



**Cavarocchi ▪ Ruscio ▪ Dennis
Associates, LLC**

**America's Healthy Future Act of 2009
Summary of the Chairman's Mark**

By Erika Miller and Kathryn Schubert

Title I: Health Care Coverage

Subtitle A – Insurance Market Reforms

Rating Rules in the Individual Market

- Establishes Federal rating, issue, renewability and pre-existing condition rules for the individual market. Issuers can only vary premium based on tobacco use, age, and family composition.
- Premiums could also vary among rating areas defined by states to reflect geographic differences.
- Establishes guaranteed issue and renewability, as well as excludes a pre-existing conditions exception and prohibits issuers from rescinding coverage.

Immediate Assistance for Those with Pre-existing Conditions

- Within one year of enactment anyone previously denied coverage due to a pre-existing condition can enroll in a high-risk pool.
- Currently covered individuals must be uninsured for 6 months before gaining access to the high-risk pool, which will exist until 2013 along with \$5 billion in funding to subsidize premiums in the pool.

Rating Rules for Small Group Market

- Same as the individual market except would be implemented with a 5-year phase-in beginning January 1, 2013, at the state level with approval by the Secretary.

Cafeteria Plans for Small Employers

- Provides a safe harbor from nondiscrimination requirements for cafeteria plans for eligible small employers.
- All employees must be eligible to participate for the eligibility requirement to be met., notwithstanding those employees under age 21, with fewer than 1,000 hours of service, less than one year of service with the employer, are covered via a bargaining agreement, or are nonresident aliens working outside the U.S.
- Establishes minimum contribution requirements for small employers as: must provide flex-credits during the plan year that are equal to at least 2% of each eligible employee's compensation for the plan year; or the value of employer-paid benefits is a least 6% of each eligible employee's compensation for the plan year or if less, then twice the amount of the salary reduction amount for the year of each eligible employee who is not a highly compensated or key employee who participates in the plan.

- Establishes an eligible employer as an employer who employed an average of 100 or fewer employees on business days during either of the two preceding year.
- Effective December 31, 2010.

Qualified Long Term Care Insurance

- Effective after December 31, 2010, allows cafeteria plans to offer as a qualified benefit contributions to a qualified long-term care insurance contract such that the amount of such contributions does not exceed the eligible long-term care premiums.
- Employee-paid premiums for such long-term care insurance contract through a flexible spending arrangement is excludible from gross income.

Pooling Requirements for Individual and Small Group Markets

- State required to apply new Federal rating rules to both the individual and small group markets. States can merge pooling and rating requirements for the two markets.
- All plans would be subject to the same risk adjustment system to be applied within rating areas.
- All health insurance issuers are required to contribute to a reinsurance program for individual policies administered by a non-profit reinsurance entity. The non-profit will use funds collected to help stabilize premiums for individual coverage, coordinate funding and operation of a risk spreading mechanism that takes the form of reinsurance.
- For insurers to meet the requirement \$20 billion in 2013 through 2015 must be collected.
- State insurance commissioners have ability to review risk spreading activities.
- Risk corridors modeled after regional Participating Provider Organizations in Medicare Part D will be provided should a plan choose to participate.

State Insurance Commissioners

- Continue to provide oversight of plans regarding consumer protections, rate reviews, solvency, reserve requirements, premium taxes, and all requirements imposed on insured plans.
- Also provide oversight of plans regarding Federal rating rules and additional state rating rules, facilitate risk-adjustment within service areas, and establish rate schedules for broker commissions in the state exchanges.
- The National Association of Insurance Commissioners (NAIC) will devise an NAIC Model Regulation within 12 months of enactment that is consistent with the new requirements. This model then becomes the new Federal minimum standard.

Rating Areas

- Defined by state insurance commissioners and reviewed by the Secretary.

Grandfathered Plans

- Individuals and groups who wish to renew coverage in an existing policy would be permitted to do so – coverage could continue only to those who were currently enrolled, dependents, or new employees (in the case of an employer) and their dependents. Grandfathered plans are not subject to new rating rules.



- Beginning January 1, 2013, Federal rating rules would be phased in for grandfathered policies in the small group market over 5 years.

Interstate Sale of Insurance

- The NAIC will develop model rules for “health care choice compacts,” which would allow for the purchase of individual health insurance across state lines.
- Effective January 1, 2013.

National Plans

- Allow for national plans with uniform benefit packages offered across state lines.
- Plans must be licensed in every state they choose to operate and would be regulated by the states in terms of solvency and other key consumer protections.
- Coverage could be offered through the exchanges.

State Exchanges and Marketing Requirements

- All private insurers in the individual and small group markets that operate nationally, regionally, statewide or locally must be available in the state exchange if licensed by a state.
- States would establish an exchange for the individual market and a Small Business Health Options Program (SHOP) exchange for the small group market, with assistance from the Secretary, in 2010. This would be one exchange with resources for individuals and small groups.
- The Secretary would establish and maintain a database of plan offerings within the exchanges.
- In 2010, 2011 and 2012 “mini-medical” plans with limited benefits and low annual caps would be prohibited from offering insurance in the state exchanges.
- The Secretary and/or states will develop a standard enrollment application, provide standardized formatting for presenting insurance options inside the exchange, standard marketing requirements, maintain call center support, allow for enrollment in local hospitals, DMVs, and Social Security offices; conduct eligibility determinations for tax credits and subsidies, and other plans for publicizing the exchange and open enrollment periods.
- In 2017 states must develop and submit to the secretary a phase-in schedule for incorporating firms with 50 or more into the state exchanges.
- State exchanges will receive initial Federal funding but then be self-sustaining.
- Effective July 1, 2010 unless otherwise noted.

Subtitle C – Making Coverage Affordable

Benefit Options

- Establishes four benefit categories: bronze, silver, gold and platinum.



- Bronze: minimum creditable coverage (MCC), or 65% actuarial value with out-of-pocket limit up to the Health Savings Account (HAS) current law limit of \$5,950 for individuals and \$11,900 for families.
 - Silver would have an actuarial value of 70% with OOP limits for MCC.
 - Gold: 80% a/v with OOP limits for MCC.
 - Platinum: 90% a/v with OOP for MCC.
 - Also available a “young and invincible” policy for those under age 25, providing only catastrophic coverage set at HAS law limit, prevention benefits exempt.
- All plans must provide preventive and primary care, emergency services, hospitalization, physician services, outpatient services, day surgery and related anesthesia, diagnostic imaging and screenings, maternity and newborn care, pediatric services (including dental and vision), medical/surgical care, prescription drugs, radiation and chemotherapy, and mental health and substance abuse services that at least meet minimum standards set by Federal and state laws.
 - No cost sharing for preventive services except where value-based insurance design is used.
 - OOP limits would be set at a sliding scale depending on the income.

Health Care Affordability Tax Credits

- Establishes a refundable tax credit for eligible individuals and families who purchase coverage through the state exchanges. Tax credit will be available for those up to 300% of the federal poverty level. Beginning in 2013 tax credits would be available on a sliding scale basis for individuals and families between 134-300% FPL. Availability for families begins in 2014 for those between 100 and 133% of FPL.
- Requires verification of personal data such as name, SSN, date of birth, with the Social Security Administration to prevent illegal immigrants from accessing state exchanges.
- Cost-sharing subsidy established to buyout any difference between the insurance purchased and its actuarial value.
 - For those between 100-150% FPL the value of the plan would be 90% actuarial value with the subsidy
 - Between 150-200%FPL the value of the plan would be 80% actuarial value with the subsidy
 - No subsidy for those over 200% FPL.

Small Business Tax Credit

- Provides a tax credit a qualified small employer for contributions to purchase health insurance for its employees. Those with no more than 25 fulltime employees (or equivalent thereof), whose employees have annual fulltime equivalent wages that average no more than \$40,000 would qualify. Full value of the credit only available for those with fewer than 10 full time employees and average wages of \$20,000 or less.
- Phase I: Credit available for two years maximum, available in 2011 and 2012.



- Phase II: begins December 31, 2012, available only for those employers purchasing insurance for their employees through the exchange.
- Credit would be equal to the applicable percentage of the small employer's contribution to the health insurance premium for each covered employee.
- Credit phased-down based on increasing number of employees, up to 25.
- Effective January 1, 2013, unless otherwise note.

