

| | Topics | H.R. 3962 - Affordable Health Care for America Act | Senate HELP (S. 1679) - Affordable Health Choices Act | Senate Finance Committee Bill (S. 1796) - America's Healthy Future Act of 2009 |
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| Restrictions on Benefits | | | | |
| 1 | Benefits Packages | <p>Prohibits pre-existing condition exclusions (§211). Requires plans to comply with rules promulgated by the Secretary of HHS regarding the nondiscrimination in benefits (§214). Prohibits the use of lifetime aggregate limits on covered benefits (§109).</p> | <p>Prohibits pre-existing condition exclusions (§101). Prohibits limits on the lifetime or annual limits on the dollar value of benefit services (§101).</p> | <p>Prohibits pre-existing condition exclusions and other limits based on health-status-related factors (§1001). Prohibits annual or lifetime limits on enrollees in the small and large group market (§1201). Permits premiums to vary based only on tobacco use, age, or family composition (§1001). Permits flexibility in plan design as long as plans do not engage in adverse selection (§1201). Encourages states to include innovative features in their health plan contracting for the state's basic health plan including: care coordination and care management, particularly for enrollees with chronic conditions; and establishment of patient-doctor relationships that maximize patient involvement in healthcare decisionmaking (§1001).</p> |

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| Prevention and Wellness | | | | |
| 2 | Preventive Services | <p>Eliminates cost-sharing for preventive services or items that are rated 'A' or 'B' by the U.S. Task Force on Clinical Preventive Services (§222).</p> | <p>Requires health plans to cover preventive and wellness services as an essential benefit (§142). Prohibits all but minimal cost sharing for preventive and wellness services (§101). Requires health plans to provide coverage for preventive services or items that have an 'A' or 'B' rating in the current U.S. Preventive Services Task Force recommendations, and with respect to infants, children, and adolescents, to provide coverage for preventive care and screenings listed in Health Resources and Services Administration guidelines (§101).</p> | <p>Requires health benefits plans to provide coverage for preventive services, including those services recommended with a grade of 'A' or 'B' by the U.S. Preventive Service Task Force and prohibits the use of cost-sharing for such services (§1201).</p> |

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| 3 | National Prevention Strategy | Requires the creation and submission every two years of a “national prevention and wellness strategy” to include: national goals and priorities for prevention and wellness; identification of health disparities; research gaps; review of the prevention delivery system capacity and workforce; and existing public health measures and standards (§2301). | Creates the National Prevention, Health Promotion and Public Health Council to develop a national prevention and health promotion strategy that incorporates the most effective and achievable means of improving health status and reducing the incidence of preventable illness and disability in the United States. Strategy will target priority areas, including reducing tobacco use, sedentary behavior, and poor nutrition (§301). | |

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| 4 | Funds for Public Health and Prevention | Establishes the Public Health Investment Fund and deposits a total of \$33.9 billion for use over the next five years (FY 2011 - FY 2015) (§2002). Allocates \$15.4 billion from the Public Health Investment Fund to be used to fund prevention and wellness activities through a " Prevention and Wellness Trust " over the next five years (§2301). Also authorizes an additional \$12 billion from the Public Health Investment Fund to go to community health centers from the Public Health Investment Fund over the next five years (§2101). | Creates a Prevention and Public Health Investment Fund to expand and sustain funding for prevention and public health programs, including wellness activities. Provides \$10 billion in funding per fiscal year from 2010-2019 (§302). | Appropriates funds to prevention and wellness efforts directly from otherwise unappropriated funds in the U.S. Treasury. |

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| 5 | Task Forces on Preventive Services | <p>Converts the existing U.S. Preventive Services Task Force into the Task Force on Clinical Preventive Services, which will conduct evidence-based systemic reviews of data and literature to determine which clinical preventive services are scientifically proven to be effective (§2301). Also codifies the existing Task Force on Community Preventive Services and authorizes it to perform the same duties regarding community preventive services (§2301). Authorizes \$30 million for each of fiscal years 2011 through 2015 for carrying out the activities of the prevention task forces (§2301).</p> | <p>Expands the existing U.S. Preventive Services Task Force. Codifies the existing Task Force on Community Preventive Services. Provides for the coordination between the existing U.S. Preventive Services Task Force and the new Task Force on Community Preventive Services (§303).</p> | |

