



Medical
Association
of Georgia

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SUMMARY

“AMERICA’S HEALTHY FUTURE ACT OF 2009”

SENATE FINANCE COMMITTEE, CHAIRMAN’S MARK

(As amended October 5, 2009)

AMERICA'S HEALTHY FUTURE ACT 2009

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TITLE I *HEALTH CARE COVERAGE*

Rating Rules in the Individual Market

- Establishes ratios for rating in the individual market limits characteristics on which premiums may vary.
- Guaranteed issue. Allows limits based on the capacity and other rules.
- Excluding coverage for pre-existing condition prohibited.
- Rescinding health coverage prohibited.

Immediate Assistance for Those With Pre-existing Conditions

- Allows those denied coverage due to pre-existing condition to enroll in high-risk pool.
- Premiums in high-risk pool calculated on same rating factors as above.
- Must be uninsured for six months to qualify.
- \$5 billion in funding to subsidize premiums.

Rating Rules for Small Group Market

- Establishes same rules for small group market, and those in the individual market phased in over five years.

Cafeteria Plans for Small Employers

- Provides safe harbor from non-discrimination requirements for eligible small employers. One hundred or fewer employees and employer provides total of 8 percent of gross wages in benefits.

Pooling Requirements for Individual and Small Group Markets

- States required to apply new federal rating rules the individual and small group markets. States have options to merge pooling and rating requirements.
- Individual and group markets would be subject to same risk adjustment.
- **Re-insurance**
 - All health insurers required to contribute to a re-insurance program for individual policies administered by a non-profit reinsurance entity.

- Non-profit must use funds collected to support re-insurance mechanisms for plans offered within the state exchange.
- Re-insurance for those defined as “high risk.”
- Contributions collected by the tax-exempt non-profit must total \$20 billion in years 2013 to 2015 to meet insurance requirements.
- Additional contributions of \$5 billion to apply to employer-sponsored retiree coverage.
- Prohibits states from imposing more stringent regulations on large group market that do not exist on small group or individual market.

State Insurance Commissioners

- Insurance commissioners responsible for all rating requirements imposed by the bill.
- NAIC devise model regulations within 12 months. HHS promulgates regulations if NAIC fails to do so.
- States must establish an exchange that complies with the requirements set forth in federal law.
- States failing to comply within 24 months shall contract with a non-governmental entity to establish a state exchange.

Rating Areas

- Defined by state insurance commissioner, reviewed by HHS for adequacy. High-quality plans may be offered in less than full rating areas, similar cost people may be pooled; risk adjusted.

Grandfather Plans

- Individuals and groups “permitted” to renew coverage in an existing policy including the “young invincible” type policies. No tax credits are offered to grandfather plans.
- May be offered in perpetuity, but only to current or new employees and their dependents.

Interstate Sale of Insurance

- No later than 2013, NAIC shall develop final rules for the creation of “health care choice compact” to allow purchase of health insurance across state lines. State Legislatures required to oppose.
- Subject to laws and regulations of the state where the policy is written or issued.

National Plans

- National plans with uniform benefit packages allowed across state lines.
- Would offer coverage through state exchanges.
- Must be compliant with benefit levels and categories in federal law.
- Pre-empts state benefit mandates.
- Required to offer silver and gold benefit levels.
- State legislative activity needed for a state to opt-out. State opt-out process similar to Medicaid waiver process. States must have a plan that provides coverage at least as

comprehensive as the coverage required under the exchange. Must show that, over 10 years, plan is budget neutral to the federal government.

State Option for a Basic Health Plan

- States may establish a federally-funded non-Medicaid state plan for people with incomes above Medicaid but below 200 percent FPL. Federal government to provide funds to participating states to provide coverage through private health care “systems” under contracts.
- States would negotiate with “health care systems” for coverage options to provide better value.
- Funding based on 85 percent of the value of individual tax credits and subsidies that would otherwise have been based on enrollment in state. Funding provided to independent state based trusts.
- Eligibility limited to people from 133- 200 percent FPL, are under 65 and don’t have access to affordable employer sponsored coverage.
- Minimum benefit package and premium cost share set at levels same as bill. Premium assistance available through plan instead of tax credits.
- Incentives for care management and preventative services and establishment of patient doctor relationships that maximize patient involvement in health care decision-making.
- Negotiating should be coordinated with any Medicaid or other state administered health care programs.
- Minimum medical loss ratio of 85 percent.
- Specific performance measures required for plans.

SUBTITLE B – STATE EXCHANGES AND CONSUMER ASSISTANCE

Plan Participation

- All private insurers in individual and small group markets must be available in their newly established state exchange. Must have internal appeal process.
- Coverage for emergency room services without regard to prior authorization or the emergency care provider’s contractual relationship with the health plan. Out of network cost sharing must be same as for in-network services.

Establishment of State Exchanges

- Creates two exchanges: States would be required to establish an exchange for the individual market and a small business health options program (SHOP) for the small group market.
- Plans with annual and lifetime limits and plans with limited benefits prohibited.
- Exchange plans available to all legal residents. Parents unlawfully in U.S. may purchase insurance for the lawfully present children.

Functions Performed by HHS Secretary and/or States

- Develop standard enrollment application form.

- Standardized format representing insurance options, standardized marketing requirements, call center support, enable to enroll in schools, hospitals, etc., conduct eligibility determination.
- Develop a rating system for plans based on relative quality and price compared to other similar plans.
- Exchange would receive initial federal funding, but would be self-sustaining in future years.

Large Employers

- Beginning 2015, states must allow small employers to purchase coverage through SHOP. Beginning in 2017, state must allow large employers (100+ employees) to purchase coverage through SHOP.

Members of Congress

- Members of Congress and congressional employees required to use employer contribution to purchase coverage through a state-based exchange rather than FEHBP.

SUBTITLE C – MAKING COVERAGE AFFORDABLE

Definition of Four Benefits Categories

- Four benefit categories would be available: Bronze, Silver, Gold and Platinum. No policies could be issued in the individual or small group market other than grandfather plans that do not meet the actuarial standards described below.
- All plans must provide preventative in primary care, emergency services, hospitalization and other minimum federal standards except in cases where there is a “value-based insurance design.”
- No lifetime limits on coverage or annual limits on benefits.
- Plan designs in state exchanges would be required to apply parity for cost-sharing within each of the following categories of the benefits:
 - In-patient hospital
 - Out-patient hospital
 - Physician services
 - Other items
- Insurers participating in exchanges required to charge the same price for same products in entire service area.
- HHS to define and update categories of covered services annually to account for changed in medical evidence or scientific advancement, gaps in access or changes in the evidence base.

Definition of Levels

- Bronze: Represents minimum creditable coverage. Would be equal to the actuarial value of 65 percent. Out of pocket limits equal HSAs.
- Silver: Actuary of value of 70 percent with out of pocket limits for MCC.
- Gold: Actuary of value of 80 percent with out of pocket limits for MCC.

- Platinum: 90 percent with out of pocket limits for MCC.
- Young and invincible policy available for those 25 years or younger for catastrophic only.
- Out-of-pocket limits based on sliding-scale based on percentage of federal poverty level.
- Small employers purchasing coverage through the exchange would be required to offer a plan with a deductible that does not exceed \$2,000 for individuals (\$4,000 for families.). Indexed to premium growth.
- Stand alone dental plans must be allowed.

Individual Premium of Credit

- The bill would provide a refundable tax credit for eligible individuals and family who purchase health insurance through the exchange refundable and advanceable directly to the insurer.
- Tax credit available to individuals with Modified Gross Income (MGI) of 300 percent of FPL.
- IRS authorized to disclose to the exchange limited tax return information to verify eligibility. Existing privacy safeguards would apply.
- Sliding-scale basis for individuals between 134 percent and 300 percent FPL from 2 percent of income at 100 percent of FPL to 12 percent at 300 percent of FPL.

Eligibility Verification

- In order to prevent illegal immigrants from accessing state exchanges by obtaining tax credits, the bill requires verification of personal data. Individuals claiming to be U.S. citizens if consistent with SSA data will be considered substantiated.
- Those lawfully in the U.S. with data consistent with DHS data will be considered substantiated.
- State may contract with Medicaid agencies to make eligibility determinations.