Application of State and Federal Laws Regarding Abortion

- Does not preempt state law with respect to abortion laws. Also maintains current Federal conscience protections and abortion-related antidiscrimination laws, rights and obligations of employees and employers under Title VII of the Civil Rights Act of 1964, other state or Federal laws, including section 1867 of the Social Security Act (EMTALA), which requires health care providers to provide emergency services.
- Abortion cannot be a mandated benefit as part of a minimum benefits package except where Federal funds appropriated for the Department of Health and Human Services are permitted. However, a qualified health plan would not be prohibited from providing coverage for abortions beyond those for which Federal funds are permitted. *Federal funds continue to be prohibited from being used to pay for abortions unless the pregnancy is due to rape, incest, or if the life of the mother is in danger.*
- Insurers who provide coverage for abortions beyond those permitted above must demonstrate that no federal premium and cost-sharing credits are used for that purpose.
- Secretary would be required to estimate on average actuarial basis the basic per enrollees, per month cost of including coverage of abortions beyond those permitted above.
- The Secretary must ensure that in each state exchange at least one plan provides coverage of abortions beyond those for which Federal funds are permitted.
- Plans would be prohibited from discriminating against any individual health care provider or facility because of its willingness or unwillingness to provide, pay for, provide coverage of, or refer for abortions.

Subtitle D – Shared Responsibility

Personal Responsibility Requirement

- Beginning in 2013 all U.S. citizens and legal residents would be required to purchase coverage through the individual market, a public program, through an employer, or in the large group market. Compliance will be ensured by reporting on the Federal income tax return.
- An initial open enrollment period for eligible individuals in the individual and small-group market would be from September 1, 2012-November 30, 21012. Each year thereafter open enrollment will take place from October 15 through November 30.
- In the event that an individual fails to maintain insurance an excise tax of up to \$1,500 for an individual or \$3,800 for a family above 300% FPL will be levied. The excise tax will be based on a sliding scale.



- Exemptions will be made for those whose lowest cost option exceeds 10% of their adjusted gross income.
- Employers with over 200 employees must automatically enroll their employees in health insurance plans offered through the employer.

Employer-Provided Health Insurance Coverage

- An employer is not required to offer health insurance coverage. If an employee is offered employer-provided health insurance, that individual is not eligible for a tax credit for health insurance purchase through the exchange. A Medicaid-eligible individual can always choose to leave the employer's coverage and enroll in Medicaid – the employer will not pay a fee should this occur.
- All employers with more than 50 employees that do not offer coverage would be required to pay a fee for each employee who receives a tax credit for insurance through a state exchange.
- Effective January 1, 2013 unless otherwise noted.

Subtitle E – Creation of Health Care Cooperatives

Taxation of Insurance Companies

- Authorizes \$6 billion for the Consumer Operated and Oriented Plan (CO-OP) to foster the creation of non-profit, member-run health insurance companies that serve individuals in one or more states.
- To be eligible for Federal funds the following requirements must be met:
 - Must be a non-profit, member corporation under state law
 - Must not provide insurance as of July 16, 2009 and be affiliated or a successor of any such organization
 - Governing documents incorporate ethics and conflict of interest standards and protect against insurance industry involvement and interference
 - Must not be sponsored by a State, county, or local government, or any government instrumentality
 - Substantially all of its activities must consist of the issuance of qualified health benefit plans in the individual and small group markets in each State in which is licensed to issue such plans.
 - Governance of the organization must be subject to a majority vote of its members (beneficiaries)
 - Must be required to operate with a strong consumer focus, including timeliness, responsiveness and accountability to its members.
 - Profits made would be required to be used to lower premiums, improve benefits or for other programs intended to improve the quality of health care delivered to its members.



- Should a CO-OP not form in every state the Secretary of HHS is authorized to use planning grants to encourage formation of new organizations or expansion of organizations currently participating in the program.
- Effective on the date of enactment.

Rather than create a public option, the Chairman's Mark creates a system of co-ops; this proposal is viewed as much weaker than a public option with many saying that they will not have the same effect on private insurance rates as a public option would.

Subtitle F – Transparency and Accountability

- In 2010 states must establish an ombudsman office to act as a consumer advocate for those with private coverage in the individual and small group markets.
- The ombudsman will be accessed by policyholders whose health insurers have rejected claims and have exhausted internal appeals.
- Authorizes \$30 million to establish a new competitive grant program to support consumer assistance organizations in each state.
- Beginning in 2010 health plans would be required to report the proportion of premium dollars spent on items other than medical care. Hospitals would be required to list standard charges for all services and Medicare DRGs.
- Mandates the development and utilization of uniform outline of coverage documents.

Subtitle G – Role of Public Programs

Eligibility Standards and Methodologies

- Expands Medicaid to all non-elderly non-pregnant individuals in 2011.
- Expands Medicaid to up to 133% FPL in 2013.
- Those under 100% FPL would not be eligible for the tax credits in exchanges, but those between 100 and 133% FPL would be.

Medicaid Program Payments

- States would continue to receive Federal financial assistance as determined by FMAP (Federal Medical Assistance Percentage).
- In 2014 additional Federal financial assistance would be provided to all states to defray the costs of covering newly-eligible beneficiaries.
- For anyone between 100 and 133% FPL who chooses the state exchange in place of Medicaid, states would be required to pay an amount equal to the state's average cost of coverage for individuals in that same Medicaid eligibility category.

Medicaid and Employer-Sponsored Insurance

- Effective January 1, 2013, requires states to offer premium assistance and wrap-around benefits to Medicaid beneficiaries who are offered ESI (employer-sponsored insurance) if it is cost-effective to do so, consistent with current law.





Treatment of the Territories

- Increase spending caps for territories by 30% and applicable FMAP by five percentage points to 55% beginning January 1, 2011. The cost of covering newly eligibles would not count toward spending caps.

Part II – Children’s Health Insurance Program

- States must maintain income eligibility levels for CHIP upon enactment, which would then expire September 30, 2013 (when current authorization is up), or until the exchange is fully operational, whichever comes last.
- After that date, a Federal floor for CHIP eligibility at 250% FPL goes into effect, requiring states to offer coverage to all children between 134 and 250% FPL.
- CHIP benefit package would include state exchange coverage and state wrap-around benefits. Enrollees would receive tax credits in the state exchanges while wrap-around benefits would be arranged by the states to provide coverage for health services of an amount, type and scope that exceeds the limits of state exchange coverage.

Part III – Improvements to Medicaid

- Requires states to establish a Medicaid enrollment website to promote enrollment in Medicaid should a Medicaid-eligible individual apply for a tax credit through the exchange website or vice versa.
- Effective January 1, 2014, all hospitals that participate in Medicaid would be permitted to make presumptive eligibility determinations in addition to providers currently eligible to do so.
- Statutory requirements regarding transparency in the development, implementation and evaluation of Medicaid and CHIP section 1115 demonstration programs that impact eligibility, enrollment, benefits, cost-sharing, or financing. States required to:
 - provide notice of intent to develop and/or renew a waiver and convene at least one meeting of the state’s medical advisory board
 - Public for written comment a notice of the proposal
 - Post the waiver proposal on the state’s Medicaid or CHIP website; and
 - Convene open meetings over the course of the development of the proposal to discuss proposed changes.

Part IV – Medicaid Services

- Identifies free-standing birth centers as Medicaid providers.
- Allows children who are eligible for Medicaid to receive hospice services without forgoing any other service to which the child is entitled under Medicaid.
- Allocates \$10 million beginning in FY2010 for five years to continue funding Aging and Disability Resource Centers.
- Extends the Money Follows the Person Rebalancing Demonstration through September 30, 2016.



Part V – Medicaid Prescription Drug Coverage

- Makes prescription drugs a mandatory benefit for the categorically and medically needy, effective January 1, 2014.
- Removes smoking cessation drugs, barbiturates, and benzodiazepines from Medicaid’s excluded drug list, effective January 1, 2014.
- Increases the flat rebate percentage used to calculate Medicaid’s basic rebate for outpatient brand name prescription drugs from 15.1% to 23.1%, except for clotting factors that receive a furnishing fee under section 1842(o)(5) of the Social Security Act and outpatient drugs that are approved by the FDA exclusively for pediatric indications, for which the basic rebate would increase to 17.1%.
- Increases the rebate for non-innovator, multiple source drugs to 13% of AMP (average manufacturer price).
- Brand name and generic prescription drug manufacturers would be required to pay rebates for beneficiaries who receive care under risk-based agreements similar to the way rebates are not required for FFS (fee-for-service) beneficiaries. Manufacturers required to pay the MCO (managed care organization) rebates directly to states, as they do under FFS. Does not prohibit MCOs from negotiating with manufacturers and wholesalers for rebates above Medicaid’s statutory rebates.
- Treats new formulations of existing brand name drugs as if they were the original product for purposes of calculating Medicaid’s additional drug rebate. New versions of existing drugs will be calculated on the original drug’s baseline AMP, while new formulations of orphan drugs would be exempted (and have a new baseline calculation).
- Changes the Federal upper payment limits (FUL) to 175% of the weighted average of the most recent AMPs for pharmaceutically and therapeutically equivalent multiple source drugs available nationally through commercial pharmacies.