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| 6 | Screening Efforts | Requires the Secretary of HHS, in collaboration with the Director of CDC, to: (1) review uptake and utilization of diabetes screening benefits , consistent with the recommendations of the Task Force on Clinical Preventive Services; and (2) to establish an outreach program to identify existing efforts by agencies of HHS and by the private and non-profit sectors to increase awareness of diabetes screening benefits (§2594). | | |
| 7 | National Education and Outreach Campaign | | Requires the Secretary of HHS to conduct a national prevention and health promotion outreach and education campaign (§304). | |

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| 8 | Health Promotion and Disease Prevention Campaign | | <p>Directs CDC to implement a health promotion and disease prevention media campaign to address obesity reduction, proper nutrition, regular exercise, smoking cessation and the leading five disease killers in the United States. Directs the Secretary of HHS to establish a website that provides science-based guidelines on nutrition, exercise, obesity reduction, and chronic disease prevention for health care providers and consumers. Calls for the development of a federal website personalized prevention plan tool, which should use the most up-to-date scientific evidence on disease prevention, will allow consumers to determine their disease risk (based on personal and family history and BMI), and will provide personalized suggestions for preventing chronic disease. Authorizes up to \$500 million for these activities (§336).</p> | |

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| Wellness Incentives and Plans | | | | |
| 9 | Employer Wellness | Establishes a grant program for small employers to assist with the creation of employee wellness programs that promote healthy behaviors in a non-discriminatory manner. Programs may include health education, screenings, behavioral change programs (including addressing obesity, nutrition, physical fitness), and creating supportive environments (such as encouraging physical activity and improving the nutritional value of food available at the workplace) (§112). | Funds CDC research into best employer-based wellness practices . Directs CDC to create a targeted educational campaign and provide technical assistance to promote benefits of workplace wellness programs and health promotion . Nothing in the bill mandates employer-sponsored wellness programs (§334). | |

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| 10 | Employer-Based Wellness Incentives for Satisfaction of a Health Standard | | <p>Allows employers to give employees participating in wellness programs a reward or premium discount worth up to 30% of the cost of coverage. Allows the Secretaries of Labor, HHS and Treasury to increase the value of the reward up to 50% of the cost of coverage. Allows employers to give employees participating in wellness programs a reward, rebate or premium discount up to 30% of the cost of coverage that is conditioned on satisfying a standard related to a health-status factor only if the plan meets certain additional requirements (§101).</p> | <p>Codifies and enhances provisions in HIPAA that would allow employers to provide rewards (including insurance premium discounts or rebates) to employees for participating in a wellness program. Allows employers to offer rewards for satisfying a standard related to a health factor (such as a target BMI or blood pressure level) as long as rewards would be capped at 30% of the cost of employee-only contributions to the plan (with secretarial discretion to increase the reward up to 50%) and the plan meets other certain requirements. These provisions also apply to carriers of federal employee health benefits plans (§1901).</p> |

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| 11 | General Wellness Incentives for Satisfaction of a Health Standard | | Allows a group health plan and a health insurance issuer offering health insurance coverage in connection with a group health plan to offer incentives to an individual who voluntarily participates in a wellness program that is reasonably designed to promote health or prevent disease (§326). | Allows group health plans and health insurers offering group health insurance coverage to provide rewards for participation in programs of health promotion and disease prevention or for satisfaction of a standard related to a health factor. Establishes a ten-state demonstration project in 2014 to allow insurance issuers to offer similar rewards for health promotion programs in the individual health insurance market in participating states. Requires participating states to ensure that consumer protections are met by verifying that premium discounts do not create undue burdens or lead to cost shifting and that consumer data is protected under existing HIPAA privacy laws (§1901). |