Cost-sharing Subsidy

- A cost-sharing subsidy would be designed to buy out any difference in cost-sharing between insurance purchased and actuarial values for individuals between 100 percent and 200 percent of FPL sliding scale.

Small Business Tax Credit

- Small employers are eligible for the credit. An employer with no more than 25 FTEs whose employees have annual full-time equivalent wages that average no more \$40,000.
- Credit also available to small employers with 10 or fewer employees whose average wages are less than \$20,000.
- Credit available from maximum of two taxable years; after two years credit would only be available to small employer that purchased insurance the exchange.
- Credit amount would be equal to the applicable percent of small employers' contribution to the premium tax credit of 35 percent of premium cost for non-elective contributions.
- Tax credit phased out for small employers between 10 and 25 percent sliding scale.
- Hours and wages of seasonal worker exempt from calculations in determining eligibility.

- Charitable organizations will be eligible to apply tax credit against organization's liability for payroll taxes.

Application of State and Federal Laws Regarding Abortion

- Would ensure that state laws regarding prohibition would not be pre-empted. Federal conscience protects and abortion-related anti-discrimination laws will not be affected.

Abortion Cannot be a Mandated Benefit as Part of a Minimum Benefits Package.

- Abortion cannot be a mandated benefit as part of a minimum benefits package.
- A qualified health plan would not be prohibited from providing coverage for abortions, but it would for those beyond which federal funds are appropriated. Federal funds continue to be prohibited from being used to pay for abortions unless pregnancy is due to rape or incest or the life of the mother is in danger.

Required Segregation of Public Funds

- No tax credit or cost-sharing may be used to pay for abortions beyond those prohibited by the most recent appropriation of the HHS. Plans that offer abortion coverage must do so through the exchange, and must do so by segregating federal funds to ensure that funds are not used to cover abortions.

Actuarial Value of Optional Service Coverage. HHS required to estimate actuarial basis per employee of abortion coverage.

- Secretary will ensure that each state exchange at least one plan provides coverage for abortions.
- Health plans participating in state exchanges will be prohibited from discriminating against a health care provider or facility for its willingness to pay for, provide coverage of, or refer for abortions.

SUBTITLED D – SHARED RESPONSIBILITY

Personal Responsibility Requirement

- Beginning in 2013, all U.S. citizens and legal residents are required to purchase coverage through: 1) the individual market, a public program such as Medicare, Medicaid, CHIP, or through an employer or 2) in the large group market in a plan with first dollar coverage for prevention.
- Exemptions for religious objections allowed.
- Grandfathered plans allow.
- Individuals required to report that they have such coverage on federal income tax returns.

Open Enrollment in the Individual Market

- Open enrollment for eligible individuals would be September 1 through November 30.

Excise Tax

- The consequence for not maintaining insurance would be an excise tax of \$750 per adult in the household. The per adult penalty would be phased in from \$0 in 2013 to \$750 in 2017.
- No excise tax on individuals with the full premium of the lowest cost option exceeds 10 percent of their AGI.
- Exemption for individuals below 100 percent FPL.
- Non-compliance shall incur no criminal penalty nor shall interest accrue for a civil penalty for failure to pay such assessment. Collection shall be limited to withholding of federal payments due.

Auto Enrollment

- Employers with 200 or more employees must automatically enroll employees into health insurance plans offered by the employer. Employees may opt-out if able to demonstrate they have coverage from another source (i.e., Medicare).
- States may auto-enroll into individual and group policies approved by HHS.

Employer-Offer of Health Insurance Coverage

- Employers not required to offer health insurance. If the employer offered coverage is unaffordable (10 percent of the employees income indexed to inflation), the employee may receive a tax credit.
- All employers with more than 50 employees that do not offer coverage will be required to pay a fee for each employee who receives a tax credit for health insurance through the state exchange. The fee to employers for employees receiving a tax credit would be established by the Secretary of HHS but could not exceed an amount equal to \$400 multiplied by the total number of full-time employees in the firm regardless of how many they are receiving with state exchange credits.

SUBTITLE E – CREATION OF HEALTH CARE COOPERATIVES

Consumer Operated and Oriented Plan (CO-OP)

- Authorizes \$6 billion dollars in funding to foster the creation of non-profit, member-run health insurance companies to serve individuals in one or more states.
- Co-ops would compete in the reformed individual and small group insurance market on a level “playing field” with other plans.
- Federal funds would be distributed as loans and grants. Loans would be provided to assist start-up costs and grants would be provided to meet states solvency requirements.
- An advisory board, chaired by the Secretary of HHS with members appointed by House and Senate leaders, will make recommendations to Secretary on loans and grants.
- A co-op that violates terms of loan or grant will be required to repay.

SUBTITLE F – TRANSPARANCY AND ACCOUNTABILITY

Ombudsman Program

- States required to establish an ombudsman program.
- \$30 million authorized to support consumer assistance organizations in each state.

Informed Consumer Choices

- In implementing state exchanges, secretary required to develop standard definitions of common insurance terms, medical terms, health care scenarios, and an annual personalized statement to help consumers understand policies and coverage.

Transparency

- Plans required to report the proportion of premium dollars spent on items other than medical care.
- Hospitals required to list standard charges for all services and Medicare DRGs.

Standardization

- Mandates development and utilization of uniform outline of coverage documents.

SUBTITLE G – ROLE OF PUBLIC PROGRAMS

PART I – MEDICAID COVERAGE FOR THE LOWEST INCOME POPULATIONS

Expanded Medicaid Eligibility

- New eligibility category for all non-elderly, non-pregnant individuals otherwise ineligible for Medicaid with incomes below 133 percent of FPL.
- States would have the options of covering these adults. These adults would not have the individual mandate to purchase insurance.
- Maintenance efforts (MOE) apply beginning 2014. States exempt from the MOE if state certifies it is currently experiencing budget deficit and projects deficit for following fiscal year.
- Individuals at 100 percent of FPL would be eligible for Medicaid and remain ineligible for tax credits in state exchanges. Non-elderly, non-pregnant adults between 100 percent and 133 percent of FPL would be able to choose between Medicaid and private coverage through their state exchange.

Medicaid Program Payments

- Beginning in 2014, additional federal financial assistance would be provided to all states to defray the cost of covering these newly eligible beneficiaries.
- States that offer minimal or no coverage to the newly eligible population would receive more assistance initially than states that do cover that population, adjusted to parity over six years.

- Additional assistance to “high-need states” i.e. those states with below national average Medicaid enrollment and seasonal adjusted unemployment rates of 12 percent+ for August 2009 Assistance in the form of full federal funding for the cost of providing medical assistance to newly eligible beneficiary for the five year period 2014-2018.

Medicaid Employer-Employee Sponsored Insurance

- Requires states to offer premium-assistance and wrap around benefits to Medicaid beneficiaries who are offered employer-sponsored insurance if it is cost effective to do so.

Medicaid Improvement Fund

- Rescinds \$700 million in funding designated for use to improve the management of Medicaid.

PART II – CHILDREN’S HEALTH INSURANCE PROGRAM

CHIP:

- The bill would maintain the current structure of CHIP. States would be required to maintain income eligibility levels for currently Medicaid and CHIP eligible children. MOE expires 2019. State may expand eligibility at any time.
- States receive a 23percent increase in federal matching rate through 2019CHIP enrollees would receive tax credits in state exchanges.
- CHIP cost-sharing rules and out-of-pocket limits are limited at five percent of family income.

PART III – IMPROVEMENTS TO MEDICAID

Enrollment Coordination with State Exchange

- States required to establish Medicaid enrollment Web site to promote seamless enrollment in Medicaid. Website to allow determination of eligibility.
- HHS to issue guidance on best practices to improve enrollment of most vulnerable in Medicaid and CHIP.

Presumptive Eligibility

- All hospitals that participate in Medicaid may make presumptive eligibility determinations in addition to providers currently eligible to do so.

PART IV – MEDICAID SERVICES

Free-standing Birth Centers Identified as Medicaid Providers

Curative and Palliative Care for Children in Medicaid: Expands eligibility for children in Medicaid to receive hospice services.