Part VI – Medicaid Disproportionate Share Payments

- Current state DSH (disproportionate share) allotments remain intact until a state trigger is tripped. It will be tripped once a state’s uninsured rate decreases by at least 50%, compared to an initial uninsured rate on the date of enactment. After the trigger is tripped, state DSH allotments will be decreased by 50%. Low DSH state allotments would be decreased by 25%.

Part VII – Dual Eligibles

- Clarifies that Medicaid demonstration authority for coordinating care for dual eligibles is as long as five years.
- Establishes a new office in CMS – the Office of Coordination for Dual Eligible Beneficiaries (OCDEB), which would be responsible for identifying and leading agency efforts to align Medicare and Medicaid financing, administration, oversight rules, and policies for dual eligibles.

Part VIII – Medicaid Quality

- Directs the Secretary of HHS in consultation with the states to develop an initial set of health care quality measures specific to adults who are eligible for Medicaid. Establishes the Medicaid Quality Measurement Program, expanding upon existing quality measures, identifying gaps in



current measurement, establish priorities for the development and advancement of quality measures and consult with relevant stakeholders.

- Effective July 1, 2011 prohibits Federal payments to states for Medicaid services related to health care acquired conditions.
- Establishes a bundled payment demonstration project under Medicaid in up to 8 states. Unit of payment for acute care provided in hospitals would be redefined and expanded to include post-acute care provided in acute care hospitals and nonhospital settings, and/or hospital and concurrent physicians' services. Demonstration would begin October 1, 2011.

Part IX – Medicaid and CHIP Payment and Access Commission (MACPAC)

- Authorizes \$11 million for MACPAC for FY2010: \$9million from Medicaid and \$2 million from CHIP.
- Subsequent years funded by appropriations.
- Expands MACPAC's mission to include assessment of adult services in Medicaid, including dual eligibles, and more detailed reporting requirements to states and Congress.
- Reporting dates would be March 15 and June 15 of each year beginning June 2010.

Part X – American Indians (AI) and Alaska Natives (AN)

- Prohibits cost-sharing (including premiums, deductibles, copayments, co-insurance, etc) for all American Indians and Alaska Natives with incomes at or below 300% FPL for state exchange plans and public programs.
- Ensures that Indian tribes, tribal organizations, and urban Indian organizations (I/T/Us) are the payers of last resort.
- I/T/Us would be added to the definition of an Express Lane Agency. Also would be allowed to accept applications for public programs and state exchange plans.
- Remove the sunset to allow I/T/Us to continue to received payment for certain Medicare covered items and services.
- Subjects AI/ANs to the responsibility to obtain insurance, but exempt them from the penalty for failing to do so. Allowed a choice of providers, including I/T/Us. Authorizes special monthly enrollment periods for AI/ANs in exchanges.

Subtitle H: Addressing Health Disparities

Standardized Collection of Data

- Establish uniform categories for collecting data on race and ethnicity, gender and primary language.
- Require CMS to collect data on individuals with disabilities. CMS required to survey providers in order to determine the locations where people with disabilities receive primary care services, the number of providers with accessible facilities and equipment, number of employees trained in disability awareness and patient care of individuals with disabilities and access to intensive care units for individuals with physical disabilities.



Sufficient Disparities Data

- Requires Federally-funded population surveys collect sufficient data on racial and ethnic subgroups to generate statistically reliable results in studies comparing health disparities populations. This would ensure that quality reporting requirements include provisions to collect data on patients by race, ethnicity, gender, primary language, and disability, and it would extend the MIPAA provisions regarding the collection of health disparities data on the Medicare population to Medicaid and CHIP.

Data Sharing

- Requires HHS to share health disparities data, measures and analyses with other relevant agencies.

Privacy and Security

- Requires HHS Secretary to ensure all appropriate privacy and security safeguards are followed for activities relating to health disparities data collection, analysis and sharing.

Subtitle I – Maternal, Infant and Early Childhood Visitation

- Adds Section 511 in Title V of the Social Security Act, which would require states, as a condition for receiving the MCH block grant, to conduct a needs assessment to identify communities that are at risk for poor maternal and child health and have few quality home visitation programs. Assessment would be separated from but coordinated with the assessments currently required under Title V and the Head Start Act, and would also review the state's capacity to provide appropriate services to those communities. States required to submit the results and proposed activities to the Secretary.
- Establishes a new state grant program for early childhood home visitation. Grantees would establish appropriate process and three and five year outcome benchmarks to measure improvement in maternal and child health, childhood injury prevention, school readiness, juvenile delinquency, family economic factors, and coordination with community resources.
- Grantees required to use an evidence-based model that:
 - Conforms to a clear consistent home visitation model that has been in existence for at least three years and is research-based; linked to outcomes; associated with a national organization or institution of higher education with comprehensive home visitation program standards; demonstrated positive outcomes that have been published in a peer-reviewed journal and has been successfully replicated in diverse communities with diverse families.
- Rigorous evaluation standards.

Title II: Promoting Disease Prevention and Wellness

Medicare

- Annual Wellness Visit: Beginning in 2011, Medicare beneficiaries would have access to a comprehensive health risk assessment, which would identify chronic diseases, modifiable risk factors and emergency or urgent health needs. Within 6 months of completing the assessment, Medicare would pay for a visit to a primary care provider to create a personalized prevention plan, including a review and update of medical and family history, a schedule and referral for



recommended, covered preventive services and immunizations, a strategy to address identified conditions and risk factors, a medication list, a list of all physicians involved in the patient's care, and counseling or referral to address modifiable risk factors.

- **Removing Barriers to Preventive Services:** Cost-sharing for preventive services covered by Medicare and recommended by the U.S. Preventive Services Task Force (USPSTF) would be eliminated.
- **Evidence-Based Coverage of Preventive Services:** The Secretary would have the authority to use the same standards of evidence that apply to any new preventive services to existing preventive services. The Secretary would also be allowed to withdraw Medicare coverage for services rated D by the USPSTF. Funding would be provided to improve provider education and patient awareness of covered preventive services.
- **Study on Beneficiary Access to Immunizations:** The mark would require a GAO study and report to Congress on the impact of the coverage of adult immunizations under Part D on access to those immunizations by Medicare beneficiaries.
- **Incentives for Health Lifestyles:** \$100 million over 5 years would be authorized and appropriated to establish an incentive to provide incentives to Medicare beneficiaries who successfully complete certain healthy lifestyle programs.

The mark places a great deal of emphasis on improving people's access to prevention and wellness services.

Medicaid

- **Improving Access to Preventive Services for Eligible Adults:** States are encouraged to improve coverage and access to recommended preventive services and immunizations and would be required to provide Medicaid coverage for comprehensive tobacco cessation services for pregnant women without cost-sharing for those services. If a state opts to provide Medicaid coverage for all USPSTF recommended services and immunizations recommended by the Advisory Committee on Immunization Practices as well as removing cost-sharing for these services, there would be a one percentage point increase in the Federal share of its FMAP for those services.
- **Incentives for Healthy Lifestyles:** The Secretary would develop criteria for health lifestyle programs using relevant, evidence-based resources. 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 certain conditions. States could design a proposal and apply for funds to provide incentives to Medicaid enrollees who successfully complete healthy lifestyle programs and would be required to monitor beneficiary participation and validate health outcomes. \$100 million is authorized for these grants during the five year period beginning January 1, 2011.

The mark's focus on prevention and wellness programs applies to both Medicare and Medicaid.

- **Medicaid State Plan Option Promoting Health Homes and Integrated Care:** The mark creates a new state plan option under which Medicaid enrollees with at least two chronic conditions or with one chronic condition and at risk of developing another could designate a provider as their health home. Qualifying providers would have to meet certain standards established by the Secretary. The state would develop a mechanism to pay the health home for services rendered and would develop a plan for tracking avoidable hospital readmissions and for producing savings



resulting from improved chronic care coordination and management. An enhanced match of 90 percent FMAP for two years would be available to states utilizing this option.

- Appropriations for Childhood Obesity Demonstration Project: \$25 million would be available for the Secretary to carry out this demonstration.

