment and retention processes.
  o Coverage and benefit policies.
  o Quality of care.
  o Interactions between Medicare and Medicaid.
• Requires MACPAC to review Medicaid/CHIP regulations and provide comments to Congress and the secretary as appropriate.
• Allows MACPAC to collect information directly from states as a condition of receiving FMAP.

Health Care Workforce and Capacity Building

**General workforce initiatives**
• Creates a National Health Care Workforce Commission to review current and projected health care workforce supply and education and training activities to determine whether the demand for health care workers, including in pediatrics, is being met.

**Primary care workforce**
• Establishes scholarships, loan repayment, and other funding streams to invest in primary care physicians, mid-level providers, and community providers, including:
  o A competitive grant program through the HRSA to develop comprehensive health care workforce development strategies at the state and local levels.
  o Loan repayment and scholarship programs targeting allied health professionals, public health professionals, mid-career health professionals.
  o Grants, loan repayment and other funding streams to medical schools and other entities to: develop and support primary care (family medicine, general internal medicine, or general pediatrics) training programs;
provide financial assistance to trainees and faculty; and enhance faculty development in primary care and physician assistant programs.

- Funds to establish and improve academic units in primary care.
- Support for graduate training in environmental health, infectious disease control, disease prevention and health promotion, epidemiological studies and injury control.
- Financial support for training in general, pediatric, and public health dentistry.
- Financial support for the recruitment and training of students in a range of behavioral health and mental health services fields, including child and adolescent psychiatry, social work, psychology, and behavioral pediatrics, school counseling, and to support in-service training in those fields.
- A Primary Extension Program to provide support and assistance to educate primary care providers about preventive medicine, health promotion, chronic disease management, mental and behavioral health services, and evidence-based and evidence-informed therapies and techniques, and to improve community health by working with community-based health connectors.

**Support for health care services and facilities**

- Creates a program to establish and fund the development of community health teams (CHTs) to support the development of primary care medical homes.
  - Authorizes HHS to provide grants and contracts to states and state-designated entities to establish community-based, inter-professional, interdisciplinary CHTs that support patients receiving health home services (e.g., prevention, patient education and care management).
- Authorizes the CDC to provide grants for community-based programs to promote healthy behaviors, including education and outreach in underserved communities, enrollment assistance in public programs, and home maternal and child health visitation programs.
- Authorizes the extension of Family-to-Family Health Information Centers.\(^\text{11}\)
- Provides grants for coordinated and integrated services through the co-location of primary and specialty care in community-based mental and behavioral health settings.
- Authorizes the development and operation of nurse-managed health clinics to provide primary care services to underserved or vulnerable populations in association with schools, colleges, federally qualified health centers or other nonprofit health or social service entities.
- Authorizes a grant program for the operation and development of School-Based Health Clinics, to provide comprehensive and accessible preventive and primary health care services to medically underserved children and families.
- Reauthorizes the Wakefield Emergency Medical Services for Children Program\(^\text{12}\) for four years and requires expanded support for emergency and trauma care.
  - Requires the secretary to support coordinated and expanded research in pediatric emergency medical care systems and pediatric emergency medicine.
  - Authorizes at least four multi-year contracts or grants to be awarded to states to support pilot projects to design and evaluate innovative models of regionalized, comprehensive and accountable emergency care and trauma systems. Project evaluations must include an assessment on their impact on pediatric emergencies.

\(^\text{11}\) Congress has amended the Social Security Act to reauthorize and extend funding through FY 2024 for the centers.
\(^\text{12}\) Congress has amended the Public Health Service Act to reauthorize EMSC through FY 2024.
Requires the secretary to provide funding to states and Indian Health Services for grants to nonprofit trauma centers, hospitals in underserved areas and other eligible entities to encourage universal access to trauma care services.

**340B Drug Pricing Program**

- Adds children’s hospitals as a covered entity under the Public Health Service Act to make their participation in the program permanent. Also added cancer hospitals, rural referral centers, critical access hospitals, and sole community hospitals.
- Prohibits newly added 340B entities from purchasing orphan drugs through the 340B program.\(^{13}\)
- Adds several program integrity requirements for covered entities and HRSA, including fines for covered entities that engage in knowing and intentional violations such as drug diversion or duplicate discounts and regular reporting of contact and other information to HRSA.
- Requires HHS to develop a system to ensure accurate pricing by manufacturers under the program and to implement an administrative process for the resolution of claims by covered entities that they have been overcharged for drugs purchased.