Long-term Services and Supports: \$10 million each fiscal year to continue funding of aging and disability resource centers.

Community First Choice Option

- CFCO would create a state plan option to provide community based attendant supports and services to individuals with disabilities who re Medicaid eligible and who require an institutional level of care.

Spousal Impoverishment

- Protect against spousal impoverishment in al Medicaid home and community based services programs by requiring same rules a provided for spouse of nursing home residents.

Home and Community Based Services

- Increase in FMAP for those states that undertake structural reforms to increase nursing home diversion to access to home and community based services.

Money Follows the Person Rebalancing Demonstration: Extends the program through September 2016.

Family Planning Services

- Provides for a new Medicaid eligibility group of non-pregnant women to receive family planning services. Ste may enroll such individual for limited time on preliminary determination of Medicaid eligibility.

Repayment of Medicaid Overpayment

- States must repay Medicaid overpayment within one year—current rule is 60 days.

PART V – MEDICIAD PRESCRIPTION DRUG COVERAGE

Change the Status of Some Excludable Drugs, adds Smoking Cessation Drugs, Barbiturates and Benzodiazepines to Medicaid Patients.

Increase the Brand-name Drug Rebate Amount

- Increases the flat rebate percentage from 15.1 percent to 23.1 percent of brand-names drugs.

Increase the Generic Drug Rebate Amount

- Increased the generic drug rebate to 13 percent of AMP.
- Comptroller General to review ate laws that have a negative impact on generic drug utilization. Due to restrictions such as pharmacists’ ability to substitute a generic drug or carve-outs of certain classes of drugs for generic substitution.

Extend to and Collect Rebates on Behalf of Managed Care Organizations

- Drug manufacturers would be required to pay rebates for beneficiaries who receive prescription drugs in a MCO plan.

Application of Rebates to Formularies of Existing Drugs

- New formulations of existing brand drugs are treated as the original product, thus, requiring additional rebate obligation for a reformulated existing drug.

Changes to Medicaid Payment for Prescription Drugs

- Changes federal upper payment limit (FUL) from 250 percent of AMP to 175 percent of AMP.

PART VI – MEDICAID DISPROPORTIONATE SHARE OF PAYMENTS

DSH Allotments

- Would remain intact unless triggered by a 50 percent decline in states uninsured rate resulting in a reduction of DSH payment by 25 percent each year or thereafter if the state's uninsured rate decreases the allotment or is further reduced pursuant to a formula.

PART VII – DUAL ELIGIBLES

A Waiver Authority for Dual Eligible Demonstrations

- Establishes the Medicaid Quality Measurement Program that would expand upon existing quality measures, identify gaps in current quality measurements, and establish priorities for the development and advancement of quality measures in consultation with relevant stakeholders.
- States would receive grant funding to support development.

Medicaid Reimbursement for Healthcare Acquired Conditions

- Prohibits payments to states for Medicaid services to Healthcare Acquired Conditions.
- HHS to define conditions consistent with Medicare but with limit to conditions acquired in hospitals.

Medicaid Bundled Payments Demonstration Project

- Establishes bundled payment demonstration project under Medicaid for up to eight states.
- Acute care to be bundled with post-acute care paid to hospitals.

Federal Coordinated Health Care Office

- Creates CHCO within CMS for the purpose of bringing together officials of Medicare and Medicaid programs to integrate benefits and improve coordination between state and federal governments.

PART VIII: MEDICAID QUALITY

Medicaid Quality Measures

- Establishes the Medicaid Quality Measurement Program within HHS to develop, (in consultation with states), health care quality measures specific to adults. (Children's measures already being developed.) Funded and pursued through grants.

Medicaid Reimbursement for Health Care Acquired Conditions

- Prohibits federal payment to states for health care acquired conditions.
- Conditions defined by Secretary.

Medicaid Bundled Payments Demonstration Project

- Establishes bundled payment demonstration project under Medicaid in up to eight states.
- Acute care would be bundled with post-acute care provided in hospitals and non hospital settings/ and or hospital and concurrent physicians' services.
- Hospitals would receive the single bundled payment.

Medicaid Global Payments Demonstration Project

- Large safety net hospital systems be permitted to alter is provider payment system from FFS to capitated global payment structure.
- Allow certain pediatric providers to be recognized as Accountable Care Organizations.

PART IX – MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION

Authorization

- \$11 million for MedPAC and expands mission to include assessment of adults services in Medicaid.

PART X – AMERICAN INDIANS AND ALASKAN NATIVES

SUBTITLE H – ADDRESSING HEALTH DISPARITIES

Standardized Collection of Data

- Requires uniform categories for collection of data on race, ethnicity, gender and primary language.

Sufficient Disparities Data

- Require federally-funded population surveys to collect sufficient data on racial and ethnic subgroups to generate statistically reliable results in studying health disparities populations.

Data Sharing

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

Privacy & Security

- Require HHS to ensure all appropriate and privacy and security safeguards are followed.
- Provides for Durable Power of Attorney to be provided to children who age out of the foster care system.
- Allows states to cover therapeutic foster care.

SUBTITLE I – MATERNAL AND INFANT AND EARLY CHILDHOOD VISITATION

MCH Block Grants

- Requires states to conduct needs assessment to identify communities that are at risk for poor maternal and child health to have quality home visitation programs.
- **New Grant Program Established**

Postpartum Depression

- Incorporates provisos of S. 324 to address postpartum depression and psychosis.

Elder Justice Act

- Incorporates provisions of S. 795 which creates a comprehensive approach to ensuring adequate public-private infrastructure to detect and prevent elder abuse.

Assisted Suicide

- Prohibits federal funds to pay for assisted suicide.

Abstinence Education

- \$50 million per year through 2014 for abstinence education and \$75 million per year for Personal Responsibility Education for Adulthood Training.

Teen Pregnancy Prevention

- \$50 million available to states for programs to educate adolescents on both abstinence and contraception for prevention of teenage pregnancy and STD transmission.

TITLE II
PROMOTING DISEASE PREVENTION AND WELLNESS

SUBTITLE A – MEDICARE

Annual Wellness Visit

- Medicare beneficiaries would have access to comprehensive health risk assessment based on guidelines outlined by the Secretary to identify chronic diseases, modified risk factors, and urgent health need.
- Assessment could be provided through interactive teleconference or Web based program.
- Medicare will pay for a visit to a primary care provider to create a personalized prevention plan which will include the administration of the HRA.

Removing Barriers to Preventive Services

- Encourages beneficiaries to receive preventative screenings by removing costs-sharing for such services.

Evidence-Based Coverage of Preventative Services

- Encourages evidence-based coverage of preventative services by giving the Secretary the authority to apply new preventative services to existing preventative services program.

Study on Beneficiary Access to Immunizations

- Requires GAO to study the impact on coverage of adult youth immunizations under Part D.

Incentives for Healthy Lifestyles

- \$100 billion over five years to establish an initiative to provide to Medicare beneficiaries who successfully participate in certain healthy lifestyle programs.

SUBTITLED B – MEDICAID

Improving Access to Preventative Services for Eligible Adults

- States required to provide Medicaid coverage for comprehensive tobacco cessation services for pregnant women without cost-sharing.
- Promotes other preventative care services and encourages their inclusion in Medicaid.

Incentives for Healthy Lifestyle

- Secretary would develop criteria for healthy lifestyle programs for evidence-based resources.
- Suited to meet Medicaid eligible beneficiaries and have demonstrated success in helping individuals control cholesterol and or blood pressure, loose weight, quit smoking, or managed preventative diseases.

Medicaid State Plan Option Promoting Health Homes and Integrated Care

- Creates a new Medicaid state plan option under which Medicaid enrollees with at least two chronic conditions could designate a provider as their health home.
- The designated provider team of health professionals would offer comprehensive management services and coordination of care.
- States incentivized to do this with enhanced match of 90 percent of FMAP for two years.

Appropriation for Childhood Obesity Demonstration Project

- \$25 million appropriated to carry the project. HHS to issue guidance to state and health care providers as to coverage and preventative services.