Title III: Improving the Quality and Efficiency of Health Care

Transforming the Health Care Delivery System

Part I – Linking Payment to Quality Outcomes in the Medicare Program

- **Hospital Value-Based Purchasing:** The mark would establish a Hospital Value-Based Purchasing (VBP) program in Medicare that moves beyond pay-for-reporting on quality measures to paying for hospitals actual performance on these measures. Value-based incentive payments would be available to acute care IPPS hospitals that meet certain quality performance standards beginning in FY 2012. Measures for the hospital VBP program would be selected from measures used in the existing reporting program. Funding for incentive payments would be generated by reducing Medicare IPPS payments to hospitals. IPPS add-on payments, such as DSH payments, IME payments, low-volume add-on payments and outlier payments would not be impacted.
- **Physician Value-Based Purchasing:** A new Physician Quality Reporting Initiative (PQRI) option would be established; beginning in reporting year 2011, CMS would be required to make PQRI incentive payments available for two successive years to eligible professionals who voluntarily complete the following on a biennial basis: (1) participation in a qualified American Board of Medical Specialties certification; and (2) complete a qualified Maintenance of Certification practice assessment. CMS also would be required to provide timely feedback to eligible professionals on their performance with respect to satisfactorily submitting data on quality measures and would be required to establish a new appeals process for participating providers who do not qualify for incentive payments. PQRI incentive payments would be extended; eligible professionals who report successfully in 2010 would receive a 2 percent bonus in 2011. Those who failed to participate successfully would face a 1 percent payment penalty in 2012 based on their 2011 reporting. For reporting periods 2012 and on, the penalties for non-reporting would be 2 percent. CMS would be required to develop a plan to integrate the PQRI program with the standards of meaningful use of certified electronic health records.
- **Expansion of Physician Feedback Program:** Beginning in 2012, the Secretary would be required to provide reports to physicians that compare their resource use with that of other physicians or groups caring for patients with similar conditions. Resource use would be measured based on the items or services furnished or ordered, and feedback reports would be based on an episode-grouper methodology. Beginning in 2015, payment would be reduced by 5 percent if an aggregation of the physician's resource use is at or above the 90th percentile of national utilization.
- **Medicare Inpatient Rehabilitation Facility, Long Term Acute Care Hospital and Hospice Quality Reporting Program:** The Secretary would be directed to establish quality reporting programs for IRFs, LTCHs and hospices. The Secretary would select quality measures by FY 2013 and implement mandatory quality measure reporting programs by FY 2014. Failure to report would result in reduction of annual MB update by 2.0 percent.



- Medicare IPPS Exempt Cancer Hospital Quality Reporting: The Secretary would be directed to establish quality reporting programs for IPPS-exempt cancer hospitals.
- Medicare Home Health Agency and Skilled Nursing Facility Value-Based Purchasing Implementation Plans: The Secretary would be directed to complete and submit to Congress Medicare value-based purchasing implementation plans for HHAs and SNFs by 2011 and 2012, respectively. In developing these plans, the Secretary would be required to consult with relevant stakeholders and take into consideration experiences with demonstrations that are relevant to value-based purchasing in each setting.
- Reducing Hospital Acquired Conditions: A new payment adjustment to hospitals ranked in the top quartile of the national, risk-adjusted hospital acquired condition rates would be applied. CMS would calculate national and hospital-specific data, and this data would be shared with hospitals and publicly reported on the Hospital Compare website. Beginning on October 1, 2014, hospitals in the top quartile would receive 99 percent of their otherwise applicable Medicare payments.

Part II – Strengthening the Quality Infrastructure

- Quality Infrastructure: The mark would provide additional resources to HHS to strengthen and improve quality measure development processes for purposes of improving quality, informing patients and purchasers and guiding payment under Federal health programs. AHRQ and CMS would be responsible for implementing this provision.
- National Strategy to Improve Health Care Quality: The Secretary would be directed to establish a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health through a transparent and collaborative process. The strategy would be updated not less than triennially and the first report would be due to Congress on December 31, 2010.
- Interagency Working Group on Health Care Quality: The President would convene a working group consisting of relevant Federal departments and agencies that would collaborate and consult on fulfilling the national quality improvement strategy and priorities.
- Quality Measure Development: The Secretary would identify, not less than triennially, gaps where no quality measures exist or existing measures need improvement, updating or expansion consistent with the national strategy and priorities. The qualified consensus-based entity as identified in MIPPA would be required to submit an annual report to the Secretary identifying gaps in quality measures. Measures would be developed to fill the identified gaps. The legislation would authorize \$75 million for FY 2010 through 2014 to carry out these activities.
- Consultation for Selection of Endorsed Quality Measures for Use in Reporting and Payment Programs: The Secretary would develop a process for consultation with the qualified consensus-based entity and the multi-stakeholder group for the selection of measures for use in reporting to and payment under Federal health programs. Beginning in 2011, the Secretary would be required to make the list of measures being considered for selection public by December 1.
- Use and Review of Quality Measures: The Secretary would establish a process for the dissemination and incorporation of measures in workforce programs, training curricula, Federal health programs and other areas deemed appropriate.



- **Funding:** For FY 2010 through 2014, the Secretary would transfer \$50 million from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund to the CMS Program Management Account to carry out the quality related activities outlined.

Part III – Encouraging Development of New Patient Care Models

- **Accountable Care Organizations:** Groups of providers who voluntarily meet certain statutory criteria can be recognized as ACOs and be eligible to share in the cost-savings they achieve for the Medicare program. Beginning on January 1, 2012, eligible ACOs may qualify for an incentive bonus, if they meet certain quality thresholds. The Secretary would be authorized to incorporate reporting requirements and incentive payments and penalties related to the PQRI, electronic prescribing, EHRs and other similar initiatives into the reporting requirements for ACOs. CMS would assign Medicare PFS beneficiaries to ACOs based on their use of Medicare items and services.

It is unclear how ACOs will affect the provision of care or physician payment, but the committees of jurisdiction in both the House and Senate have expressed interest in exploring this concept.

- **CMS Innovation Center:** An Innovation Center within CMS would be created and would be authorized to test, evaluate and expand different payment structures and methodologies which aim to foster patient-centered care, improve quality and slow the rate of Medicare cost growth. The Center would be required to consult regularly with outside experts and stakeholders. \$10 billion from the Part A and Part B Trust Funds would be appropriated to the Center over 10 years.
- **National Pilot on Payment Bundling:** The Secretary would be required to develop, test and evaluate alternative payment methodologies through a national, voluntary pilot program that is designed to provide incentives to providers to coordinate care across the continuum and to be jointly accountable for the entire episode of care starting in 2013. If the pilot improves patient outcomes, reduces costs and improves efficiency, the Secretary would be required to submit an implementation plan to Congress to make the pilot a permanent part of the Medicare program. The pilot program's bundled payment would be made to a Medicare provider or other entity comprised of multiple providers to cover the costs of acute care inpatient and outpatient hospital services, physician services and post-acute care; this payment would include the costs of any rehospitalizations that occur during the covered period for the 8 conditions selected to be included in the pilot.
- **Reducing Avoidable Hospital Readmissions:** CMS would calculate national and hospital-specific data on readmission rates for 8 conditions selected based on spending and readmission rates. Starting in FY 2012, the Secretary would share these data with hospitals and publicly report it on the Hospital Compare website. Starting in FY 2013, hospitals with readmission rates above a certain threshold would have payments for the original hospitalization reduced by 20 percent if a patient with a selected condition is re-hospitalized with a preventable readmission within 7 days and by 10 percent if a patient with a selected condition is re-hospitalized with a preventable readmission within 15 days.
- **Transitional Care Program to Reduce Preventable Readmissions:** The mark establishes a three-year Medicare pilot program. Beginning in 2011, the Secretary would fund eligible hospitals and community-based partnership organizations to provide patient-centered, evidence-based care transition services to Medicare beneficiaries at the highest risk of preventable rehospitalization. A hospital in collaboration with partnership organizations must identify at least one evidence-



based care transition intervention to be utilized as the model of service delivery for targeted high-risk beneficiaries. The program's funding level would be set at \$500 million over three years.

- Extension of Gainsharing Demonstration: The authority to conduct this demonstration would be extended until September 30, 2011. On March 31, 2011, the quality improvement and achieved savings report would be due, and the final report would be due on September 30, 2012. An additional \$1.6 million would be appropriated in FY 2010.

