



NASHP Chart – A Crosswalk of ACA Provisions with Proposed Language Under the House American Health Care Act.

Note: This chart summarizes major provisions included in the 2010 Patient Protection and Affordable Care Act and provisions included in the most recent House health reform drafts, collectively known as the American Health Care Act, released on March 6, 2017.

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Topic Area	ACA	Energy and Commerce and Ways and Means Draft Committee Bills (as of March 6, 2017)
Federal support/enforcement to expand coverage		
<p>Increasing coverage (private and public markets discussed below)</p>	<p>Coverage mandates:</p> <ul style="list-style-type: none"> ● Individual Mandate: Requires all U.S. citizens and legal residents to have health coverage. Assesses a tax penalty on those lacking coverage. ● Employer Mandates: Requires all employers with more than 200 employees to automatically enroll employees in health insurance plans (opt out is available for employees). All employers with more than 50 employees are assessed a fee if they have at least one employee who receives a premium tax credit <p>Individual Market Affordability Assistance:</p> <p><i>Advance Premium Tax Credits:</i> Refundable credits, which can be paid in advance, are given to individuals and families with incomes between 100-400% of the FPL to be used for the purchase of coverage through a state or federal health insurance exchange.</p>	<p>Coverage mandates:</p> <ul style="list-style-type: none"> ● Zeros penalty tied to individual mandate (effective repeal of individual mandate). Retroactive to January 1, 2016 (W&M) ● Zeros penalty tied to employer mandate (effective repeal of employer mandate). (W&M) Retroactive to January 1, 2016 (W&M) ● Institutes continuous coverage requirement beginning in benefit year 2019 for open enrollment, and 2018 for special enrollments. Assesses a 30 percent late-enrollment surcharge on top of premiums for individuals that have more than 63 days during which they did not have coverage over the prior 12 months. The surcharge discontinues after 12 months (applied equally to individuals regardless of health status. (E&C) <p>Individual Market Affordability Assistance:</p> <p><i>Advance Premium Tax Credits:</i> Repeals ACA tax credits in 2020 (both individual and small business).</p> <p>Adds an age-rating factor to PTC credit calculations for 2019. (W&M)</p> <ul style="list-style-type: none"> ● Increases amount of PTC allocated to individuals up to age 39 and between 150-400% FPL. ● Increases amount of PTC allocated to individuals age 40-49 between 250-400% FPL. ● Lowers PTC allocated to individuals age 50+ between 150-400% FPL.

		<ul style="list-style-type: none"> • Reduce the cost of providing insurance in individual and small group markets to individuals with high utilization of health services. • Increase health insurance options available in individual and small group markets • Promote access to preventive, dental, vision, mental health, and substance use services. • Provide payments directly or indirectly to health care providers for the provision of services specified by the Administration. • Provide assistance that reduces out-of-pocket spending for individuals. <p>Appropriates \$15 billion annually in 2018 and 2019. 85% of states allotted funding in 2018-19, will be based on claims incurred during benefit year 2015 and, subsequently, 2016 (the most recent years of medical loss ratio data). To receive the remaining 15%, states must have fewer than three plans that offer coverage on-exchange in 2017 or total uninsured rate must have increased from 2013-2015.</p> <p>In 2020, the Administration will set an allocation methodology based on cost, risk, low-income uninsured, and issuer competition. A state match will also be phased in at this time. Appropriates \$10 billion per year from 2020-2026</p> <p>CMS may use the resources available to help stabilize premiums in states that opt not to use this funding to institute their own programs.</p>
Insurance Standards and Consumer Protections**	Qualified Health Plan (QHP): A health insurance plan that meets certain parameters set forth by the ACA including limits on cost-sharing, provision of essential health benefits, and provides minimum essential coverage.	Changes definition of Qualified Health Plan (W&M) Repeals language associating QHPs with standards set by the health insurance exchanges including requirements that QHPs be certified or recognized by the exchange through which they are offered and regulations developed under section 1311(d) by the Secretary or exchanges. Additional changes include:

<p>**Changing these provisions would require full repeal of ACA, not just the budget reconciliation vote that Congress is currently pursuing because they have no direct impact on the budget.</p>	<p>Protections that limit consumer spending:</p> <ul style="list-style-type: none"> ● Out-of-pocket spending limits ● Elimination of annual and lifetime limits ● Elimination of cost-sharing for preventive services defined by the U.S. Preventive Services Task Force <p>Standard benefits package (for qualified health plans (QHPs): Requires QHPs to offer a package of essential health benefits (EHB) that cover a comprehensive set of services defined within 10 benefit categories, which include mental health and substance abuse services.</p> <p>Extension of dependent coverage: Requires employer-sponsored insurance plans to offer employees’ dependents health coverage up to age 26.</p> <p>Guaranteed issue requirement: Requires health plans to offer coverage to any eligible applicant regardless of health status, including those with pre-existing conditions.</p> <p>Institution of rate review program: Requires state/ federal review of any premium increases in excess of 10% over the prior year. Requires state to report on premium trends and offer recommendations for plans that should be excluded from the marketplace. Provides grants to states to support the rate review program.</p>	<ul style="list-style-type: none"> ● Repeals requirement that QHPs offer at least one QHP at the silver-level and one-plan at the gold level in an exchange. ● Clarifies that a QHP does not have to be offered through an exchange. ● Mandates that QHPs cannot include coverage for abortions, other than when necessary to save the life of the mother. ● Prohibits grandmothers or grandfathered health plans from being considered QHPs. ● Repeals prohibition that catastrophic plans may qualify as QHPs. <p>Protections that limit consumer spending: No change.</p> <p>Standard benefits package (for qualified health plans (QHPs): Maintains 10 essential health benefit categories, though eliminates actuarial calculations associated with benefit design (see below).</p> <p>Extension of dependent coverage: No change.</p> <p>Guaranteed issue requirement: No change.</p> <p>Institution of rate review program: No change.</p>
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<p>Ban on rescissions: Prohibits issuers from revoking coverage other than in cases of fraud or intentional misrepresentation of facts.</p> <p>Actuarial values: Establishes four standard tiers of health insurance based on actuarial values (60%, 70%, 80% and 90% of the expected costs the plan will cover). The tiered system sets the minimum amount of coverage individuals must purchase to receive tax credits and sets benchmarks for premium and cost sharing subsidies.</p> <p>Limits on allowable rating factors: Issuers offering health plans through the marketplaces may only rate (or price) their products based on age (3:1 ratio), tobacco use (1.5:1 ratio), geographic area, or family size. As described above, the law explicitly prohibits rating factors related to medical underwriting (i.e. a consumer’s health condition.)</p> <p>Ban on gender and health status rating: Prohibits issuers from charging different premiums to individuals based on gender or health status.</p> <p>Non-discrimination standards: Prohibits discrimination on the basis of race, color, national origin, sex, age, or disability for health programs or activities funded by federal Health and Human Services Administration (HHS) and by issuers offering coverage in the health insurance marketplace.</p> <p>Network adequacy requirements: Requires marketplace plans to offer a sufficient choice of providers—meaning an adequate number and mix of provider types (including mental health and substance abuse providers) to assure accessibility of services without unreasonable delay. Networks must include essential community providers that serve predominantly low-income, medically-underserved individuals, such as federally qualified health centers.</p> <p>Enables an appeal process: Establishes an avenue for consumers to appeal coverage denials to the insurer and be guaranteed the right to an independent external review.</p>	<p>Ban on rescissions: No change.</p> <p>Actuarial values: Repeals actuarial value standards specified by the ACA, effective in 2020. (E&C)</p> <p>Rating factors: Loosens age rating ration to 5:1. Enables state flexibility to set their own ratios, effective in 2018. (E&C)</p> <p>Ban on gender and health status rating: No change.</p> <p>Non-discrimination standards: No change.</p> <p>Network adequacy requirements: No change.</p>
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<p>Easing purchasing and transparency</p>	<p>Health insurance marketplaces: Establishes individual and small-group health insurance exchanges where individuals and businesses with up to 100 employees can purchase coverage. Exchanges may be run by a governmental agency, quasi-government agency, or non-profit organization. Exchanges are required to perform certain functions related to consumer outreach and service as well as provide health plan oversight.</p> <p>Exchanges intend to promote greater transparency through a simplified approach to “shopping” for health insurance. They are empowered to provide tools that guide consumers through the process of obtaining health insurance, from plan search through enrollment including coordination of outreach and enrollment support via health insurance navigators and assisters.</p> <p><i>Regional exchanges:</i> States may form regional exchanges and/or for multiple exchanges may exist in a state (the latter only if the exchanges serve distinct geographic regions).</p>	<p>Distribution of tax credits: <i>Health insurance exchanges.</i> Through 2019, ACA exchanges are the only source through which consumers may procure an advanceable tax credit. Non-advanceable tax credits are available to purchase coverage off an exchange. (W&M)</p> <p><i>Transition to age-adjusted tax credits.</i> Empowers treasury to create a system to deliver age-adjusted PTC. Emphasizes the distribution system should, where possible, build upon what was established under the ACA. Each entity authorized to take actions under these programs would be subject to requirements for PTC distribution per the discretion of the Treasury. In cases where a plan is sold off an exchange, the provider of the eligible health insurance (or, if allowed by the Secretary, an agent or broker) shall be considered the proxy for conducting the responsibilities normally designated to an Exchange. Implemented in 2020. (W&M)</p> <p><i>Flexible use of tax credits (W&M)</i></p> <ul style="list-style-type: none"> • Allows consumers to use tax credits to purchase catastrophic coverage • Allows consumers to use tax credits to purchase certain plans off-exchange <p>Distribution of financial assistance in individual and small group markets via the Patient and State Stability Fund: Allows states flexibility to define certain parameters around which they will establish or maintain mechanisms through which they provide assistance related to the Stability Fund (E&C)</p>