SUBTITLED C – WORKPLACE WELLNESS

HIPAA Codification

- Codifies portions of HIPAA that relate to the tax deductibility of expansion benefits such as gym membership and rewards based on attainment of certain health standards.
- Allow group health plans to provide rewards for participation in wellness programs.

TITLE III

IMPROVING THE QUALITY AND INEFFICIENT OF HEALTHCARE

SUBTITLE A – TRANSFORMING THE HEALTH CARE DELIVERY SYSTEM

PART I – Linking Payment to Quality outcomes in the Medicare Program

Hospital Value-based Purchasing

- Creates a program that moved beyond pay-for-reporting quality measures to provide value-based incentives payments to acute care hospitals that meet certain quality performance standards.
- Payments would be adjusted based on performance.
- Secretary has the authority to replace the measure if it found all hospitals are effectively in compliance with measure.
- Reductions and payments to hospitals would be used to fund an incentive pool that would phase-in payments to hospitals.

Physician Quality Reporting Initiative

- Establishes a new PQRI option that provide incentive payments for two successive years to professionals who voluntarily complete maintenance of certification program and complete a qualified maintenance of certification practice assessment.
- Maintenance of certification is designed to demonstrate the physician's use of evidence-based medicine and will seek to improve quality of care through follow-up assessments.
- Provisions for timely feedback. Appeals process available.
- Eligible professionals who successfully report entitled to one percent bonus in 2010 and .5 percent bonus in 2011.
- Eligible professionals who fail to participate successfully in the program face a 1.5 percent payment penalty in 2013; calculated at 98.5 percent of allowed charges. In 2014 and beyond penalty for non-reporting is 98 percent of allowed charges.

Expansion of Physician Feedback Program

- Secretary required to provide reports to physicians that compare their resource use with that of other physicians and/or groups of physicians caring for patients with similar conditions.
- Feedback reports based on episode group or methodology.
- Appropriate adjustments requires, (i.e., demographic characteristics).
- Beginning 2014 payment would be reduced by five percent if an aggregation of the physician resource use is at or above the 90 percentile of national utilization. After five years, Secretary has the authority to rebase the 90 percentile threshold.

Value-Based Modifier for Physician Payment Formula

- Secretary of HHS to apply a separate budget-neutral payment modifier to the FFS payment formula replacing the Geographic Adjustment Factor. The modifier would have the effect of paying physician differently based upon the relative quality of care achieved for Medicare beneficiaries relative to cost.
- Cost based on composite of appropriate measures that take into scout justifiable differences in practice costs as well as demographic characteristics and baseline health status of the Medicare beneficiaries.
- Quality base on composite of appropriate risk-based measure of quality that reflect the health outcomes and health status of Medicare beneficieate served by physicians.
- HHS required to seek endorsement of the entity with a contract with Secretary under Sec 1890 and take into consideration rural and underserved communities.
- Secretary required to publish specific measures of quality and cost, specific date of implementation of the payment adjustment an prospective performance periods.
- Require to begin implementation of the value-based payment adjustment in 2013 rulemaking process.
- Modifier should be applied in a way that promotes systems-based care. All physician payments subject to modifier by 2017.

Medicare Inpatient Rehabilitation Facility, Long-term Acute Care Hospital and Hospice Quality Reporting

- Secretary to establish quality reporting programs for rehabilitation facilities, long-term care facilities and hospices.
- Failure to report quality measures result in two percent reduction.

Medicare IPPS Exempt Cancer Hospital Quality Reporting

- Quality reporting programs required for IPPS exempt cancer hospitals.
- Implement mandatory quality measure reporting.

Medicare Home Health Agency and Skilled Nursing Facility Value-based Purchasing

Implementation Plans

- Secretary to submit to Congress a Medicare value-based purchasing implementation plan for HHAs and SNFs.

Reducing Hospital Required Conditions

- Applies new payment adjustments to hospitals ranked in the top quartile of national list adjusted hospital acquired condition rate.

PART II – STRENGTHING THE QUALITY INFRASTRUCTURE

National Strategy to Improve Healthcare Quality

- Secretary to establish national quality improvement strategy, including priorities to improve delivery of health care services and patient outcomes through a transparent and collaborative process.
- Focus on high cost, chronic disease, patient safety reducing medical errors, preventable hospital admission and re-admissions, etc. would be a comprehensive strategic plan.
- National strategy to be updated not less than every three years.

Interagency Working Group on Health Care Quality

- President would convene a working group consisting of relevant federal departments to work collaborative on fulfilling the quality improvement strategy.

Quality Measured Development

- Secretary would identify gaps where no quality measures exist and update those that do exist.
- A qualified consensus entity would be required to submit an annual report to the Secretary describing areas where gaps in quality measures exist. Secretary would then develop measures that would fill identifiable gaps.

Consultation for Selection for Endorsed Quality Measures for Use in Reporting and Payment Programs

- Secretary would develop process for consultation with qualified consensus entity. The secretary shall make a public list of measures considered for selection.

Use and Review of Quality Measures

- Secretary would establish a process to disseminate measures and incorporate measures where applicable in workforce programs, federal health programs and other areas deemed appropriate by secretary.

Free Clinics:

- Added to list of providers eligible for Medicare and Medicaid HIT incentives.

PART III – ENCOURAGE AND DEVELOPMENT OF THE NEW PATIENT CARE MODELS

Accountable Care Organizations

- Qualified ACO will be able to participate in savings they achieve in the Medicare program and have an opportunity to qualify for incentive bonuses.
- ACOs defined as groups of providers and suppliers who have an established mechanism for joint decision-making such as capital purchases.
- Practitioners would be defined as physicians, nurse practitioners, physicians' assistants, clinical nurse specialists, other practitioners.
- Incentive payments based on meeting certain quality thresholds.

CMS Innovation Center

- Secretary to create an Innovation Center for CMS to test, evaluate, and expand different payment structure and methodologies which are aimed to foster patient-centered care, improve quality and slow the rate of Medicare, Medicaid and CHIP cost growth. Models include medical home models.
- Payment made through comprehensive models or can be salary-based. May promote improved quality and reduced costs by developing a collaborative of institutions
- May facilitate local inpatient care through electronic monitoring.
- Promote greater effectiveness and timely access to outpatient services (i.e. physical therapy) to models that do not require physician referral.
- Center authorized to terminate or modify design of models at any time.
- Required to consult regularly with outside stakeholders.

National Pilot Program on Payment Bundling

- The Secretary required to develop, test and evaluate alternative payment methodologies through national voluntary pilot programs designed to provide incentives for providers to coordinate patient care across the continuum and to be jointly accountable for the entire episode of care.
- The bill goes into great detail on specifics of the program, how payments will be bundled, etc.

Reducing Affordable Hospital Re-admissions

- Beginning in 2012, Secretary to share hospital reporting data and will publically report the data and starting in 2013 hospitals with re-admission rates above a certain threshold would have payments from the original hospitalization reduced by 20 percent if a patient with a selective condition is re-hospitalized with a preventable re-admission within seven days and 10 percent if re-admitted within 15 days.
- Certain diseases such as metastatic malignancies, trauma and burns are excluded.

Transitional Care Program to Reduce Preventable Re-admissions

- Three-year Medicare pilot program called the Community Care Transitions Program will fund hospitals to provide community-based partnership organizations to provide patients center and evidence-based care transition services for Medicare beneficiaries of the highest risk of preventable re-hospitalization.

Extension of Gainsharing Administration

- Extended until September 2011.

Home-based Chronic Care Management Program

- Creates a pilot project to bring primary care services through interdisciplinary teams to the highest cost Medicare beneficiaries in their home. Providers eligible for shared savings if they achieve quality outcomes, patient satisfaction and cost savings.

PART IV – STRENGTHENING PRIMARY CARE AND WORKFORCE IMPROVEMENTS

Primary Care/General Surgery Bonus

- Establish a new 10 percent bonus on select E&M codes under Medicare beginning 2011. The codes would be office visits, home visits, nursing facilities visits, and domiciliary care home or custodial care facilities.
- The bonus would be available to primary care practitioners including APRNs and PAs who provide 60 percent of their services in these codes.
- In addition, General Surgeons providing care in a health professional shortage area would be eligible for a 10 percent bonus on five major procedure codes.
- Fifty percent of the code bonuses would be offset through and across the board reduction to all other codes except for physicians who primarily provide services in each HPSA zip code.