Part IV – Strengthening Primary Care and Other Workforce Improvements

- Primary Care/General Surgery Bonus: The mark would establish a new 10 percent bonus payment on select evaluation & management codes under the Medicare fee schedule for 5 years beginning January 1, 2011. The codes to which this would apply include office visits, home visits, nursing facility visits, and domiciliary, rest home or custodial care visits. The bonus would be available to primary care practitioners who have a specialty designation of family medicine, internal medicine, geriatric medicine or pediatric medicine (or are an advanced practice nurse or physician assistant) and furnish 60 percent of their services in the select codes. Qualifying practitioners providing care in a HPSA would receive the 10 percent bonus on hospital visit codes that are typical of primary care medicine though only 10 percent of these visits would count toward the 60 percent threshold. Half of the cost of bonuses would be offset through an across the board reduction to all other codes, except for physicians who primarily provide services in a HPSA zip code.

It should be noted that while the mark provides for a 10 percent bonus and the House bill only provides for a 5 percent bonus the Senate version is set to expire after 5 years while the House bonus will not. Also, there is significant opposition to this proposal from specialists who object on the basis on having this paid for through a 0.5 percent reduction in their codes.

- Redistribution of Unused GME Slots to Increase Access to Primary Care and Generalist Physicians: A policy to redistribute currently unused residency slots as a way to encourage increased training in primary care and general surgery would be established. CMS would calculate the number of unused residency slots, defined as the difference between total available resident slots and a hospital's actual FTE of residents, over the last 3 years. 80 percent of these unused slots would be included in a pool for redistribution. Rural teaching hospitals with less than 250 beds would be exempt. Certain other hospitals would also be exempt if they demonstrate they have a specific plan to fill the unused slots within 2 years of enactment. The Secretary would be required to increase the resident limit for each qualifying hospital submitting a timely application. Hospitals receiving an increase would be required to ensure that the number of FTE residents in primary care residency is not less than the average during the 3 most recent cost reporting periods and that not less than 75 percent of the positions attributable to such an increase are in a primary care or general surgery residency. The IME adjustment for the resident positions that are redistributed would reduce the formula multiplier in the IME adjustment factor by 50 percent.

It is unclear if this provision coupled with the primary care bonus payment would have an impact on the primary care pipeline issue. Also, it would have to be determined on a case-by-case basis how much the reduction in the IME adjustment would affect teaching hospitals.

- Promoting Greater Flexibility for Residency Training Programs: For cost reporting periods beginning on or after July 1, 2010, all time spent by a resident would count toward the direct



GME payment without regard to the setting where the activities are performed, if the hospital continues, or in the case of a jointly operated residency program, the involved entities continue to incur the costs of the stipends and the fringe benefits of the resident during the time the resident spends in the setting. Effective for discharges on or after July 1, 2010, all the time spent by a resident in patient care activities in a nonhospital setting would be counted towards indirect GME payment if the hospital continues, or in the case of a jointly operated residency program, the involved entities continue to incur the costs of the stipends and the fringe benefits of the resident during the time the resident spends in the setting.

- **Rules for Counting Resident Time for Didactic and Scholarly Activities and Other Activities:** When calculating direct GME payments, Medicare would count the time that residents in approved training programs spend in certain non-patient care activities in a nonhospital setting that is primarily engaged in furnishing patient care; this would include time spent in didactic conferences and seminars but would not include research that is not associated with the treatment or diagnosis of a particular patient. Medicare would count all vacation, sick leave and other approved leave spent by the resident in an approved training program.
- **Preservation of Resident Cap Positions from Closed and Acquired Hospitals:** The Secretary would promulgate regulations to establish a process where residency allotments in a hospital with an approved medical residency program that closes could be used to increase the residency limit for other hospitals.
- **Proposal on Development of National Workforce Strategy:** The Secretary would create a Workforce Advisory Commission that would be comprised of external stakeholders and representatives of health professionals, schools of higher education for health care professionals, public health experts, health insurers, business, labor, state or local workforce investment boards and any other health professional organization or practice. The Commission would develop and present a national workforce strategy to the Secretary and Congress after examining the current and projected health care workforce supply, the current and projected demand for health professionals, the health care workforce education training capacity, the implications of new and existing Federal workforce policies, and the workforce needs of specific populations.

While this proposal is intriguing, it is unclear how robust the Commission would be.

- **Demonstration Project to Address Health Professions Workforce Needs:** Establishes a demonstration grant program which would award competitive grants to provide aid and supportive services to low-income individuals with the opportunity to obtain education and training for occupations in the health care field that pay well and are expected to experience labor shortages or be in high demand. The mark appropriates \$85 million per year for FY 2010 through 2014 for these demonstrations with no more than \$5 million annually for FY 2010 through 2012.

Institutes of higher education would be eligible to receive these grants.

- **Extension of Family-to-Family Health Information Centers:** Funding for the family-to-family health information centers would be extended at \$5 million for FY 2010 through 2012.

Improving Medicare for Patients and Providers

Part I – Ensuring Beneficiary Access to Physician Care and Other Services

- Sustainable Growth Rate: The mark provides a 0.5 percent increase in 2010. The conversion factor for 2011 and subsequent years would be computed as if the increase in 2010 had never applied.

This provision does not provide a long term physician pay fix. Chairman Baucus was unlikely to provide such a fix because of the associated cost.

- Extension of Floor on Medicare Work Geographic Adjustment: The 1.00 floor for the geographic index for physician work would be extended for an additional two years through December 2012.
- Misvalued Relative Value Units: The Secretary would be required to periodically identify physician services as being potentially misvalued and make appropriate adjustments to the relative values of such services. The Secretary will look at codes where there has been the fastest growth, codes that have experienced substantial changes in practice expense, codes for new technologies or services, multiple codes that are frequently billed in conjunction with furnishing a single service, codes with low relative values, codes that have not been subject to review since the implementation of the RBRVS, and other codes deemed appropriate by the Secretary. Adjustments will be subject to budget neutrality adjustments.
- Therapy Caps: The exceptions process would be extended two years through December 31, 2011.
- Extension of Treatment of Certain Physician Pathology Services Under Medicare: Direct payments for the technical component for certain pathology services would be extended until January 1, 2012.
- Extension of Increased Payments for Ambulatory Services Under Medicare: The additional 3 percent payment for rural ambulance services and 2 percent for other areas is extended until January 1, 2012.
- Extension of Long Term Care Hospital Provisions: The Long Term Care Hospital provisions included in the Medicare, Medicaid and SCHIP Extension Act of 2007 would be extended by 2 years.
- Extension of Payment Adjustment for Medicare Mental Health Services: The MIPPA provision that increased payments for certain Medicare mental health services by 5 percent would be extended until January 1, 2012.
- Permitting Physician Assistants to Order Post-Hospital Extended Care Services: Physician assistants who do not have a direct or indirect employment relationship with a SNF but who is working in collaboration with a physician would have to certify the need for post-hospital extended care services for Medicare payment purposes for services furnished on or after January 1, 2010.
- Recognizing Attending Physician Assistants as Attending Physicians to Serve Hospice Patients: For a hospice written plan of care, the provision would include physician assistants in the definition of attending physician and would continue to exclude physician assistants from the authority to certify an individual as terminally ill.
- Medicare Diabetes Self-Management Training: State-licensed or registered health care professionals who are certified diabetes educators would be recognized as Medicare providers of diabetes outpatient self-management training services.

- Medicare Improvement Fund: The fund would be eliminated.
- Medicare Part B Special Enrollment Period for Disabled TRICARE Beneficiaries: A 12 month special enrollment period for military retirees, their spouses and dependent children who are otherwise eligible for TRICARE and entitled to Medicare Part A based on disability or ESRD but who have declined Part B would be created.

Part II – Rural Protections

- Extend Medicare Rural Hospital Flexibility Program: The FLEX grant program would be extended 2 years until 2012, which would allow Small Rural Hospital Improvement (SHIP) funding to be used to support small rural hospitals' participation in the delivery system reforms outlined in this legislation.
- Extend Hospital Outpatient Department Hold Harmless for Small Rural Hospitals; Extend and Expand Hospital Outpatient Department Hold Harmless for Sole Community Hospitals (SHCs): Small rural hospitals, SHCs with not more than 100 beds, and SHCs with more than 100 beds would receive 85 percent of the payment difference in CY 2010 and 2011.
- Extend Reasonable Cost Reimbursement for Laboratory Services in Small Rural Hospitals: Reasonable cost reimbursement for clinical diagnostic laboratory service for qualifying rural hospitals with under 50 beds would be reinstated from July 1, 2010 and extended for 2 years until July 1, 2012.
- Extend Rural Community Hospital Demonstration Program: The demonstration would be extended for an additional 2 years and the maximum number of participating hospitals would be expanded to 30 and rural areas in all states would all be considered eligible sites.
- Extend Medicare Dependent Hospital Program: The Medicare dependent hospital classification would be extended 2 years until September 30, 2013.
- Temporary Improvements to the Medicare Inpatient Hospital Payment Adjustment for Low-Volume Hospitals: A temporary adjustment that would increase payment in FY 2011 and 2012 for certain low-volume hospitals would be created. A low-volume hospital could be located more than 15 road miles from another comparable hospital and have 2,000 discharges of individuals entitled to or enrolled for Medicare Part A benefits.
- Revisions to the Demonstration Project on Community Health Integration Models in Certain Rural Counties: The mark would strike the limitation on the number of eligible counties that may participate in the demonstration project within the qualifying states. It would be required that physician services be included within the scope of the demonstration.
- MedPAC Study on Adequacy of Medicare Payments for Health Care Providers Serving Rural Areas: MedPAC would be required to review payment adequacy for rural health care providers and provide a report to Congress by January 1, 2011. MedPAC shall analyze the rural payment adjustments outlined in this section and beneficiaries access to care in rural communities, and adequacy of Medicare payments to rural providers and quality of care.