	<p>No-wrong door eligibility: Requires states to develop a single form for consumers to use when applying for health insurance subsidies. Enables states to contract with Medicaid to determine eligibility for Medicaid coverage.</p> <p>Maintenance of provider directories: Mandates issuers to develop provider directories and to post accurate information about provider availability and networks.</p>	<p>Eligibility determinations Repeals requirements for eligibility determinations set forth in sections 1411, and 1412 of the ACA in the context of determinations made for PTC, Effective in 2020. (W&M)</p> <p>Maintenance of provider directories: No change</p>
<p>Establishing coverage options and alternatives</p>	<p>Consumer-Operated and -Oriented Plan Program (CO-OPs): Fosters the creation of qualified nonprofit health insurance issuers to increase competition in the individual and small group markets.</p> <p>Multi-state Program: Directs the Office of Personnel Management to contract with at least two private health insurers per state to offer marketplace coverage options that [intend to] provide statewide or cross-state coverage.</p> <p>Basic Health Plan: This option for states creates an insurance product available to citizens or lawfully present non-citizens with income between 133-200% of the FPL who do not qualify for Medicaid, CHIP, or other minimum essential coverage. States receive 95% of the premium tax credits and cost-sharing reductions that would have otherwise been provided to (or on behalf of) eligible individuals if these individuals enrolled in QHPs through the marketplace.</p> <p>Limitations on high-deductible plans and scope of Health Savings Accounts (HSAs), Health Reimbursement Accounts (HRAs), and Flexible Spending Accounts (FSAs)</p> <ul style="list-style-type: none"> ● Limits FSA and HRA flexibility: Excludes over-the-counter, non-prescribed drugs as reimbursable expenses. ● Increased tax on HSA funds: Imposes an increased tax on distributions to HSAs not spent on qualified medical expenses. ● Limits FSA contributions: Limits FSA contribution amounts to \$2,500 per year, adjusted for cost of living. 	<p>Consumer-Operated and -Oriented Plan Program (CO-OPs): No change</p> <p>Multi-state Program: No change</p> <p>Basic Health Plan: No change</p> <p>Flexibility for high-deductible plans and scope of Health Savings Accounts (HSAs), Health Reimbursement Accounts (HRAs), and Flexible Spending Accounts (FSAs)</p> <ul style="list-style-type: none"> ● Repeals ACA’s limits on use of HSAs to pay for over-the-counter medications beginning in 2018 (W&M) ● Repeals the increased tax to pre-ACA rates beginning in 2018 (W&M) ● Repeals the limit on FSA contributions beginning in 2018 (W&M) ● Increases limit on aggregate HSA contributions to the maximum sum of an annual deductible and out-of-pocket expenses permitted under a high-deductible plan (at least \$6,550 in self-only coverage; \$31,000 for family coverage in 2018). (W&M) ● Allows both spouses to make catch-up contributions to one HSA beginning in 2018 (W&M)