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| 12 | Evaluation of Wellness Incentives | | Directs Secretary of HHS to conduct an evaluation of the effectiveness of federal health and wellness initiatives in changing in the health status of the American public, specifically the Federal workforce, as related to: absenteeism; productivity; workplace injury; medical costs; and health conditions (including workplace fitness, healthy food and beverages, and incentives in Federal Employee Health Benefits Plans) (§362). | Requires the Secretaries of HHS, Treasury, and Labor to submit a report to Congress on: the effectiveness of wellness and disease prevention programs in promoting health and preventing disease; the impact of a wellness program on a participant's access to care and the affordability of coverage; the impact of premium-based and cost-sharing incentives on employee behavior and their role in changing behavior; and the effectiveness of different types of rewards. The report will be due three years after the date of enactment and shall include recommendations for any legislative or administrative action (§1901). |

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| 13 | Research on Financial Incentives to Promote Wellness | Requires the Secretary of HHS to award grants to conduct research and demonstration projects on the use of financial incentives to encourage individuals and communities to: promote wellness; adopt healthy behaviors; and use evidence-based preventive health services . Requires that focus areas include: obesity (among other priorities); the initiation and sustainability of wellness promotion; adoption of healthy behaviors and use of evidence based preventive services; and populations at high risk of preventable diseases and conditions (§2301). | | |

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| 14 | Individualized Wellness Plans | | <p>Establishes a pilot program in up to ten community health centers to provide individualized wellness plans to at-risk populations (risk factors include weight, exercise rates, nutritional status and blood pressure). Permits the wellness plan to include: nutritional counseling; a physical activity plan; stress management; and compliance assistance provided by a community health center employee. Outcomes for participants who receive the wellness plan will be compared with a control group (§327).</p> | |

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| Additional Grants and Grant Programs | | | | |
| 15 | Community Grants | <p>Establishes a community prevention and wellness services grant program to support the delivery of evidence-based, community-based prevention and wellness services in priority areas, as identified in the national strategy. Not less than 50% of the funds shall be awarded for the primary purpose of achieving a measurable reduction in one or more health disparities (§2301). Also authorizes \$30 million for each of the next five years to provide grants and training to community health workers to promote positive health behaviors and outcomes in medically underserved areas regarding the following targeted areas: nutrition; physical activity; and overweight and obesity (§2530).</p> | <p>Requires the Secretary of HHS to award community transformation grants for programs that aim to prevent and reduce the incidence of chronic diseases by: creating healthier school environments; creating the infrastructure to support active living and access to nutritious foods; developing programs for various age levels that increase access to nutrition, physical activity, enhance community safety or address other chronic disease priority areas; highlighting healthy options at restaurants and other food venues; assessing and implementing worksite wellness programming and incentives; reducing ethnic and racial disparities; and addressing the needs of special populations. Measures for evaluation include changes in weight, proper nutrition, and physical activity. Such funds shall not be used to create video games or to carry out any other activities that may lead to higher rates of obesity or inactivity (§321).</p> | |

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| 16 | Grants: "Healthy Living, Aging Well" | | <p>Requires the Secretary of HHS to award Healthy Aging, Living Well grants to states or local health departments and indian tribes to conduct a 5 year pilot program for individuals aged 55-64 to "evaluate chronic disease risk factors, conduct interventions and ensure that individuals ... receive clinical treatment to reduce risk." Community screening activities may include screening for physical activity and nutrition. Interventions may target improving nutrition, increasing physical activity, and promoting healthy lifestyles. Requires the Secretary of HHS to evaluate programs based on prevalence of uncontrolled chronic disease risk facts among new Medicare enrollees who reside in areas receiving grants as compared with national/historical data (§322).</p> | |

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| 17 | Grants: "Right Choices" | | Requires the Secretary of HHS to award grants to states, which will administer temporary “Right Choices” programs to provide uninsured adults with chronic disease health risk assessment, a care plan, and referrals to community-based resources and screenings to prevent chronic diseases (§311). | |