Part III – Medicare Part D Improvements

- Improving Coverage in the Part D Coverage Gap: The mark would establish a discount program for beneficiaries enrolled in Part D and have drug spending that falls into the coverage gap. Manufacturer discounts would be available on brand-name drugs covered under Part D

and included on plan formularies; this discount would be available for the entire coverage gap until the catastrophic limit is reached.

- **Improving the Determination of Part D Low-Income Benchmarks:** The Secretary would be required to exclude Medicare Advantage rebates and bonus payments from the MA-PDP premium amount when calculating the regional LIS benchmark amounts.
- **Voluntary De Minimis Policy for Low-Income Subsidy Plan:** Beginning in 2011, plans that bid a nominal amount above the regional low-income subsidy (LIS) benchmark can choose to absorb the cost of the small difference between their bid and the LIS benchmark in order to qualify as a LIS-eligible plan.
- **Special Rule for Widows and Widowers Regarding Eligibility for Low-Income Assistance:** Beginning in 2011, the surviving spouse of a LIS-eligible couple must undergo a redetermination of his eligibility status no earlier than one year from the next redetermination that would have occurred after the death of a spouse. Subsequently, the LIS widow/widower would be determined or redetermined for LIS on the same basis as other LIS-eligible beneficiaries.
- **Facilitation of Reassignments of Beneficiaries in LIS Plans:** Those plans whose bids exceed the regional benchmark amount and whose LIS beneficiaries are reassigned would be required to transmit recent drug utilization data to the beneficiary's new plan within 30 days of notification of reassignment. Within 30 days of receipt, the plans with the reassigned beneficiaries would be required to provide beneficiaries with information about formulary differences between the old and new plans with respect to their drug regimen.
- **Funding Outreach and Education of Low-Income Programs:** The mark would provide \$45 million for outreach and education activities related to Medicare low-income assistance programs; these funds would be allocated to specified entities to conduct these activities.
- **Strengthening Formularies with Respect to Certain Categories or Classes of Drugs:** The mark would remove the criteria specified in MIPPA that the Secretary would use to identify protected classes of drugs and give the Secretary authority to identify classes of clinical concern. The current six classes of concern would be codified.
- **Reducing the Part D Premium Subsidy for High-Income Beneficiaries:** Beginning in 2011, the mark would reduce Medicare premium subsidy amount for beneficiaries whose modified adjusted gross income exceeded the thresholds used under Part B. Instead of setting the premium subsidy at 74.5 percent of total Part D premiums, the mark would decrease the Medicare premium subsidy to reflect the percentages used to decrease the Part B premium subsidy under current law.
- **Simplifying Part D Plan Information:** The Secretary would be required to establish two or more categories of prescription drug plans offered by Part D sponsors based on ranges of the actuarial values of the prescription drug benefits provided under the plan.
- **Limitation on Removal or Change of Coverage of Covered Part D Drugs Under a Formulary Under a Prescription Drug Plan or a MA-PD:** The mark would prohibit Part D sponsors from removing a covered drug from a plan formulary, apply a cost or utilization management tool that imposes a restriction or limitation on the coverage of such a drug, or increase the cost sharing of such a drug other than the date on which Part D sponsors may begin marketing their plans with respect to the immediately succeeding plan year.

Medicare Advantage

- **MA Benchmarks and Rebates:** The mark would set the base calculation of MA benchmarks on actual plan costs as reflected in plan bids rather than statutorily set rates, encouraging plans to compete more directly on the basis of price and quality rather than on the level of extra benefits offered to enrollees. Beginning in 2014, MA plans that bid below the new benchmark rates would receive a rebate amount equal to 100 percent of the difference between their bids and the new benchmarks rather than the 75 percent of the difference as under current law. MA plans would be required to use 100 percent of any rebate amount to provide additional benefits to their enrollees.
- **Bidding Rules:** MA plans would be required to have their bid information certified by a member of the American Academy of Actuaries. Beginning in 2012, the Secretary would establish bidding rules that plans would follow in order to protect the integrity and fairness of the bidding process.
- **Payment Areas:** The Secretary would be required to establish new MA payment areas for urban areas for plans beginning in 2012; these payment areas would be based on the definition of Metropolitan Statistical Areas as determined by the OMB. The Secretary would be required to combine one or more rural counties in a state into a single service area beginning in 2015. Bidding and service areas would be the same as payment areas beginning in 2012.
- **Bonus Payments:** Two new bonus payments for local and regional plans would be established, equal to a maximum of five percent of the national U.S. Per Capita Costs of Medicare on a per member per month basis. A new bonus payment would be created for care coordination and management activities conducted by MA plans. A second bonus would be created for prior year achievement or improvement in plan quality performance.
- **Efficiency Bonus:** An efficiency bonus for local and regional plans that bid significantly below per capita fee-for-service costs would be created; this bonus would be available in addition to the rebates and bonuses for providing care coordination and meeting quality thresholds.
- **Benefit Protection and Simplification:** Beginning in 2011, the mark would prohibit MA plans from charging cost sharing that is greater than the cost sharing under the original Medicare program for certain services for which beneficiaries need the highest level of predictability and transparency, such as chemotherapy, renal dialysis and skilled nursing care. Plans would be required to use the most significant share of their rebates and bonuses to meaningfully reduce Part A, B and D cost sharing relative to the traditional FFS program. Plans would use the next share to add preventive and wellness benefits. The remainder could be used to add non-covered benefits.
- **Simplification of Annual Beneficiary Election Periods:** The annual enrollment period dates for MA and Part D would be shifted from October 15 to December 7 beginning in 2011. The annual open enrollment period for MA plans would be eliminated.
- **Extension for Specialized MA Plans for Special Needs Individuals:** Special needs plans (SNPs) authority would be extended through December 31, 2013. By January 1, 2013, SNPs would need to have beneficiaries enrolled in their plans that meet the definitions for each kind of SNP. If beneficiaries do not meet these definitions, beneficiaries would have to be transitioned from SNPs to other MA plans or original Medicare by 2013.

- Extension of Reasonable Cost Contracts: The length of time reasonable cost plans may operate regardless of any other MA plans serving the area would be extended until January 1, 2013.

Improving Payment Accuracy

- Home Health Payment Changes: Beginning in CY 2013, the Secretary would be directed to rebase payments to reflect the number and mix of home health services, the level of intensity of services and the average cost of providing care. The mark sets out a schedule for the rebasing with it being completed in CY 2016. The Secretary would be directed to ensure adjustments in home health spending will be no greater than 3.5 percent per year during the four year transition relative to home health payment levels at the date of enactment of this legislation.
- Provider-Specific Cap on Home Health Outlier Payments: The Secretary would be directed to establish a provider-specific annual cap of ten percent of revenues that a home health agency may be reimbursed in a given year from outlier payments starting in CY 2011.
- Reinstatement of Rural Home Health Payment Adjustment: Between CY 2010 and CY 2015, the Secretary would be directed to provide for a three percent add-on payment for HH providers serving rural areas.
- Study Regarding the Development of Home Health Payment Reforms to Ensure Access to Care and Quality Services: The Secretary would be instructed to conduct a study to evaluate the costs and quality of care among efficient home health providers relative to their peers in providing ongoing access to care and in treating beneficiaries with varying severity levels of illness and develop recommendations on ways to reform home health payments and case mix adjustments based on this analysis.
- Hospice Payment Reforms: The Secretary would be required to collect additional data and information in order to revise payments for hospice care after consulting with hospice providers and the MedPAC.
- Medicare DSH Changes: Starting no later than 2015 and continuing on an annual basis, the Secretary would make DSH payments equal to 25 percent of the DSH payments that would otherwise be made, as articulated in the March 2007 MedPAC report to Congress. In addition to this amount, an additional payment would be made to reflect hospitals' continued uncompensated care costs.
- Plan to Reform Medicare Hospital Wage Index: By December 31, 2011, the Secretary would be required to provide a plan to Congress on how to comprehensively reform the Medicare wage index system.
- Extend Section 508 Reclassifications: These reclassifications would be extended until September 30, 2011.
- Advanced Diagnostic Imaging Services: The mark would increase the utilization rate assumption for calculating the payment for advanced imaging equipment from 50 percent to 65 percent for 2010 through 2013. The rate would be further increased to 75 percent beginning in 2014. The Secretary would be required to conduct a study on the estimated impact of the utilization rate change on beneficiary access, utilization of advanced diagnostic imaging services, and the estimated savings to the Medicare program over the period of 2010 through 2019.
- Durable Medical Equipment: The mark would eliminate the 2014 additional add-on payment. Starting in 2010, the option to purchase a power-driven wheelchair with a lump-sum payment

would be limited only to complex, rehabilitative power wheelchairs. Pharmacies would be eligible for an exemption from the accreditation requirements under certain standards, allowing the Secretary to determine accreditation standards that are more appropriate for pharmacies.