**Charitable Hospital Requirements**

- Establishes additional requirements for hospitals to retain their tax-exempt status that include:
  - A community needs assessment at least every three years.
  - An implementation strategy to meet the community needs identified through the assessment.
  - A report to the IRS on how needs are being met, any needs not being met, and why.
  - Adoption of a financial assistance policy to include free or discounted care, including the basis for calculating amounts charged to patients.
  - Adoption of a written policy that requires the provision of emergency medical care consistent with the federal Emergency Medical Treatment and Labor Act, regardless of eligibility for financial assistance.
  - Limits on amounts charged to eligible individuals under the financial assistance policy to the amounts generally billed (prohibits the use of gross charges).
  - Adoption of a billing and collection practice that does not engage in extraordinary collection actions
- Requires hospitals that fail to meet these requirements to pay an excise tax of $50,000.
- Requires organizations that operate more than one hospital facility to separately meet the requirements of this section for each facility.
- Requires the secretary of the Treasury to review at least once every three years the community benefit activities of each hospital subject to the new requirements.
- Requires the secretaries of the Treasury and HHS to annually report to Congress on levels of charity care, bad debt expense, unreimbursed costs for means-tested and non-means-tested government programs with respect to tax-exempt, taxable, and government-owned hospitals, and community-benefit-related costs incurred by private tax-exempt hospitals.

\(^{13}\) The Medicare and Medicaid Extenders Act of 2010 includes a provision which clarifies that children’s hospitals are not “newly-added entities” to the 340B program and, therefore, are not subject to the orphan drug exclusion.
Price Transparency

- Requires insurers (with the exception of self-funded plans) to report annually on health care costs to the secretary. The reports must be made public and include: claims payment policies; periodic financial disclosures; enrollment and disenrollment data; data on denied claims; rating practices; cost-sharing information for out-of-network coverage; activities that improve health care quality, and all non-claims based costs and premium revenues.
- Authorizes the establishment of medical reimbursement data centers to collect reimbursement data from health insurers and make such information available to the public. The data centers shall develop fee schedules and other data base tools to reflect market rates for services within geographic areas.
- Requires hospitals to make public a list of standard charges for items and services provided by the hospitals, including for Diagnosis Related Groups.
- Requires pharmacy benefit managers (PBMs) that contract with health plans under Medicare or the Exchange to report to the secretary information regarding: the generic dispensing rate; rebates, discounts, or price concessions negotiated by the PBM; and the payment difference between health plans and PBMs, and PBMs and pharmacies.
- Requires drug, device, biological and medical supply manufacturers to report transfers of value made to a physician, physician medical practice, a physician group practice, and/or a teaching hospital.

Quality Measurement and Reporting

- Authorizes the development of a National Strategy and Priorities for Health Care Quality to develop consensus-based strategies and measures. Requires the strategy to include children and vulnerable populations.

Quality measures development

- Requires the secretary to develop, and periodically update (not less than every 3 years), provider-level outcome and efficiency measures for hospitals and physicians, as well as other providers as determined appropriate by the Secretary, for use in federal health programs. Includes measures for acute and chronic conditions, as well as for primary and preventive care for distinct populations, including children.
  - Requires the outcome measures for acute and chronic care to take into account the five most prevalent and resource-intensive conditions.
  - Requires the measures to include the “full scope of services comprising a cycle of care” and to address multiple dimensions, including improved outcomes, and cost savings.
- Authorizes grants and/or contracts for quality measure development, with a focus on outcomes, functional status, care coordination, informed decision-making, meaningful use of health information technology, safety, effectiveness, patient-centeredness, appropriateness and timeliness of care, efficiency, equity, patient-experience and use of innovative strategies.
- Delineates the duties of a consensus-based entity (e.g., the National Quality Forum) for quality measurement.
- Requires the secretary to support infrastructure/information systems development to allow the collection and analysis of consistent data on quality and resource use measures across a broad range of patient populations, providers, and geographic areas over time.
**QHP quality reporting requirements**
- Requires the secretary to develop reporting requirements for use by QHPs and health insurance issuers and to develop a system to rate QHPs on quality and price.
- Establishes accreditation and annual state reporting requirements on quality of care measures for QHPs.
- Requires QHPs to provide information to enrollees and Exchanges on quality measures.
- Requires the secretary to develop an enrollee satisfaction system for QHPs, as well as a methodology to measure health plan value.
- Requires QHPs to report pediatric quality measures (as developed under CHIPRA) to the secretary at least annually.