Redistribution of Unused GME Slots to Increase Primary Care in Generalist Physicians

- Redistributes 65 percent of currently unused residency slot so as to encourage training in the area of primary care and general surgery.

Promoting Greater Flexibility For Residency Training Programs

- All time spent on a residency would count toward Medicare direct GME payment without regard to setting or activities performed.

- Time spent by resident in patient care activities in a non-hospital setting would be counted toward Medicare indirect medical education payment if the hospital continues to jointly operate residency training programs.

Rules for Counting Resident Time for Didactic and Scholarly Activities and Other Activities

- Allows hospitals to count time that residents spend in approved training programs for certain non-patient care activities in non-hospital settings that is primarily engaged in furnishing patient care.

Preservation of Resident Cap Physicians From Closed and Acquired Hospitals

- Residency allotments of hospital with an approved residency program that closes could be used to increase the otherwise applicable residency limit of other hospitals.
- Establishes criteria for allocation.

Proposal on Development of a National Workforce Strategy

- Secretary to create a workforce advisory committee to address workforce shortages and encourage training in key focus areas such as improving care coordination use of HIT and increase access to primary care services.
- Stakeholders develop and present a national workforce strategy to Secretary.

Demonstration Project to Address Health Professions Workforce Needs

- Establishes demonstration grants to address needs in health professions workforce.
- Competitive grants to provide aid and supportive services to low income individuals with the ability to obtain education and training.
- Grants also to six states for three years to develop core training competencies and certification programs for personal and home care aids.

Extension of Family-to-Family Health Information Centers

- Extended with appropriation of \$5 million for two years.

Teaching Health Centers

- Qualified teaching health centers eligible for payments of direct GME expenses or other indirect expenses. Programs in addition to existing Medicare-supported residency slots. Teaching health center means a community based facility ambulatory patient care center that operate a primary care residency program.
- The program will be funded with \$230 million over five years from the Medicare Part A trust fund pursuant to a formula. Additional grants are authorized.

Advanced Practice Nurse Training

- Adds \$50 million over four years to establish a graduate nurse educational demonstration program in Medicare. Payments made to eligible hospitals for costs of APRN training in the area of primary and preventative care, chronic care management etc.

- Participants must have an affiliation with an accredited school of nursing and two or more non-hospital community-based settings in rural or underserved areas.

SUBTITLED B – IMPROVING MEDICARE FOR PATIENTS AND PROVIDERS

PART I – INSURING BENEFICIARY ACCESS TO PHYSICIAN CARE AND OTHER SERVICES

Sustainable Growth Rate (SGR)

- .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 (i.e., a temporary one year fix).

Extension of Floor on Medicare Work Geographic Adjustment

- Would extend the 1.00 floor for geographic index for an additional two years.
- Practice expense to be readjusted in 2010 to reflect $\frac{3}{4}$ of the difference between relative cost of employee wages and rents

Misvalued Relative Value Units (RVU)

- Secretary required to periodically identify potentially mis-valued codes and make appropriate adjustments.
- Focus on the fastest growth codes that have experienced substantial changes in the practice expense, codes for new technologies or services, multiple codes that frequently build in conjunction with furnish a single service.

Therapy Caps

- Extends exception process for therapy caps for two years.

Extension of Treatment of Certain Physician Pathology Services Under Medicare

- Extends provision for direct payments through 2012.

Extension of Increased Payments for Ambulance Services Under Medicare

- Extends provisions until January of 2012.

Extension of Long-term Care Hospital Provisions

- Extended by two years.

Extension of Payment Adjustment for Medicare Mental Health Services

- Extends provisions until January 2012

Permitting Physician Assistants to Order Hospital Extended Care Services

- PAs who do not have a direct or indirect employment relationship with a skilled nursing facility but are working in collaboration with a physician may certify need for a post-hospital extended care services for Medicare payment purposes.

Recognizing Attending Physicians' Assistants as Attending Physicians to Serve Hospice Patients

- PAs may provide written plan of care for terminal ill patients.
- Physicians must continue to certify individual as terminally ill.

Medicare Diabetes Self-management Training as Certified Diabetes Educators as Providers Diabetes Self-management Training.

Medicare Improvement Fund

- Would eliminate funding for the Medicare improvement fund designed to make improvements under the original fee-for-service program.

Medicare Part B Special Enrollment Period For Disability Tri-care Beneficiaries

- Creates a special 12-month enrollment period for military retirees as a once-in-a-life-time enrollment period in Medicare Part A and Part B.

Federally Qualified Health Centers

- Directs HHS to establish a prospective payment system(PPS) for Medicare-covered services furnished by Federally Qualified Health Centers. Update methodology to be developed by Secretary.
- Preventative services made eligible for reimbursement
- PPS would be extended to insurers participating in state exchanges which would be required to provide payment for services provided by FQHC.

Guidelines to Ensure Emergency Room Access

- Directs Secretary to convene a working group of experts in emergency care to recommend within 18 months boarding and diversion standards for hospital and guidelines, measures and incentives for implementation and enforcement of such standards.

Medicare Payment for Biosimilar Products.

- Part B Biosimilar Products to be assigned a separate billing code and be reimbursed at the ASP plus 6 percent.

Access to Critical Lab Tests

- Labs authorized to bill for certain tests ordered less 14 days of hospital discharge on samples taken while patient was in the hospital.
- Lab tests such as DNA, RNA, chromosomes, protein etc.
- The provision is effective for two years. Lab must be independent of the hospital.

- Provides a trigger for sunset of the proviso based on amount of funds spent to cover such tests.

Public Meeting and Report to Congress on Payment for New Clinical Lab Tests.

- Secretary of HHS to convene public meeting on payment system for clinical lab diagnostic tests and submit a report to Congress providing recommendations for legislative and administrative actions to reform reimbursement mechanisms.

PART II – RURAL PROTECTIONS

Extend Medicare Rule Hospital Flexibility Program and Study on Applying the MDH Program to Urban Hospitals.

- Extends the FLEX grants program for critical access hospitals until 2013.
- Secretary to conduct a study on need for additional Medicare inpatient payment for urban Medicare-dependent hospitals paid under the prospective payment system which receive additional payment such as DSH or IME. Purpose is to compare these hospitals with other PPS hospitals.

Extend Hospital Out-patient Department Hold Harmless For Small Rural Hospitals; Extend and Expand Hospital Out-patient Department Hold Harmless for Sole Community Hospitals

- Small rural hospitals would receive 85 percent of the payment difference between 2010 and 2011 perspective payment system payments.

Extend Reasonable Cost Reimbursement for Laboratory Services in Small Rural Hospitals

- Extended two years.
- A provision for hospitals with less than 50 beds to receive 100 percent of reasonable cost reimbursement for clinical diagnostic labs covered under Part B.

Extend Rural Community Hospital Demonstration Program: Extended through 2012.

Extend Medicare Dependent Hospital Program: Extended through September 2013.

Temporary Improvements to Medicare In-patient Hospital Payment Adjustment For Low-volume Hospitals

- Provides a temporary adjustment to increase payments through 2012 for certain low-volume hospitals. Reduces from 25 to 15 miles its location from another comparable hospital and have 1,500 discharges of individuals entitled to Medicare Part A benefits. Applicable percentage increase max 25 percent.

Revisions to Demonstration Project on Community Health Integration Models in Certain Rural Counties

- Expands current demonstration projects to develop and test new models of delivery of health care services to all counties.

- Physicians' services may be included within scope of demonstration project.

MedPAC Study on Adequacy of Medicare Payments for Health Care Providers Serving Rural Areas

- MedPAC to review payment adequacy for rural health care providers serving Medicare.
- Analysis of rural payment adjustments outlined in the bill.
- Recommendations on appropriate modifications to rural payment adjustments.

Technical Correction Related to Critical Access Hospitals (CAHs)

- Clarifies CAH are eligible to receive 101 percent of reasonable costs for providing outpatient services regardless of billing methodology for providing qualifying ambulatory services.