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| 18 | Community-Based Overweight and Obesity Prevention Program | <p>Establishes a community-based overweight and obesity prevention program to prevent overweight and obesity among children through improved nutrition and increased physical activity. Secretary of HHS will award grants and contracts to entities that will:</p> <p>(1) serve communities with high levels of overweight/obesity; or (2) plan and implement overweight/obesity prevention programs in schools or workplaces. Authorizes \$10 million for FY 2011 and such sums as may be necessary for each of FY 2012 through FY 2015 to carry out this program (§2535).</p> | | |

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| Healthcare Workforce | | | | |
| 19 | Community Health Workforce | Establishes a program to provide support for the development and operation of primary care training programs for medical residents in community-based settings , such as community health centers (§2214). | Creates grants to promote the community health workforce that will be used for education and outreach efforts regarding positive health behaviors in medically underserved communities. Such grants will target certain geographic areas, including those with a high percentage of residents who suffer from chronic diseases (§443). | |
| 20 | Primary Care Workforce | Establishes grant and loan repayment programs for primary care workforce . Creates several public health training programs for primary care (§2211; §2212; §2213; §2215; §2216). | Establishes the Primary Care Extension Program to educate providers about preventive medicine, health promotion, chronic disease management, mental health services, and evidence-based therapies. The purpose of the program is to improve community health by working with community-based health connectors (§455). | |

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| 21 | Federal Health Centers | Requires the Administrator to certify, and recertify at least every five years, federally qualified behavioral health centers as meeting specific criteria, including the provision of outpatient clinical primary care services. Such primary care services must include screening for diabetes, hypertension, and cardiovascular disease, as well as monitoring weight, height, BMI, blood pressure, blood glucose, and lipid profile (§2513). | | |
| 22 | Medical-Legal Partnerships | Requires the Secretary of HHS to establish a nationwide demonstration project to award grants for the formation of medical legal partnerships between a health care provider (e.g., a community health center) and an attorney to assist patients and their families navigate health-related programs and activities and to achieve specific goals, such as enhancing wellness and prevention of chronic diseases (§2537). | | |

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| Quality | | | | |
| 23 | Improving Quality | Provides \$25 million for the development of new quality measures . Requires the Secretary of HHS to develop, test, and update new patient-centered and population-based quality measures for the assessment of health care services in the United States (§1442). | Requires the Director of CDC to award grants or contracts to eligible entities for purposes of developing, improving, updating, or expanding quality measures prioritizing certain areas (including those that assess health outcomes, functional status of patients and health disparities). Data from the reporting of these quality measures will be made available. Grants will also be given to the National Quality Forum to develop, test and disseminate education tools to help patients understand treatment options (§203). | Requires the Secretary of HHS to identify, not less than triennially, gaps where no quality measures exist, or where existing quality measures need improvement, updating or expansion, consistent with the national strategy and priorities. The Secretary would then be required to develop measures that would fill identified gaps. Measures developed under this section would be applicable to all age groups, where appropriate, and focus on a minimum of the following areas: 1) patient outcomes and functional status; 2) coordination of care across episodes of care and care transitions; 3) meaningful use of health information technology; 4) safety, effectiveness, patient centeredness, appropriateness, and timeliness of care; 5) efficiency of care; 6) equity of health services and health disparities; 7) patient experience and satisfaction; and 8) other areas deemed appropriate by the Secretary (§3013). |