- **Treatment of Certain Cancer Hospitals:** The Secretary would be required to conduct a study to determine if the outpatient costs incurred by PPS-exempt cancer hospitals with respect to Medicare's ambulatory payment classifications exceed those costs incurred by other hospitals reimbursed under OPPS. If the costs were determined to be excessive, the Secretary would be required to provide for an appropriate adjustment for services furnished starting January 1, 2011.

Ensuring Medicare Sustainability

- **Market Basket Cuts:** The provision would reduce market basket updates for home health providers by one percent in 2011 and 2012. Market basket updates for hospice providers would be reduced by 0.5 percent in 2013-2019. For inpatient and outpatient hospitals, inpatient psychiatric facilities, inpatient rehabilitation facilities and long term care hospitals, there would be a 0.25 percent reduction in 2010 and 2011; these entities would also be subject to 0.2 percent market basket reduction from 2012-2019.
- **Productivity:** The mark would provide for updates based on market basket or CPI minus full productivity estimates for all Parts A and B providers who are subject to a market basket or CPI update.
- **Temporary Adjustment to the Income-Related Premium for Part B of Medicare:** The current income thresholds for 2011 through 2019 would be frozen.
- **Medicare Commission:** An independent Medicare Commission would be established and charged with developing and submitting proposals to Congress aimed at extending the solvency of Medicare, slowing Medicare cost-growth, and improving the quality of care delivered to Medicare beneficiaries. The Commission would be composed of 15 members who would be appointed by the President and confirmed by the Senate. Members of the Commission would serve six-year, staggered terms and would continue to serve until replaced. Beginning with the 2013 Trustees report, the CMS Office of the Actuary would be required to project whether the Medicare per-capita growth rate in 2015 will exceed the average growth rates in the CPI and the CPI for medical care projected for 2015. If the cost growth were estimated to be greater than the average of CPI and CPI-M, the Commission would be required to submit a proposal to Congress by January 1, 2014 that would reduce excess cost growth by 0.5 percentage points in 2015. If the Commission fails to submit a proposal, the Secretary would be required to submit one by January 5, 2014. Once the report is submitted, MedPAC would be required to review and present its analysis of the proposal. By April 1, 2014, the Senate Finance Committee and relevant House committees would be required to report out the Commission's proposal or an amended proposal that achieves the same level of reductions in excess cost growth. If a committee fails to report a legislative package by this deadline, the Commission's package would automatically be reported from that committee. The package would be required to be brought to the floor within 15 days of discharge. If a package that meets the level of Medicare savings described is not enacted into law by August 15, 2015, the mark would require the Commission's original proposal to take effect automatically. The Commission would be required to make additional proposals on January 1 of 2015, 2016 and 2017, but the targeted level of Medicare savings would increase each year. In any year where excess cost growth is not projected, the Commission would not be required to submit a proposal. In 2019, the mark would require

Congress to pass a joint resolution to continue further proposals and subsequent action by the Commission.

This proposal would not eliminate MedPAC as earlier proposals and legislation would. The Commission's sole function would be to control Medicare costs.

Patient-Centered Outcomes Research

- **Patient-Centered Outcomes Research Institute:** The mark would authorize the establishment of a private, non-profit corporation that would be known as the "Patient-Centered Outcomes Research Institute," which would assist patients, clinicians, purchasers, and policy makers in making informed health decisions by advancing the quality and relevance of clinical evidence through research and evidence synthesis. Research conducted would compare the clinical effectiveness, risk and benefits of two or more medical treatments, services or items.
- **Administration of the Institute:** A Board of Governors with 21 members would be established; this Board would be responsible for carrying out the duties of the Institute. It could not delegate the following activities: approving and monitoring disbursements from the Patient-Centered Outcomes Research Trust Fund, identifying research priorities, and adopting priorities, methodological standards, peer review processes and dissemination protocols. The Board members would be appointed to 6 year terms, and individuals would be prohibited from serving more than 2 terms.
- **Research of the Institute:** The Institute would be charged with identifying national priorities for comparative clinical effectiveness research and establishing a research project agenda. The Institute would consider the need for a systematic review of existing research before providing for the conduct of new research. A process would be established for peer-review of primary research under which evidence would be reviewed to assess scientific integrity and adherence to the methodological standards adopted by the Institute.
- **Addressing Subpopulations:** Research would be designed to take into account potential differences in outcomes among different subpopulations.
- **Institute Contracts:** The Institute would be allowed to enter into contracts with Federal agencies as well as with appropriate private sector research or study-conducting entities for the management and conduct of research in accordance with the research agenda.
- **Advisory Panels:** The Institute would be required to appoint expert advisory panels to assist in identifying research priorities and establishing the research project agenda. The panels would be charged with advising the Institute to ensure that information produced from the research is clinically relevant to decisions made by clinicians and patients at the point of care. Expert advisory panels would be appointed to assist in carrying out the research project agenda with respect to primary research. In the event of a clinical effectiveness study on a rare disease, the Institute would appoint a separate expert advisory panel for the purposes of designing research studies for rare diseases the value and feasibility of conducting research on a particular disease.
- **Methodology Committee:** A standing methodology committee would be established to develop and improve the science and methods of comparative effectiveness research. Within 2 years of enactment, the committee would be charged with determining a process to establish and maintain detailed methodological standards for comparative clinical effectiveness studies. This committee would also establish and maintain standards regarding clinical outcomes measures, risk-adjustment, and other aspects of research and assessment.

- **Dissemination of Information:** The Institute would be required to disseminate the findings of research to clinicians, patients, and the public in a comprehensible manner and form so they are useful to patients and providers in making health care decisions. The dissemination would discuss conclusions and considerations specific to certain subpopulations, comorbidities, or risk factors and include considerations including the limitations of the research and what further research might be needed.
- **Oversight:** The Institute would be required to submit an annual report to Congress, the President and the public, containing a description of the activities conducted, the research agenda and budget of the coming year, a description of research priorities, dissemination protocols and methodological standards, a list of individuals participating in any peer-review process, a description of the Institute's coordination with other private and public entities and any other relevant information.
- **Institute Transparency and Access:** The mark would direct the Institute to establish procedures to ensure transparency, credibility and access through public comment periods, forums, public availability of information and protocols for conflict of interest.
- **Conflicts of Interest:** The Comptroller General would be required to consider and disclose any conflicts of interest of potential Board appointees.
- **Use of Institute Findings:** Several limitations would be placed on the use of the Institute's comparative effectiveness research findings. The Institute would not mandate coverage, reimbursement, or other policies from any public or private payer. The Secretary would be prohibited from denying coverage based solely on a study conducted by the Institute and would have to use a transparent process when using research in making coverage determinations. The Institute's research would be prohibited from use in determining coverage, or creating reimbursement or incentive programs, for a treatment in ways that extend the life an elderly, disabled or terminally ill patient of lower value than extending the life of a person who is younger, non-disabled or not terminally ill. The Institute would be prohibited from developing or employing a dollars per quality adjusted life year as a threshold to establish what health care is cost-effective or recommended.
- **Patient-Centered Outcomes Research Trust Fund:** A new trust fund would be created to fund the Institute and its activities. Money would come from the general fund of the Treasury and the Medicare Trust Funds. \$10 million of ARRA funds would also be transferred into this fund. Fees would also be imposed on insured and self-insured health plans that would be directed to the fund.
- **Coordination with the Federal Coordinating Council:** ARRA would be amended by adding a duty that the Federal Coordinating Council would provide support to the Institute, including the Institute Chair to the Board of the FCC, requiring the FCC to include an inventory of its activities with respect to CER and requiring the FCC to coordinate its activities with the Institute.
- **NCD Study:** The Comptroller General would be required to submit a report to Congress within 18 months after the date of enactment on the process for making national coverage determinations under the Medicare program.