Reimbursement for DXA Services

- Reinstates reimbursement for dual energy x-ray absorptiometry services to 70 percent of 2006 rates.

Super Rural Ambulance Payments

- Extends bonus payments under Mediate to ambulance service provider which serve the most rural quartile of counties.

PART III – MEDICARE PART D IMPROVEMENTS

Improving Coverage in Part D Coverage Gap

- Provides for discount drug manufacturer discounts on brand-named drugs that are covered under Part D which would be available during the donut hole gap once the beneficiary exceeds the catastrophic limit the discount would end.
- Available to those who do not qualify for low income subsidy, are not enrolled in employer-sponsored retiree drug plan and do not have an annual income that exceeds Part B income thresholds (\$85,000 for singles and \$170,000 for couples in 2009).
- Discount would be 50 percent off the negotiated price. Manufacturers required to participate in the discount in order to have drug covered Medicare Part D.
- The agreement would require manufacturers to discount drug prices at the pharmacy or through mail order services.

Improving the Determination of Part D Low-income Benchmarks

- Excludes Medicare Advantage rebates and bonus payments from the Medicare Advantage Prescription Drug Plan premium amount when calculating the low income subsidy benchmarks. The effect would be to increase the number of plans that can serve low income subsidy beneficiaries at fully subsidized premiums.

Voluntary De Minimus Policy for Low-income Subsidy Plans

- Provides flexibility to enroll beneficiaries into plans in order to maintain adequate low-income subsidy plan choices.

- The provision will help maintain plans that wish to serve low-income subsidy beneficiaries at fully subsidized premiums.

Special Rule for Widows and Widowers Regarding Eligibility for Low-income Assistance

- Extends the period by which a re-determination of subsidy eligibility is made for persons who suffer the death of a spouse.
- No earlier than one year between the next determination.

Facilitation of Re-assignment of Beneficiaries in Low-income Subsidy Plans

- Plans with low-income subsidy beneficiaries that are re-assigned to other plans are required to transmit recent drug utilization data to the new plan within 30 days of notification.
- Formulary difference required to be submitted to plan participants.

Funding Outreach and Education of Low-income Programs

- Extends funding for beneficiary outreach and education activities related to low-income programs for Medicare.

Strengthening Formularies with Respect to Certain Categories or Classes of Drugs

- Repeals prior law requiring HHS to identify classes and categories of drugs that should be protected or covered entirely by Part D plans.
- This bill would give the Secretary authority to identify classes of clinical concerns.

Reducing the Part D Premium Subsidy for High-income Beneficiaries

- Reduces Medicare premium subsidy amount for beneficiaries whose modified adjusted gross income exceeds \$85,000 for an individual or \$170,000 for a couple in 2009.
- Expands IRS authority to disclose income information to Social Security Administration for purposes of adjusting Part B subsidy to include Part D subsidy adjustments.

Simplifying Part D Plan Information

- HHS to establish two more categories of prescription drug plans offered by Part D sponsors based on ranges of actuarial values of the prescription drug benefit provided.

Limitation on Removal or Change of Coverage of Covered Part D Drugs Under a Formulary Under a Prescription Drug Plan of MA-PD

- Part D sponsors are prohibited from removing a covered drug from a plan formulary, apply cost utilization management tools that impose restriction of limitation of coverage such as preferred status, usage restriction, step therapy, prior authorization or quantity limitation or increase the cost of the drug through tiering or other methods on any date other than the date on which Part D sponsors may begin marketing their plans.
- Exceptions are allowed if there is a change from a brand name to a generic drug during the plan year.

Medicare Part D Copayment Equity

- Cost sharing for Part D full-benefit, dual eligibles receiving care at home or in community based setting would be equal to cost sharing of institutional care patients.

AIDS Drug Assistance Programs and Indian Health Services

- Allows these drugs to count towards annual out of pocket threshold.

Generic “First Fill”

- Allows drug plan sponsors (including MA drug plans) to waive copayments for generics.

Long-Term Care Pharmacy

- Requires Medicare Part D drug plans to employ utilization management techniques, such as automated dose dispensing to reduce the quantity dispensed per fill for beneficiaries who reside in long-term care facilities to reduce waste associated with 30 day refills.

Pharmacy Benefit Manager Transparency

- Requires PBMs to share with HHS and plans contracts with Medicare Part D or exchanges. Plans would be given access to information on their own PBM contracts.
- Information to be disclosed include: percent of all prescriptions that are provided through retail pharmacies, compared to mail order pharmacies, generic dispensing and substitution rates, aggregate amount and types of rebates and price concessions.

OIG Report

- On drugs commonly used by Dual Eligibles on Part D formularies.
- Comparing prescription drug price paid by Part D insurer to those negotiated by state Medicaid plans for top 200 drugs, including amounts of discounts in order to assess financial impact of any price discrepancies on federal government or beneficiaries.

SUBTITLE C – MEDICARE ADVANTAGE

MA Benchmarks and Rebates

- The bill changes the statutory payment mechanism for Medicare Advantage Plans so as to encourage plans to compete more directly on the basis of price and quality rather on the level of extra benefits offered to enrollees.

Bidding Rules

- Bid information submitted by MA plans required to be certified by American Academy of Accuracies.

Payment Areas

- Reformulates payment areas to establish urban areas for plan bids.

Bonus Payments

- Bonus payments to MA plans would be restructured so that they would be equal to or less than five percent of the national U.S. per capita costs of Medicare on a pro-member pro-month basis.
- Bonuses would be made available based on performance criteria and would depend on benchmark rates.

Grandfather Policy

- Allow MA plan to grandfather benefits for current enrollees in certain parts of country where average bids are at or below 75 percent of local FFS costs.
- Amount of extra benefits phased out by 5 percent per year.
- Plans retaining grandfathered benefits would be required to submit bid under competitive bidding process.
- Performance bonus payment not available to enrollees in grandfathered plans.

Transitional Benefits

- Requires HHS to provide transitional extra benefits in 2012 to beneficiaries who enroll in MA that experience significant reduction in extra benefits through competitive bidding. Authorizes \$5 billion for this purpose.

CMS Actuary Certification

- Prevents implementation of MA provisions for competitive benchmarks and bonus payment from taking effect if CMS certifies that would result in current beneficiaries losing Medicare benefits.

Benefit Protection and Certification

- MA plans would have to apply the full amount of rebates and bonus to cover the costs of additional benefits.
- By reducing costs sharing, at preventative and wellness benefits or not covered benefits.
- Requires a complaint system and uniform appeals process for Medicare part D plans.

Simplification of Annual Beneficiary Election Periods

- Changed to October 15 through December 7.
- Provides a 45 day grace period in which a subscriber to a MA plan may disenroll and revert to FFS.

Extension of Specialized MA Plans for Special Need Individuals

- Extends special needs program authority through 2013.
- Requires special needs programs to be certified by NCQA in order to participate in MA program.

Extension of Reasonable Cost Contracts: Extends for three years.

Private Fee for Service Plans

- Clarifies that new-employee offered private fee-for-service plan areas defined as areas serving.

MediGap

- Request the NAIC to create new model plans for Medicare C and F that include cost sharing to encourage the use of appropriate Part B Physician Services.

SUBTITLED D – IMPROVING PAYMENT ACCURACY

Home Health Payment Changes

- HHS would rebase payments to home health care to reflect the number of mix of HH services, level of intensity, and average cost of providing care.

Provider-Specific Cap on Home Health Outlier Payments

- Secretary directed to establish a provider-specific cap of 10 percent of revenues.

Provider-Specific Cap on Home Health Outlier Payments

- Secretary directed to establish a provider-specific cap of 10 percent of revenues that HH agency may be reimbursed in a given year.
- To ensure that providers would not be paid in excess of 10 percent of cap.

Reinstatement Rural Health Home Payment Adjustment

- Provides three percent additional payment of HH providers serving rural areas.

Study Regarding the Development of Home Health Payment Reforms to Ensure Access to Care and Quality Services

- Secretary shall conduct a study to evaluate costs and quality of care among the physician home health providers relative to their peers.