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| 24 | Comparative Effectiveness Research | Creates the Center for Comparative Effectiveness Research at the Agency for Healthcare Research and Quality supported by a combination of public and private funding that will conduct, support and synthesize comparative effectiveness research (§1401). | Requires eligible entities to make recommendations to the Secretary of HHS for national priorities for performance improvement in population health and in the delivery of health care services and will ensure that priority is given to areas that, among other things, have the greatest potential for improving the health outcomes, efficiency, and patient-centeredness of health care and address gaps in quality and health outcomes measures, comparative effectiveness information, and data aggregation techniques (§204). Also establishes a new Center for Health Outcomes Research and Evaluation within HHS to collect and analyze health outcomes and effectiveness data in order to identify the manner in which diseases, disorders and health conditions can most effectively be prevented, diagnosed, treated, and clinically managed (§219). | Establishes a non-profit Patient-Centered Outcomes Research Institute to assist patients, clinicians, purchasers, and policy-makers in making informed health decisions by advancing the quality and relevance of evidence concerning the prevention, diagnosis, treatment, and management of diseases, disorders, and other health conditions. The Institute shall identify national priorities for comparative clinical effectiveness research , taking into account factors including: (1) disease incidence, prevalence, and burden; (2) evidence gaps in clinical outcomes; (3) practice variations in delivery and outcomes; (4) the potential for new evidence to improve patient health, well-being, and quality of care; (5) the effect, or potential for an effect, on health expenditures associated with a health condition, medical treatment, service, or item; (6) the effect, or potential for an effect, on patient needs, outcomes, and preferences, including quality of life; and (7) the relevance to assisting patients and clinicians in making informed health decisions (§3501). |

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| 25 | National Strategy for Quality Improvement | Requires the Secretary of HHS to establish national priorities for quality and performance improvement , which should reflect areas that contribute to a large burden of disease, have high potential to decrease morbidity and mortality and improve performance, address health disparities, and have the potential to produce the most rapid change based on current evidence (§1441). | Requires the Secretary of HHS to develop a national strategy for quality improvement to improve the delivery of health care services, patient health outcomes, and population health. Strategy will identify priorities, including those: that have the greatest potential for improving health outcomes, efficiency, and patient-centeredness of care; that address health care for patients with high-cost chronic diseases; that reduce health disparities; and that emphasize quality in Federal payment policy. Strategy will be reviewed and updated at least triennially (§201). | Requires the Secretary of HHS to develop a national strategy to improve health care quality to improve the delivery of health care services, patient health outcomes, and population health. Strategy will identify priorities, including: improving patient safety; reducing hospital readmissions and infections; and reducing disparities and the health needs of patients with high-cost chronic diseases (§3011). |
| 26 | Quality Report Card | | Requires the Secretary of HHS to publish an annual national health care quality report card , which will include national priorities, analysis of progress (and gaps) for strategic plans, and consumer and provider feedback (§201). | |

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| 27 | Best Practices | Creates a Center for Quality Improvement to identify, develop, evaluate, and help implement best practices for quality improvement activities in the delivery of health care services. Best practices must be consistent with standards on HIT and data collection in §3004 of this bill (§2401). | Funds research within the CDC for examining best practices relating to prevention , identifying effective public health services, and analyzing the successful translation of interventions from the academic setting to real-world clinics and communities (§331). | |
| 28 | Built Environment | | Establishes a CDC health impact assessment program to assess the effect of the built environment on health outcomes (§333). | |

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| Coordination of Care | | | | |
| 29 | Reimbursement | Requires the Secretary of HHS to design and implement payment mechanism policies that: seek to improve health outcomes and prevent and manage chronic diseases ; and that promote integrated, patient-centered, quality and efficient care (§324). | Directs group health plan and insurance issuers to develop and implement a reimbursement structure for providers that creates incentives for implementing care coordination and chronic disease management under the medical home model , and for implementing wellness and health promotion activities , which may include: weight management; physical fitness; nutrition; healthy lifestyle support; and heart disease and diabetes prevention (§101). | Requires the Secretary of HHS to develop, test, and evaluate alternative payment methodologies through a national, voluntary pilot program that is designed to provide incentives for providers to coordinate patient care across the continuum and to be jointly accountable for the entire episode of care (§3023). |

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| 30 | Medical Homes | Establishes a new program to support the development and operation of interdisciplinary training programs for health professionals to improve coordination within and across health care settings, including training in medical home models and models that integrate physical, mental, or oral health services (§2252). | Creates program to fund Community Health Teams to support the development of medical homes by increasing access to comprehensive, community based, coordinated care. A patient's care is coordinated by multidisciplinary, interprofessional teams consisting of primary care providers, specialists, nurses, dietitians and other health professionals. Teams will collaborate with community resources to coordinate disease prevention, chronic disease management and manage the transition between health care providers/settings. Priority will be given to patients with chronic diseases or conditions identified by the Secretary. Teams shall assist PCPs with promoting effective strategies for treatment planning, monitoring health outcomes and resource use, sharing information, treatment decision support, and organizing care (§212). | |