		<ul style="list-style-type: none"> • HSAs may be used to pay for medical expenses incurred before the HSA was established, if the HSA was established within a 60-days of enrollment in a high deductible plan beginning in 2018. (W&M)
<p>Market stabilization vehicles, and additional issuer requirements</p>	<p>Medical loss rebates: Requires most insurance companies that cover individuals and small businesses to spend at least 80% of their premium income on health care claims and quality improvement. The remaining 20% may be allocated to administrative and marketing costs and plan profits.</p> <p>Reinsurance program: Temporary program (2014-16) through which issuers are eligible for payments if enrollee costs exceed a specified threshold. All health insurance issuers and self-insured plans contribute funds to the program.</p> <p>Risk Corridors program: Temporary program (2014-16) through which marketplace issuers are required to spend 80% of premium dollars on healthcare and quality improvement. Issuers falling below 3% of the target are required to pay into the program. Funds collected are intended to be used to reimburse plans whose costs are 3% above the spending threshold.</p> <p>Risk adjustment program: Program through which HHS redistributes funds from plans with lower-risk enrollees to plans with higher-risk enrollees based on a risk calculation developed to evaluate the average financial risk of marketplace enrollees. States have the option to operate their own risk adjustment program, though to date all have defaulted to federal operation of the program.</p> <p>Health issuer fees: Imposes an annual fee on health insurance of a base rate, grown to reflect growth of premium rates. Fee is reduced for non-profit issuers.</p> <p>Merged markets: Permits states to merge individual and small group markets.</p> <p>Single risk pool: Requires issuers to consider all plans sold in a state’s individual market as part of a single risk pool, whether the plans exist on or off an exchange.</p>	<p>Medical loss rebates: No change.</p> <p>Reinsurance program: No change.</p> <p>Risk Corridors program: No change.</p> <p>Risk adjustment program: No change.</p> <p>Health issuer fees: Repealed in 2018.</p> <p>Merged markets: No change.</p> <p>Single risk pool: No change.</p>

<p>Employer market reforms</p>	<p>Small employer tax credit: Provides small employers (up to 25 employees) with a temporary tax credit for purchase of health insurance (up to 50% of employer contribution if employer contributes at least 50% of premium costs).</p> <p>Small business Health Options Program (SHOP): Creates the SHOP marketplace to enable purchase of health coverage by small-employers (up to 50 employees, with a state option to expand the definition to up to 100 employees).</p> <p>Cadillac tax: Imposes an excise tax on insurers of employer-sponsored health plans with aggregate values that exceed \$10,200 for individual coverage and \$27,500 for family coverage (indexed based on the consumer price index for urban consumers). Implementation of the tax has been repeatedly delayed, with implementation now slated for 2020.</p>	<p>Small employer tax credit: Repeals ACA tax credits in 2020 (both individual and small business). Restricts small business tax credits so they cannot be used for plans that cover elective abortions, effective 2018-19 (W&M)</p> <p>Cadillac Tax: Postpones effective date of the Cadillac tax until after December 31, 2024 (W&M)</p>
<p>Prescription drug benefits</p>	<p>Prescription drugs are included as one of the 10 EHBs. The ACA requires private plans and plans covering the Medicaid expansion population to cover all 10.</p> <p>A tax on drug manufacturers and importers is created as part of the ACA funding mechanism, and the ACA gives manufacturers 12 years of exclusive use before generics can be developed.</p> <p>The ACA includes provisions to close the Medicare Part D coverage gap (the “donut hole”) by phasing down the copayments for drugs until it is at the standard 25% in 2020 and stepping up the percent discount that manufacturers provide.</p>	<p>No change.</p> <p>Repeals tax on drug manufacturers beginning after December 31, 2017. (W&M)</p>
<p>Medicaid</p>		
<p>Medicaid expansion</p>	<p>Coverage expansion: Expanded Medicaid to all non-Medicare-eligible individuals under age 65 with incomes up to 138% FPL, based on modified adjusted gross income (Supreme Court ruling resulted in expansion being optional for states)</p>	<p>Repeals coverage expansion: Repeals state option to expand Medicaid above 138% FPL as of December 31, 2019. (E&C)</p> <p>Modifies and repeals enhanced match: Repeals enhanced match available for newly eligible beneficiaries as of December 31, 2019.</p>