**Medicare quality reporting requirements**
- Reduces payment for physicians and providers (including long-term care hospitals, rehabilitation hospitals, psychiatric hospitals, etc.) that fail to report on measures.
- Adds reporting requirements for other providers, including PPS-exempt cancer hospitals.
- Creates and expands Internet sites to make quality information publicly available (e.g., “Physician Compare”)

**Quality Improvement and Safety**

**Non-payment for health care-acquired conditions and prevention of readmissions**
- Requires the secretary to issue regulations to prohibit Medicaid payments to states for any amounts expended on medical assistance for specified health care-acquired conditions (HACs).
  - Requires the regulations to incorporate current state practices related to nonpayment and to include conditions that are based on the presence of a secondary diagnosis code, similar to the Medicare program.
  - Allows the secretary to exclude certain conditions if they are deemed inapplicable to Medicaid beneficiaries.
- Makes further payment reductions under the Medicare HAC non-payment program to hospitals that are in the top quartile of risk-adjusted HACs.
- Requires studies on the expansion of HAC non-payment policies to other settings (e.g., inpatient rehabilitation centers, outpatient departments, and others).
- Establishes a hospital readmissions reduction program for Medicare beneficiary discharges to reduce payment for hospitals with “excess readmissions” for applicable conditions.
  - Requires information on readmissions to be made public.
- Establishes a quality improvement program for hospitals with high severity-adjusted readmission rates for Medicare beneficiaries through patient safety organizations.
- Requires insurers to implement activities to prevent hospital readmissions and improve patient safety through a comprehensive hospital discharge program.

**Quality improvement infrastructure and programs**
- Creates CMMI to test innovative payment and service delivery models and to reduce program expenditures.
- Expands the functions of the Agency for Healthcare Research and Quality (AHRQ) to support best practices for quality improvement and systems redesign; translate research into practice; develop tools and interventions to reduce variations in health care delivery; identify and improve factors that contribute to the sustainability of quality improvement and patient safety strategies; and build capacity at the state and community levels.
o Specifically refers to children’s health care as a focus of funding activities.

o Requires AHRQ to implement a national application of Intensive Care Unit Improvement projects relating to the adult, pediatric and neonatal patient populations and develop methods for addressing health care-associated infections and reducing preventable hospital admissions and readmissions.

o Expands AHRQ demonstration projects for improving the quality of children’s health care and use of health information technology through Pediatric Quality Improvement Collaboratives and Learning Networks and other vehicles.

o Requires grants or contracts to be provided to health care providers, provider associations, academic health centers and other eligible entities to support technical assistance on quality improvement.

o Establishes AHRQ demonstration programs to integrate quality improvement and patient safety training into the education of health professionals.

o Authorizes AHRQ to award grants or contracts to implement multi-disciplinary, collaborative medication management services in the treatment of chronic disease.

**Care coordination, integration and medical homes**

- Allows states to provide coverage to Medicaid enrollees with chronic conditions through a health home, comprised of a team of health professionals who provide comprehensive care.
  - Requires states to track avoidable readmissions and associated savings resulting from the improved care coordination.

- Established several demonstration projects, including a Medicare at-home (“Independence At Home”) demonstration program for high-risk and high-need beneficiaries.

- Authorizes HHS to provide grants to states or state-designated entities to support primary care medical homes with priority given to patients with chronic conditions (including children) and to implement a coordinated system for early identification and referral for children at risk for developmental or behavioral problems.

- Establishes a number of payment and delivery system innovation programs through AHRQ to promote integrated care across service lines under Medicare, including shared savings programs, payment bundling pilots and related evaluation measures, community-based care transition programs, and others.

**Incentives for home and community-based services (HCBS) under Medicaid**

- Creates a “Community First Choice Option” for states to provide home and community-based attendant services to assist eligible individuals in accomplishing activities of daily living and health-related tasks. States receive an increase in FMAP of 6 percentage points for these services.

- Creates a new optional eligibility category for states to provide full Medicaid benefits to an individual who receives HCBS with an income up to 300 percent of the supplemental security income rate, eliminating the requirement that the state seek a waiver.
  - Also allows states to target specific populations.

- Provides incentive payments to states to provide long-term services and supports in the home and community rather than in an institution. Participating states receive an increase in FMAP to cover non-institutional services.

**Value-based purchasing, pay-for-performance programs and incentives under Medicare**

- Establishes a hospital value-based purchasing (VBP) program, initially focusing on acute myocardial infarction, heart failure, pneumonia, surgeries and healthcare-associated infections.
  - Includes care and efficiency measures and rewards for high performance or improved scores.
Requires information on hospital performance to be made public through the Hospital Compare Web site and a Government Accountability Office study on the impact of the program.