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| Alternative Care Providers | | | | |
| 31 | School-Based Health Clinics | Requires the Secretary of HHS to establish a school-based health clinics (SBHC) program consisting of awarding grants to eligible entities to support SBHCs, which will be organized through school, community, and health provider relationships to provide comprehensive primary care health services during school hours to children and adolescents. Authorizes \$50 million for FY 2011 and such sums as may be necessary for each of FY 2012 through FY 2015 (§2511). | Requires the Secretary of HHS to award grants for the costs of the operation of school-based health clinics which will provide, at a minimum, comprehensive physical and mental primary health services during school hours to children and adolescents by health professionals. Makes health education services, such as nutrition counseling, physical education, and prevention of chronic disease counseling, optional under this section (§312). | |

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| Indian Health Services | | | | |
| 32 | Indian Health Services: Community Health Representatives | Requires the Secretary of HHS, acting through the Indian Health Service, to maintain a Community Health Representative Program under which Indian Health Programs will provide for the training of Indians as community health representatives to be used in the provision of health care, health promotion, and disease prevention services to Indian communities (§3101). | | |

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| 33 | Indian Health Services: Community Health Aide Program in Alaska | Requires the Secretary of HHS, acting through the Indian Health Service, to develop and operate a Community Health Aide Program in Alaska under which the Service: (1) provides for the training of Alaska Natives as health aides or community health practitioners; (2) uses such aides or practitioners in the provision of health care, health promotion, and disease prevention services to Alaska Natives living in villages in rural Alaska; and (3) provides for the establishment of teleconferencing capacity in health clinics located in or near such villages for use by community health aides or community health practitioners (§3101). | | |

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| 34 | Indian Health Services: School Health Education Programs | <p>Authorizes the Secretary of HHS, acting through the Indian Health Service, to award grants to Indian Tribes and Tribal Organizations to develop comprehensive school health education programs for children from pre-school through grade 12. Allows awarded grants to be used for purposes which may include, but are not limited to: developing school programs on nutrition education, personal health, oral health, and fitness; developing behavioral health wellness programs; and developing chronic disease prevention programs (§3101).</p> | | |

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| 35 | Indian Health Services: Diabetes Prevention and Control | Requires the Secretary of HHS to screen each Indian who receives services from the Indian Health Service for diabetes and for conditions which indicate a high risk that the individual will become diabetic and establish a cost-effective approach to ensure ongoing monitoring of disease indicators. Authorizes the Secretary to provide, through the Service, Indian Tribes, and Tribal Organizations, dialysis programs, including the purchase of dialysis equipment and the provision of necessary staffing. Also authorizes the Secretary of HHS to make grants to urban Indian organizations to provide services for the prevention and treatment of, and control of, diabetes among urban Indians (§3101). | | |

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| Food Issues | | | | |
| 36 | Menu Labeling | Requires chain restaurants (i.e., restaurants with 20 or more locations) to put the calorie content of their menu items directly on the menus , to provide a written statement concerning suggested daily caloric intake, and to make other nutritional information available , so that consumers can make informed choices about what they eat (§2572). | Mandates that vending machines owned or operated by an individual who owns or operates at least 20 such machines and restaurants that are part of a chain with 20 or more locations disclose calories on the menu board/drive-thru board or adjacent to self-serve food and food on display in written form along with a statement concerning suggested daily caloric intake. Also requires that such entites make available to customers upon request: additional nutrition information pertaining to total calories and calories from fat, as well as amounts of fat, saturated fat, cholesterol, sodium, total carbohydrates, complex carbohydrates, sugars, dietary fiber and protein (§325). | |