Increased funding to states: States expanding Medicaid for the newly-eligible population received 100% federal match for 2014-2016, gradually phasing down to 90% federal match in 2020

For states that expanded Medicaid prior to March 23, 2010, halts the phase up of matching rate after coverage year 2017; percentage would remain at 2017 levels for future years. Matching rate only applies for expenditures made by individuals eligibility for the matching rate and enrolled in Medicaid

After January 1, 2020, applies match rate only to expenditures for newly eligible individuals who were enrolled in Medicaid under a State plan or waiver as of December 31, 2019. Enrollees may not have a break in eligibility for more than one month after that date for state to receive enhanced match. After January 1, 2020, states may only enroll newly eligible individuals at the state's traditional FMAP. (E&C)

Community-based attendant services and supports: Repeals bonus federal match (6 percent) available for community-based attendant services and supports. (E&C)

Per capita cap: Creates a per capita cap financing structure for Medicaid beginning in 2020.

- Uses FY2016 as the base year to establish a per capita limit for spending for each of the following groups:
 - Elderly and disabled
 - Children
 - ACA expansion
 - Other eligible people not including in the first three groups
- Spending targets would increase yearly based consumer price index—urban
- The base of the per capita cap excludes DSH spending, Medicare premiums and other cost sharing, and safety net provider payments
- Any state exceeding their cap will receive reductions to their Medicaid funding in the following fiscal year.
- The per capita cap does not apply to
 - CHIP Medicaid expansion
 - Individuals receiving assistance through Indian Health Service Facilities

	<p>Benchmark benefits: Benefits for newly-eligible individuals based on a Medicaid benchmark plan that includes the ACA’s essential health benefits</p>	<ul style="list-style-type: none"> ○ Individuals entitled to coverage under the Breast and Cervical Cancer Early Detection Program ○ Unauthorized aliens eligible for Medicaid emergency medical care ○ Individuals eligible for Medicaid family planning ○ Dual-eligibles ○ Individuals eligible for premium assistance ○ Tuberculosis-related services <p>Medicaid Safety-net Fund: Provides \$10 billion over 5 years for states that have not implemented Medicaid expansion under the ACA as of July 1 of the preceding year. Applies from coverage year 2018-2022. Funding may be used to adjust payment amounts made to Medicaid providers.</p> <ul style="list-style-type: none"> ● Match rate would increase to 100% for CY2018-2021 and 95% in CY2022 ● State allotments would be determined according to the number of individuals in the state below 138% FPL as published in the 2015 American Community Survey (ACS). <p>Repeals benchmark benefits: Repeals requirement that Medicaid plans must provide the same essential health benefits required by qualified health plans on the exchanges (as of December 31, 2019) (E&C)</p> <p>Codifies state option to expand Medicaid: Asserts <i>National Federation of Independent Business (NFIB) v. Sebelius</i>—that Medicaid expansion is at the option of a state. (E&C)</p>
<p>Other Medicaid changes (not including LTSS delivery system changes and DSH reductions)</p>	<p>Systems changes: States were required to implement a number of changes to their Medicaid programs (related to eligibility and enrollment, operations, etc.), regardless of whether they opted to implement the Medicaid expansion</p>	<p>Eligibility determinations:</p> <p><i>Presumptive eligibility.</i> Repeals state authority to make presumptive eligibility determinations except in cases of children, pregnant women, and breast and cervical cancer patients (E&C).</p> <p><i>Redetermination of expansion populations.</i> Requires states with Medicaid expansion populations to re-determine eligibility of expansion enrollees every 6 months. Provides a temporary 5% FMAP for states to comply. (E&C)</p> <p><i>Requirement to document citizenship status.</i> Requires individuals to provide documentation of citizenship or lawful presence before obtaining Medicaid</p>