As anticipated, the Finance Committee created an independent entity to conduct comparative effectiveness research.

Sense of the Senate Regarding Medical Malpractice

- The mark acknowledges that health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance. States should be encouraged to develop and test alternatives to the current civil litigation system as a way of improving patient safety, reducing medical errors, encouraging the efficient resolution of disputes, increasing the availability of prompt and fair resolution of disputes and improving access to liability insurance while preserving an individual's right to seek redress in court. Congress should consider establishing a state demonstration program to evaluate alternatives.

Title IV: Transparency and Program Integrity

- **Limitation on Medicare Exception to the Prohibition on Certain Physician Referrals for Hospitals:** No later than 18 months after enactment, only hospitals meeting certain requirements would be exempt from the prohibition on self-referral. Hospitals that have physician ownership and a provider agreement in operation on November 1, 2009 and met other specified requirements would be exempt.
- **Physician Payment Sunshine:** The mark would provide for transparency in the relationship between physicians and applicable manufacturers with respect to payments and other transfers of value and physician ownership or investment interests in manufacturers. Annual transparency reports, penalties for noncompliance, procedures for the submission of information and public availability of this information would be required. Any manufacturer of a covered drug, device, biological or medical supply that makes payment or another transfer of value to a physician, a physician medical practice, a physician group practice or a hospital with an approved medical residency program will be required to report these transactions annually to the Secretary. By October 1, 2010, the Secretary would be required to establish procedures to ensure the public availability of the reported information.
- **Prescription Drug Samples:** Drug manufacturers and authorized distributors would be required to report the information required under the Prescription Drug Marketing Act of 1987 to the Secretary.
- **Nursing Home Transparency:** Changes would be made to improve the transparency of information about SNF and nursing homes, enforcement of SNF and nursing home standards and rules, and training of SNF and nursing home staff.
- **Imaging Self-Referral Sunshine:** With respect to certain imaging services, the referring physician would be required to inform the individual at the time of referral that the individual may obtain the services from a person other than the referring physician, a physician who is a member of the same group practice as the referring physician or an individual who is directly supervised by the physician or by another physician in the group practice. The new requirement would apply to services provided after January 1, 2010.
- **Hospital Average Charge Information:** Beginning in 2011, there would be a national requirement for acute care hospitals to make their charges for each Medicare DRG available to the public and upon request to any patient served by the facility.

Title VI: Revenue Items

- **Excise Tax on High Cost Insurance:** An excise tax on insurers would be imposed if the aggregate value of employer-sponsored health coverage, including major medical, dental, vision

and other supplementary health insurance, for an employee exceeds the threshold amount. The tax is equal to 35 percent of the value that exceeds the threshold amount of \$8,000 for individual coverage and \$21,000 for family coverage for 2013. The threshold amounts are indexed to the CPI for Urban Consumers. For self-insured group health plans, a Health FSA, or an HRA and with respect to employer contributions to an HAS, the excise tax would be paid by the employer. This would take effect for taxable years beginning after December 31, 2012.

- Value of coverage in the form of Health FSA reimbursements: In instances where reimbursements are limited to the amount of the salary reduction, the value of employer-provided coverage is equal to the amount of the aggregate salary reduction for the year. In cases where the Health FSA provides for reimbursement in an amount greater than the aggregate salary deduction, the value is determined in the same manner as for COBRA.
 - Amount subject to the excise tax and reporting requirement: The taxable amount is the sum of the aggregate premiums for health insurance coverage, the amount of any salary reduction contributions to a Health FSA for the taxable year, and the dollar amount of the employer contributions to an HAS, minus the dollar amount of the threshold.
 - Penalty for Under Reporting Liability for Tax to Insurers: The penalty for under reporting would be equal to any additional excise tax that each insurer and administrator would have owed if the employer has reported correctly increased for interest from the date that the tax was otherwise due to the date paid by the employer. This penalty may be waived if the employer can demonstrate that the failure is due to reasonable cause and not willful neglect.
 - Certain Transition Relief and Other Rules: There would be a transition rule under which the threshold amount would be increased by 20 percent for health insurance plans in the 17 states in which health care was the least affordable in 2012. The initial 20 percent would be reduced by half each year thereafter.
- Employer Health Insurance Reporting: Employers would be required to disclose the aggregate value of the health insurance coverage benefit on the employee's annual W-2. The method of determining the value would be the same as what is currently used for COBRA.
 - Modify the Definition of Qualified Medical Expenses: Medical expenses with respect to medicine for the purposes of employer provided health coverage, HSAs, and Archer MSAs is defined the same as for the purposes of the itemized deduction for medical expenses. OTC medicines may not be reimbursed through a Health FSA or HRA.
 - Health Savings Accounts: The additional tax on distributions from an HSA that are not used for qualified medical expenses is increased to 20 percent of the disbursed amount, beginning with disbursements made after December 31, 2009.
 - Limiting Flexible Spending Arrangements Under Cafeteria Plans: Salary reductions by an employee for a taxable year for purposes of a coverage under a Health FSA under a cafeteria plan would be limited to \$2,000 for a taxable year. The exclusion would not be limited for coverage offered through an HRA. This would be effective for the taxable year beginning after December 31, 2012.

- **Corporate Information Reporting:** The general information reporting requirement would no longer include exceptions for payments to corporations. Reporting would be required to include gross proceeds for both property and services. This would apply to payments made in taxable years beginning after December 31, 2011.
- **Requirements for Section 501(c)(3) Hospitals:** The following provisions would be effective for taxable years beginning the date after enactment.
 - **Community health needs assessment:** Each hospital would be required to conduct a community health needs assessment at least once every three years and adopt an implementation strategy to meet the community needs identified. The hospital would be required to disclose in its annual information report to the IRS how it is addressing the needs identified in the assessment. Failure to conduct an assessment in any applicable three-year period would result in a penalty of up to \$50,000.
 - **Financial assistance policy:** Each hospital facility would be required to adopt, implement and widely publicize a written financial assistance policy and a policy to provide emergency medical treatment to individuals. Individuals who are eligible for financial assistance under the policy would not be discriminated against in the provision of treatment.
 - **Limitation on charges:** Each hospital facility would be required to bill patients who qualify for financial assistance no more than the amount generally billed to insured patients. The amounts billed may be based either the best, or the average of the three best, negotiated commercial rates, or Medicare rates.
 - **Collection processes:** A hospital facility would be required to follow current Medicare law and regulations regarding the collection of debts, but may not undertake certain extraordinary collection actions against a patient without first making reasonable attempts to inform the patient about the hospital's financial assistance policy.
 - **Reporting and disclosure requirements:** The IRS would be required to review information about a hospital's community benefit activities at least once every three years. The mark would also require that each organization make its audited financial statements widely available.
- **Annual Fee on Manufacturers and Importers of Branded Drugs:** A fee would be imposed annually on any person that manufactures or imports prescription drugs; these fees would be credited to the Medicare SMI trust fund. The aggregate fee would be \$2.3 billion payable annually and apportioned based on market share. The fee would be assessed beginning in calendar year 2010.
- **Annual Fee on Manufacturers and Importers of Medical Devices:** A fee would be imposed annually on any person that manufactures or imports medical devices. The aggregate fee would be \$4 billion payable annually and apportioned based on market share. The fee would be assessed beginning in calendar year 2010.
- **Annual Fee on Health Insurance Providers:** The fee would apply to any company subject to Federal Income Tax as an "insurance company" and includes any insurer that: sells employer-sponsored group health coverage; sells health insurance coverage to individuals; a company that underwrites policies for government-funded insurance. This "fee" does not apply to a self-

insured employer group health plan. Health insurance providers will pay an aggregate \$6 billion fee annually; this fee would be apportioned among the providers based on relative market share. The fee would be assessed beginning in calendar year 2010.

- **Annual Fee on Clinical Laboratories:** The aggregate fee on the clinical laboratory sector would be \$750 million annually, beginning in 2010. It would be apportioned based on market share.
- **Repeal Business Deduction for Federal Subsidies for Certain Retiree Prescription Drug Plans:** The mark repeals the rule that states the exclusion for subsidy payments is not taken into account for purposes of determining whether a deduction is allowable with respect to retiree prescription drug expenses.

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