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| Medicare | | | | |
| 37 | Preventive Services | <p>Waives all Medicare cost sharing (both co-insurance and deductibles) for preventive services, including: an initial preventive physical examination; diabetes outpatient self-management training; medical nutrition therapy services; cardiovascular and diabetes screening; and additional preventive services (§1305).</p> | | <p>Waives cost sharing (co-payment and deductible) for preventive screening services covered by Medicare and rated 'A' or 'B' by the U.S. Preventive Services Task Force (§2002). Gives the Secretary of HHS the discretionary authority to modify or eliminate coverage of certain preventive services and appropriates funds to conduct education and outreach activities to Medicare beneficiaries and providers regarding the coverage of preventive care (§2003). Appropriates \$2,000,000 to carry out a GAO study on efforts to improve utilization of preventive services in Medicare (§2003). Directs the Secretary of HHS to encourage use of and integration with HIT with regard to the health risk assessment and the personalized prevention plan. Allows the Secretary to experiment with personalized technology that encourages adherence to provider recommendations (§2001).</p> |

| | Topics | H.R. 3962 - Affordable Health Care for America Act | Senate HELP (S. 1679) - Affordable Health Choices Act | Senate Finance Committee Bill (S. 1796) - America's Healthy Future Act of 2009 |
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| 38 | Annual Wellness Visits | | | <p>Provides beneficiaries with access to a comprehensive health risk assessment (HRA) that would be completed prior to or as part of an annual wellness visit, in which beneficiaries, through authorized Medicare payment, would visit a primary care provider to create a personalized prevention plan. The plan would address chronic disease conditions and risk factors including weight, BMI, and blood pressure. Beneficiaries would be referred to Medicare-covered health education and preventive counseling or community-based interventions to improve nutrition, physical activity and weight. Enables beneficiaries, during the first year of enrollment, to receive either the Initial Preventive Physical Examination (IPPE) or the Annual Wellness Visit, but not both. No co-payment or deductible would apply. Directs the Secretary of HHS to develop guidelines for the HRA within one year of enactment (§2001).</p> |

| | Topics | H.R. 3962 - Affordable Health Care for America Act | Senate HELP (S. 1679) - Affordable Health Choices Act | Senate Finance Committee Bill (S. 1796) - America's Healthy Future Act of 2009 |
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| 39 | Management of Chronic Care | | | Creates a home-based chronic care coordination project to bring primary care services to the highest cost Medicare beneficiaries. To be eligible for the program, a beneficiary must: have at least two chronic illnesses, such as congestive heart failure, diabetes, ischemic heart disease, stroke, etc.; have been hospitalized during the last 12 months; and have at least two functional dependencies (§3024). |
| 40 | Incentives for Healthy Lifestyles | | | Establishes a three-year demonstration project, with the option to extend an additional two years, to provide incentives to beneficiaries who successfully participate in certain healthy lifestyle programs . Project would be conducted in up to ten sites (at least two must be in rural areas, and at least two must serve minority communities). Programs would target: high blood pressure; high cholesterol; tobacco use; overweight or obesity; diabetes; and falls. Appropriates \$15 million for each fiscal year from 2010 to 2015 (§2005). |

| | Topics | H.R. 3962 - Affordable Health Care for America Act | Senate HELP (S. 1679) - Affordable Health Choices Act | Senate Finance Committee Bill (S. 1796) - America's Healthy Future Act of 2009 |
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| 41 | Certified Diabetes Educators | Recognizes certified diabetes educators as certified providers for purposes of Medicare diabetes outpatient self-management services (§1313). | | Recognizes certified diabetes educators as certified providers for purposes of Medicare diabetes outpatient self-management services (§3109). |
| 42 | Reimbursement Rates | Increases the Medicare payment rate by 5% for primary care services of physicians specializing in primary care. Provides an additional 5% to eligible practitioners practicing in health professional shortage areas (§1303). | | Authorizes Medicare payment for beneficiary visits to a physician, practitioner or other health professional (including a health educator, registered dietitian, or nutrition professional) to create a personalized prevention plan . As part of this determination, the administration of the health risk assessment (HRA) will be taken into account (§2001). |
| 43 | Primary Care | | | Establishes a payment bonus for primary care practitioners equal to 10% of services for visits in which at least 60% of the visit was dedicated to primary care services, from January 2011 to January 2016 (§3031). |