	<p>New eligibility floor -This raises Medicaid eligibility levels for all children to 138% FPL, which required some states to transition children from separate CHIP to Medicaid coverage</p> <p>Maintenance of effort (MOE): This provision requires states to maintain the Medicaid and CHIP eligibility levels, standards, methodologies, and procedures for children that were in place in 2010 through FFY 2019</p> <p>Enrollment simplification: Provides a new presumptive eligibility (PE) authority for hospitals</p>	<p>coverage. Nullifies prior requirements that states enroll Medicaid applicants in Medicaid and establishment of a reasonable period for individuals to provide documentation to verify their citizenship or eligible immigration status. (E&C)</p> <p><i>Consideration of lump sum/lottery payments.</i> Requires states to consider monetary winnings from lotteries and other lump sum payments as if they were obtained over multiple months for the purposes of determining MAGI for Medicaid and CHIP eligibility. Counts lottery winnings about \$80,000. Allows states to define a hardship exemption, within parameters established by HHS, under which a state may continue to provide Medicaid coverage if the denial would cause undue medical or financial hardship (E&C)</p> <p><i>Rescinds state flexibility on equity limits:</i> Repeals state authority to elect a home equity limit above the statutory minimum for Medicaid eligibility determinations. Effective 180 days after enactment except where state legislation would be required to amend the state plan. (E&C)</p> <p>Eligibility threshold for children: Reverts mandatory Medicaid income eligibility for children to 100 percent FPL. (E&C)</p> <p>Enhanced data and reporting (to enable per capita cap): Requires modernization of Medicaid data and reporting systems to include data on medical assistance expenditures for all Medicaid enrollees. Intent is to enable a “full picture” of Medicaid spending and smooth transition toward the per capita payment model. Provides a temporary increased FMAP for state to improve data reporting systems. (E&C)</p>
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<p>Medicaid demonstrations and state options for long-term services and supports</p>	<p>Money follows the Person: The rebalancing demonstration program -- through September 2016 -- allocated an additional \$2.25 billion to the program and expanded eligibility criteria.</p> <p>Home and community-based services: Provided states with additional options for providing home and community based services (HCBS) through Medicaid state plans instead of waivers for certain individuals.</p> <p>Community First Choice: Created an option in Medicaid to allow states to provide community-based supports for individuals with disabilities who need institutional-level care. States were provided with an enhanced federal match rate.</p> <p>Balancing Incentive Program: Provided qualifying states with an enhanced federal match rate from 10/1/11 to 9/30/15 to increase access to non-institutional LTSS options for individuals</p>	
<p>Medicaid health home</p>	<p>Established a Medicaid state plan option to coordinate care through a health home model for individuals with two or more chronic conditions, or who have one chronic condition and are at risk for developing another, or who have one serious mental illness. States receive enhanced federal funding (a 90% match) for the first eight quarters of implementation.</p>	
<p>Children’s Health Insurance Program (CHIP)</p>		
<p>CHIP financing and policy changes</p>	<p>Reauthorized CHIP: Extended funding for CHIP through FFY 2015</p> <p>Enhanced funding to states: Introduced a 23% point increase in the federal CHIP match rate (not to exceed 100%) beginning in FFY 2016 through FFY 2019</p> <p>Maintenance of effort (MOE): Requires states to maintain Medicaid and CHIP eligibility levels, standards, methodologies and procedures for children that were in place in 2010 through FFY 2019</p>	<p>Flexibility on eligibility: Allows states to cover mandatory Medicaid eligible children (up to 100 percent FPL) under CHIP. (E&C)</p>

	Option to extend CHIP coverage: Provided states an option to offer CHIP coverage to children of state employees who were eligible for health benefits (if certain conditions were met)	
Delivery System Reforms		
Center for Medicare and Medicaid Innovation (CMMI) within CMS	CMMI demonstration programs reward providers and systems for value over volume. CMMI funds a number of initiatives (such as the State innovation Model - SIM) that address payment and delivery system reform and population health and prevention. CMMI also has a prevention and population health group that provides national leadership.	
Accountable care organizations (ACOs)	The ACA defines ACOs and establishes a Medicare Shared Savings ACO program .	
Medicare-Medicaid Coordination Office	Created to address issues for individuals dually-enrolled in Medicare and Medicaid	
Provider Payments		
Hospital readmissions reduction program	Penalizes hospitals for excess readmissions within 30 days of discharge.	
Hospital-Acquired Condition (HAC) reduction program	Penalizes the worst-performing quarter of hospitals.	
Medicaid coverage for tobacco cessation for pregnant women	Medicaid must cover counseling and medication for tobacco cessation without cost sharing.	