Hospice Payment Reforms

- Secretary to collect data and information in order to evaluate revision of payments for hospice care and implement changes as appropriate based on that data.
- Creates Medicare Hospice Concurrent Care Demonstration which would allow patients who are eligible for hospice to also receive all Medicare covered services.. Secretary to examine improvement in patient care, quality of life and cost effectiveness.

Medicare DSH Changes

- Reduces DSH payments to an amount equal to 25 percent of the payment that would otherwise have been made, which represents an empirically justified amount.
- In addition to this amount, there would be additional funding to reflect the hospitals continued uncompensated care costs which would be empirically justified.

Plan to Reform Medicare Hospital Wage Index

- HHS to submit a plan to Congress on how to comprehensively reform the Medicare Wage Index system for hospitals.
- Secretary to restore the ratios used in determining geographic hospital wage index reclassification to pre Oct. 1, 2008 levels. Until one year after reform plan submitted.
- Budget neutrality required.

Advanced Diagnostic Imaging Services

- Payment rates would be reduced based on increasing the SN rate of use based on the assumed utilization rate of 65 percent in lieu of 50 percent (75 percent in 2014).
- Assumed utilization rates for technical component of imaging services of contiguous body parts raised from 25 percent to 50 percent.

Durable Medical Equipment

- Elimination of additional payment in 2014.

Power Wheelchairs

- Lump sum payment option eliminated starting in 2011.

Treatment of Certain Cancer Hospitals

- Secretary required to conduct a study to determine if outpatient costs incurred by exempt cancer hospitals exceed those costs by other hospitals reimbursed under the outpatient perspective payment system.

Nurse Midwifery and Reimbursement Equity

- Increases Medicare payment rate for nurse midwives from 65 percent to 100 percent of the physician fee schedule.

SUBTITLE E – INSURING MEDICARE STABILITY

Market-Basket Cuts

- Market-basket updates for home health providers reduced by one percent in 2011 and 2012.
- Hospice providers by .5 percent from 2013 through 2019.
- Hospitals reduced by .25 percent and .2 percent through 2019.
- Productivity adjustment may be applied.

Productivity

- Would adjust downward hospital basket payments with an adjustment for productivity.
- Establishes separate formula for clinical lab productivity.

Temporary adjustment to the income-related Premium for Part D of Medicare

- Freeze the current income thresholds from 2011 through 2019.

Medicare Commission

- Establishes an independent Medicare Commission that would develop and submit proposals to Congress aimed at extending the solvency of Medicare, slowing Medicare growth and improving quality.
- Fifteen members appointed by President and confirmed by the Senate.
- Commission tasked with presenting proposals to Congress that would reduce Medicare spending by targeted amounts.
- Commission would be prohibited from presenting proposals that would ration care, increase revenues, or otherwise change Medicare beneficiary cost-sharing benefits or eligibility standards.
- Should include recommendations for reduced expenditures under Parts C & D through reductions in federal premium subsidies to MA-PD and PDP plans and performance bonuses to MA plans.
- Proposals required to be submitted to MedPAC and CBO for evaluation.
- Congress would consider the proposal or similar proposal with same budget targets. Only budget-neutral and germane amendments would be considered.
- If Congress does not enact into law by August, the original proposal would automatically go into effect.
- May submit non-binding recommendations regarding improvements to payment systems for providers.
- Growth to be reduced by one percent in 2016, 1.25 percent in 2017 and 1.5 percent in 2018. Growth target in 2019 and beyond would be GDP per capita plus one percent.
- In 2009 Congress require to hold a vote under fast-track procedures on whether the Commission should extend beyond 2019. Commission continues unless Congress affirmatively votes to terminate it.
- Changes implemented as a result of the provision would not be subject to administrative or judicial review.
- Commission granted immediate authority to advise Secretary on priorities for health services research related to payment reforms and would have access to federal data and research.
- Establishes a Consumer Advisory Committee of ten consumer representatives that would advise the Commission on impact of payment policies on consumers.
- GAO to conduct a study in 2015 on impact of Commissions proposal on beneficiaries access to providers, affordability of premiums and quality of care.
- No reduction in Medicare outlay may be utilized to offset any non-Medicare outlays.

MedPAC Review and Report on Medicaid and Commercial Payments to Congress

- To extend feasible, MedPAC shall report aggregate Medicaid and commercial trends in spending, utilization and financial performance for providers on an aggregate national basis.

SUBTITLE F – PATIENT-CENTERED OUTCOMES RESEARCH

Patient-centered Outcome Research Institute:

- The bill would create a new, non-profit tax exempt corporation known as the “Patient-centered Outcome Research Institute” to assist patients, clinicians, or purchasers and policy-makers in making informed decisions by advancing the quality and relevance of clinical evidence through research and evidence synthesis.
- The institute would have a board of governors. 15 members, three of whom would represent physicians and surgeons.
- The institute would identify national priorities for comparative clinical effectiveness research. In setting priorities, the institute would consider the following: disease incidents and prevalence in the United States; evidence gaps in terms of clinical outcomes; practice variations; the potential for new evidence to improve health and quality of care; expenditures associated with health care treatment strategy; patient needs, outcomes and preferences including quality of life; and relevance to assisting patients in making informed health decisions.
- The institute would be required to conduct research and synthesis of evidence using systemic reviews and assessments of existing evidence, primary research such as randomized clinical trials, and other methodologies recommended by the methodology committee.
- The institute would be allowed to request and obtain data from federal, state and private entities including from clinical databases and registries if request is granted.
- The institute required to establish a process for peer review of primary research. The peer review process is public and designed in a manner to avoid bias and conflicts.
- The institute would design research to take into account potential differences and outcomes among different subpopulations such as racial, ethnic and minorities, women, age and groups with different comorbidities and risk factors.
- The institute would be prohibited from disseminating research findings from a study or assessment that would include practice guidelines, coverage recommendations or policy recommendations.
- The institute would have to establish procedures to ensure transparency, credibility and access through public comment periods, forums and public availability of information.
- Limitations established around the use of the institute’s comparative effectiveness research findings.
- The institute would not mandate coverage, reimbursement or other policies for any public or private payer. None of the reports would be construed as mandates, common guidelines, or policy recommendations.
- The institute would be prohibited from denying coverage based solely on its study.
- Secretary would be prohibited from using the institute’s research in determining coverage or creating reimbursement or incentive programs for treatment in the ways that treat extending the life of the elderly, the disabled or terminally ill patients of lower value than extending the life of a person who younger, not disabled or not terminally ill.

- The institute is prohibited from developing or employing a dollar per quality adjusted life year or similar measures as a threshold to establish what health care is cost effective or recommended.

SUBTITLE G – ADMINISTRATIVE SIMPLIFICATION

- The bill would establish a timeline for accelerating the development, adoption and implementation of a set of operating rules for each of the nine HIPAA transaction standards that would create as much as uniformity implementation standards as possible.
- It would create a unique health plan identifier and additional requirements on plans to comply with operating rules regarding trans-eligibility verification claims status, claims remittance, etc. Health plans would have to comply with this by 2016 and could be assessed or fined for failure to comply. The penalty would be \$1 per day, per covered life, up to a maximum of \$20 per covered life.

SUBTITLE H – SENSE OF THE SENATE REGARDING MEDICAL MALPRACTICE

Sense of the Senate that health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance. The states should be encouraged to develop and test alternatives to the current litigation system as a way of improving patient safety, reducing medical errors, encouraging the effective resolution of disputes, increasing the availability of prompt and fair resolution of disputes, improving access to liability insurance while preserving an individual’s right to seek redress in court. States encourage to establish demonstration programs to evaluate alternatives to the current civil litigation system.

TITLE IV TRANSPARENCY AND PROGRAM INTEGRITY

Limitation on Medicare Exception to the Prohibition on Certain Physicians Referrals Hospitals

- Eighteen months after the date of enactment only hospitals meeting certain requirements would be exempt from the prohibition on self-referral.
- Hospitals that have physician ownership in operation on November 1, 2009 would be exempt from a self-referral ban.
- Hospital could not have converted from an ambulatory surgery center to a hospital after the date of enactment.
- Exempt hospitals required to file data to ensure bona fide investments.
- Physician ownership could not expand.
- Ownership interest to a physician could not be offered on more favorable terms than to any other. Significant other provisions.