| | Topics | H.R. 3962 - Affordable Health Care for America Act | Senate HELP (S. 1679) - Affordable Health Choices Act | Senate Finance Committee Bill (S. 1796) - America's Healthy Future Act of 2009 |
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| Medicaid | | | | |
| 44 | Preventive Services | Requires coverage and eliminates cost-sharing of preventive services under Medicaid that are recommended with grade 'A' or 'B' by the Task Force for Clinical Preventive Services, vaccines recommended by CDC, and services appropriate for those covered by Medicaid (§1711). | | States that opt to provide Medicaid coverage for all USPSTF recommended services as well as remove cost-sharing for those services would receive an FMAP increase of 1% for those services (§2101). |

| | Topics | H.R. 3962 - Affordable Health Care for America Act | Senate HELP (S. 1679) - Affordable Health Choices Act | Senate Finance Committee Bill (S. 1796) - America's Healthy Future Act of 2009 |
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| 45 | Medical Home | <p>Establishes a five-year medical home pilot program to test the medical home concept with Medicaid beneficiaries including medically fragile children and high-risk pregnant women. Requires the federal government to match costs of community care workers at 90% for the first two years and 75% for the next three years, up to a total of \$1.235 billion. Does not specify the obese as a high-risk group (§1722).</p> | | <p>Creates a new Medicaid state plan option under which Medicaid enrollees with at least two chronic conditions, or with one chronic condition and at risk of developing another chronic condition, could designate a provider as their health home. Chronic conditions include being overweight (BMI >25), asthma, diabetes, and heart disease, among others. Teams of providers could be free-standing, virtual, or based at a hospital, community health center, community mental health center, clinic, physician's office, or physician group practice. Allows designated provider to offer: care management; care coordination and health promotion; comprehensive transitional care; use of health information technology; and referral to community and social support services. States that adopt this option will receive an enhanced match (FMAP) of 90% for two years. Appropriates up to \$25 million in planning grants for states (§2104).</p> |

| | Topics | H.R. 3962 - Affordable Health Care for America Act | Senate HELP (S. 1679) - Affordable Health Choices Act | Senate Finance Committee Bill (S. 1796) - America's Healthy Future Act of 2009 |
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| 46 | Incentives for Healthy Lifestyles | | | <p>Establishes an initiative to provide incentives to Medicaid enrollees who successfully participate in healthy lifestyle programs. Beneficiaries must also demonstrate changes in health risks and outcomes, including the adoption and maintenance of healthy behaviors. States are permitted to collaborate with community-based programs, non-profit organizations, providers, and faith-based groups, and states are required to monitor beneficiary participation and validate health outcomes. These programs must be comprehensive and uniquely suited to address the needs of Medicaid eligible beneficiaries and have demonstrated success in helping individuals lower or control cholesterol and/or blood pressure, lose weight, quit smoking and/or manage or prevent diabetes, and may address co-morbidities, such as depression, associated with these conditions. Authorizes \$100 million over five years, beginning in January 2011 (§2103).</p> |

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| 47 | Childhood Obesity Demonstration Project | | | Appropriates \$25 million for fiscal years 2010 through 2014 for the childhood obesity demonstration project authorized under CHIPRA 2009 (Section 1139A(e) of the Social Security Act) (§2105). |
| 48 | Guidance for coverage of obesity-related services | | | Requires the Secretary of HHS to provide guidance and relevant information to states and health care providers regarding Medicaid's coverage of obesity-related services and preventive services . Each State shall design a public awareness campaign to educate Medicaid enrollees regarding availability and coverage of such services, with the goal of reducing incidence of obesity (§2106). |
| 49 | Medicaid Quality Measures | | | Requires the Secretary of HHS to identify and publish a recommended core set of adult health quality measures for Medicaid-eligible adults and establish a quality measures program (§1671). |