- Requires the secretary to develop plans for VBP for ambulatory surgery centers, skilled nursing facilities, and home health agencies; to consider a plan to transition to VBP for physicians and other practitioners; and to develop separate pilot pay-for-performance programs for certain psychiatric hospitals/units, long-term care hospitals, rehabilitation hospitals, PPS-exempt cancer hospitals, and hospice programs.\(^{14}\)

### Patient-centered outcomes research and shared decision-making

- Establishes the “Patient-Centered Outcomes Research Institute,” to build evidence on treatment options.
  - Requires the AHRQ to broadly disseminate research findings and develop informational tools for the public and providers.
- Requires HHS to establish and disseminate patient decision aids to providers and patients.
- Requires the Food and Drug Administration to assess standardized formats for summarizing the benefits and risks of prescription medications.

### Public Health

#### Infrastructure

- Establishes the Prevention and Public Health Fund (PPHF) within HHS to support an expanded and sustained national investment in prevention and public health programs including prevention research, health screenings, and initiatives, and immunization programs. Authorizes $18.75 billion for the PPHF between FY 2010 and 2022 and $2 billion per year after that.\(^{15}\)
- Creates the National Prevention, Health Promotion and Public Health Council in HHS to focus on prevention, wellness, and health promotion practices, the public health system, and integrative health care, and to develop a national prevention, health promotion, and public health strategy.
- Directs the secretary to convene a national public/private partnership for the purposes of conducting a national prevention and health promotion outreach and education campaign, including a national media campaign focusing on nutrition, physical activity, and smoking cessation, using science-based social research.

#### Condition-specific initiatives and programs

- Requires the secretary to prepare a biennial national diabetes report card that addresses quality of care, risk factors and outcomes; to improve vital statistics collection related to diabetes and other chronic diseases; and to conduct a study on the appropriateness of diabetes medical education.
- Authorizes the Substance Abuse and Mental Health Administration to award grants to establish centers of excellence in the treatment of depressive disorders.
- Permits the secretary to work through the CDC to track the epidemiology and data on treatment approaches and outcomes related to congenital heart disease through a National Congenital Heart Disease Surveillance System, and to expand and coordinate National Institutes of Health (NIH) research on congenital heart disease.

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\(^{14}\) Some of the VBP efforts have been merged into broader payment reform efforts, including the Quality Payment Program under Medicare and a new VBP arrangement for post-acute care facilities.

\(^{15}\) Congress has amended the ACA to reduce funding levels each year. In FY 2018, the PPHF was funded at $900 million; in FY 2020 and 2021, the fund will receive $950 million and will not be funded at $2 billion until 2028.
• Requires the secretary to provide guidance to states and providers regarding preventive and obesity-related services that are available to Medicaid enrollees, including obesity screening and counseling for children, and requires states to design public awareness campaigns to educate Medicaid enrollees regarding availability and coverage of those services.
  o Requires the secretary to report to Congress on the status and effectiveness of these efforts.
• Establishes a Pregnancy Assistance Fund at HHS, in coordination with the Department of Education, to award competitive grants to states to assist pregnant and parenting teens and women.
  o States may make funding available to eligible institutions of higher learning for programs that help pregnant or parenting teens complete high school, and to use funds to provide intervention and outreach services.

Innovative Medical Therapies

• Directs the NIH to develop a Cures Acceleration Network to award contracts and grants to eligible entities, including medical centers and disease advocacy organizations, to accelerate the development of medical products and behavioral therapies.
• Requires the secretary to license a biological product if it is biosimilar to or interchangeable with a licensed biological (reference) product.

Miscellaneous Provisions

Nondiscrimination
• Prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in HHS-funded and/or administered health programs and activities.
• Protects individuals against discrimination under the Civil Rights Act, the Education Amendments Act, the Age Discrimination Act, and the Rehabilitation Act, through exclusion from participation in or denial of benefits under any health program.

Physician ownership
• Prohibits self-referrals to physician-owned hospitals and the expansion, or creation, of new physician-owned hospitals.
  o Exempts grandfathered hospitals with the highest Medicaid volume in its county, as long as they are not the only hospital in that county.

Durable Medical Equipment (DME) and Home Health Services under Medicare
• Requires DME or home health services under Medicare Part A and Part B to be ordered by a Medicare-eligible professional or physician enrolled in the Medicare program.
  o Allows the secretary to extend these requirements to other Medicare items and services (not implemented to date).
• Requires providers to maintain and provide access to written orders or requests for payment for DME, certification for home health services, or referrals for other items and services.
• Requires physicians to have a face-to-face encounter with an individual prior to issuing a certification for home health services or DME.
o Allows the secretary to apply the face-to-face encounter requirement to other items and services (not implemented to date)
o Requires the face-to-face encounter may be performed by a physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife, or physician assistant.