Disproportionate Share Hospital (DSH) and other hospital payments	<ul style="list-style-type: none"> • Reduces Medicare DSH payments and aggregates Medicaid DSH allotments. • Reduces Medicare payments to certain hospitals for hospital-acquired conditions by 1% 	Repeals Medicaid DSH cuts (E&C) <ul style="list-style-type: none"> • In 2018 for non-expansion states • In 2020 for expansion states
Provider Workforce		
National Healthcare Workforce Commission	Reauthorized funding for existing grant programs under the Public Health Services Act (PHSA) including federal health workforce programs administered by Health Resources and Services Administration (HRSA) National Health Service Corps (NHSC) funding reauthorized through Community Health Center Fund (CHCF)	
Additional federal support for medical education	<ul style="list-style-type: none"> • Increased federally-supported medical student loans, increased loan rates/amounts for nursing students. • Established pediatric specialty and public health loan repayment programs 	
Community Health Center Fund		Increases funding to the Community Health Center Fund to support FQHCs. (E&C)
Funding freeze on prohibited entities		Imposes a one-year freeze on mandatory funding to prohibited entities which include non-profit, essential community providers primarily engaged in family planning and reproductive health services, that provide abortions in cases that do not meet the Hyde amendment exception for federal payment and received over \$350 million in federal and state Medicaid dollars in fiscal year 2014. (E&C)
Quality Improvement		
National Quality Strategy (NQS)	NQS works with stakeholders to align clinical quality measures around shared aims and priorities. It identifies and prioritizes areas of focus for quality improvement nationwide. It developed measure sets for nine topics aligned with six quality priorities. Measure alignment is done with an eye toward minimizing provider burden.	
Patient-Centered Outcomes Research Institute (PCORI)	PCORI funds comparative effectiveness research (CER) to help policymakers and others make informed decisions based on evidence-based information; however, CER may not be, “construed as mandates, guidelines, or recommendations for payment, coverage, or treatment or used to deny coverage.”	

Population Health

<p>Prevention and Public Health Fund</p>	<p>The Epidemiology and Laboratory Capacity for Infectious Diseases (ELC) Cooperative Agreement, which awards funds to all 50 state health departments, receives nearly half its funding from the fund (see ASTHO, Prevention and Public Health Fund). ELC awards to states and localities totaled \$245 million in 2016. According to the CDC, “Funds provided through the ELC mechanism help pay for more than 1,000 full- and part-time positions in the state, territorial, local, and tribal health departments. These positions include epidemiologists, laboratorians, and health information systems staff,” in 2013. Trust for America’s Health estimates that states would lose more than \$3 billion over five years if the fund were repealed.</p> <p>The fund supports the Preventive Health and Health Services (PHHS) Block Grant to states, which supports rapid responses to emerging health issues. The CDC allocated \$160 million in PHHS Block Grant funding 2015, aligned with Healthy People 2020 goals. The ELC also gave states and cities \$60 million in July 2016 to fight Zika.</p>	<p>Repeals Prevention and Public Health Fund appropriations from fiscal year 2019 onward. Unobligated fund remaining at the end of FY 2018 will be rescinded. (E&C)</p>
<p>Tax-exempt hospital community needs assessment/ community benefits</p>	<p>The ACA requires nonprofit hospitals seeking to retain their tax-exempt status to conduct community health needs assessments and develop a plan for addressing those needs. Final rules specify that the community needs addressed by hospitals may include the need to, “ensure adequate nutrition, or to address social, behavioral, and environmental factors that influence health in the community.”</p> <p>The rule requires each hospital to obtain and consider input from a governmental public health department.</p>	
<p>Office of Minority Health</p>	<p>The ACA reauthorized the Office of Minority Health and moved it to the Office of the Secretary. It also created individual offices of minority health within each agency: CDC, HRSA, SAMHSA, AHRQ, FDA, and CMS.</p>	
<p>Enhanced demographic data collection to monitor disparities</p>	<p>The ACA called for enhanced data collection for federal programs, including Medicaid and CHIP, to help address disparities.</p>	

Other taxes to fund the law

		<p>Repeals medical device tax (W&M)</p> <p>Restores pre-ACA threshold for tax deductions based on medical-expenses (from 10 percent to 7.5 percent) (W&M)</p> <p>Repeals tanning tax in 2018. (W&M)</p> <p>Repeals net investment tax in 2018. (W&M)</p> <p>Repeals limit on remunerations that pay be paid to health insurance providers in 2018. The ACA had capped this at \$500,000. (W&M)</p> <p>Repeals health insurance tax beginning after December 31, 2017. (W&M)</p>
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