- Exempt hospitals would not be permitted to increase the number of operating rooms procedure rooms or beds.
- Certain hospitals may be allowed to expand.

Physician Payment Sunshine

- Requires a drug manufacturer or medical device manufacturer or medical supply company that makes payment or transfers anything of value to a physician or hospital to report such transactions on an annual basis.

Prescription Drug Samples

- Drug manufacturers required to report drug samples distributed, destroyed or returned to the manufacturer.

Nursing Home Transparency

- Requires disclosure of ownership, compliance and ethics programs to be followed by SNF by their employees and agents as well as quality assurance in performance improvements.
- The bill would require the Secretary to include a nursing home compare Web site. States would be required to submit survey information to the Secretary for posting on the Web site.
- Require notice to federal government of facility closure
- Secretary required to establish national program for State and national background checks similar to MMA program paid for with a federal match not to exceed \$3 million for newly participating states and \$1.5 million for previously participating states.

Imaging Self-Referral Sunshine

- The bill amends the in-office ancillary exception and would require physicians to disclose to patients at the time of the referral any ownership interest in MRI, CT Scan or PET/CT Scan.

Hospital Average Charge Information

- In 2011, the bill would establish a national requirement for acute care hospitals to make their charges for each Medicare DRG available to the public upon request.

TITLE V FRAUD, WASTE AND ABUSE

Providers Screening

- Requires HHS to screen all providers and suppliers before granting Medicare billing privileges including license checks and may include screening measures such as fingerprint prints, criminal background checks, multi-state database inquiries and random and unannounced site visits.

- Renewed every five years.
- Requires initial application fee of \$350 and a discounted fee for current providers for \$250. States given authority to impose similar screening procedures in Medicaid.
- Hardship waiver available to state if it demonstrate the fee would impeded beneficiary access to care.
- States failing to create effective screening programs would be subject to a financial penalty through a reduction of FMAP.

Data Matching

- The bill would require CMS to complete the development of the comprehensive “1 PI” integrated data repository. This would consolidate certain data sharing at matching segments across federal health care claims and payment.

Conditions of Participation and Coverage

- Medicare and Medicaid providers and suppliers would be required to implement compliance programs as a condition of participation. Physicians would be required to keep documentation on referrals to programs at high-risk of fraud and abuse and to provide such documentation upon request of the Secretary.

Payment

- Maximum period for submission of Medicare claims would be reduced to 12 months.

Overpayments

- Medicare providers have 60 days to repay Medicare overpayments identified through an internal compliance audit.

Deterrence/Civil and Criminal Penalties

- Reduces the “willful” standard to convict of crime to eliminate the requirement that the physician had actual knowledge of the law or a specific intent to violate the law. They must do so voluntarily and purposely to do what the law forbids.

Providers Self-disclosure Protocol

- Secretary required to establish mechanism for providers to voluntarily disclose specific information regarding actual and potential violation of the physician self-referral law.

Program Exclusions

- Medicare law clarified that hardship waivers can be based on hardship imposed on beneficiaries of a federal health care program.

Recovery Audit Contractors

- Extends RAC to Medicare Part C and Part D and Medicaid by end of 2010.
- CMS to submit an annual report to Congress on the effectiveness of the program.

Program Integrity Funding and Reporting Requirements

- Increases funding for the health care fraud and abuse control program.

Medicaid Integrity Program

- Funding increased by \$10 million per year for 10 years.

National Correct Coding Initiative

- Requires state to use NCCI in state Medicaid programs.

TITLE VI REVENUE ITEMS

Excise Tax on High Cost Insurance

- The bill imposes a 40 percent excise tax on insurers of the aggregate value of employer sponsored health care coverage for an employee that exceeds a threshold amount.
- The threshold amount is \$8,000 for individuals and \$21,000 for family coverage.
- Excise tax does not include fixed indemnity health coverage purchased by the employee with after tax dollars.
- Contains a transition rule which allow the 17 states in which health care was least affordable , the threshold amount is increased by 20 percent
- For retired individuals over age 55 the threshold amount is increased by \$1,850 for individual coverage and \$5,000 for family coverage.
- Same increase as retired provision for individual engaged in “high risk” professions. Professions delineated. Only medially-related profession listed except ambulance crew.

Employer Health Insurance Reporting

- An employer would be required to disclose the value of the benefit provided by the employer to the employees for health insurance coverage on the annual W2 form.

Modified the Definition of Qualified Medical Expenses, Individual Deduction for Medical Expenses

- Cannot use pre-tax dollars of HAS or FSA to cover the costs of over-the-counter medicines.

Health Savings Accounts

- Additional tax of 20 percent on amounts disbursed or non-qualified medical expenses.
- The current tax on HSA funds that are not used for qualified medical expenses is increased from 10 percent to 20 percent.

Limiting Flexible Spending Arrangements Under Cafeteria Plans

- Salary reductions for an employee under a health flex savings account is reduced from an unlimited amount to \$2,500.

Corporate Information Reporting

- Current law requires persons engaged in a trade or business that makes payments in excess of \$600 to report to the IRS those payments.
- Corporations are currently exempt from such reporting.
- The bill would eliminate the exemption for payments to corporations.

Requirement for Section 501(c)(3) Hospitals

- The bill requires additional reporting of non-profit hospitals including a requirement to conduct a community health needs assessment at least once every three years and the implementation of a strategy to meet the community needs identified.
 - \$50,000 fine for non-compliance
 - **Financial Assistance Policy:** hospitals must develop a policy that describes the eligibility criteria for financial assistance to patients whether such assistance includes free or discounted care.
 - **Limitation on charges:** Each hospital facility would be required to bill patients who qualify for financial assistance no more than the amount billed generally to insured patients. The hospital may not use gross charges when billing individuals for financial assistance.
 - **Collection Process:** Required to follow Medicare law and regulations regarding collection of debts but may not undertake certain extraordinary collection actions even if otherwise permitted by law against a patient without first making reasonable attempts to inform the patient about the hospitals financial assistance policy.

Reporting and Disclosure Requirements

- The IRS would be required to review information on the hospitals community benefit activities reported on the Form 990 at least once every three years.
- Requires HHS to report to Congress on the levels of charity care, bad debt expenses, unreimbursed costs, etc. by private tax-exempt hospitals.

Annual Fee on Manufacturers and Importers Branded Drugs

- The Bill would impose a fee on any person that manufactures or imports prescription drugs in the U.S.
- The fee would be accredited to Medicare's Supplemental Insurance Trust Fund in the amount of \$2.3 billion annually apportioned among the covered entities based on relative market share of sales.
- The market share would be determined on branded drugs, single source or innovator multiple source drugs but excludes orphan drugs.
- The market share would be based on government programs such as Medicare, Medicaid, VA, etc.

Annual Fee on Manufacturers and Importers of Medical Devices

- The bill would impose a fee on medical device manufacturers and importers of \$4 billion annually apportioned among the covered entities based on relative market share. Sales of medical devices that are regulated by the FDA as a medical device except Class I and Class II (if less than \$100) products and products intended for use on animals.
- Fee assessed are not deductible.

Annual Fee on Health Insurance Providers

- The bill provides for an annual fee of providers of health insurance in the amount of \$6 billion apportioned among providers based on relative market share.

Repeal Business Deduction for Federal Subsidies for Certain Retiree Prescription Drug Plans

- The bill eliminates the amount of subsidies that employers get for their prescription drug plans and may not deduct from gross income.
- Thus is not an amount that can be deducted from taxes.

Modify the Itemized Deductions for Medical Expenses

- Increases the threshold for deductions from 7.5 percent to 10 percent of AGI.
- Individual age 65 or older remains at 7.5 percent.

Credit to Encourage New Therapies

- Creates temporary credit capped at \$1 billion over 2 years to encourage investments in new therapies.
- Limited to small companies with fewer than 250 employees
- Limit to 50 percent of investments
- Defines Qualified projects

Executive Compensation

- Limits the deductibility of “excessive remunerations” (exceeds \$500,000) for executives of an insurance provider if at least 25 percent of the gross premium income is from health insurance plans that meet the minimum creditable coverage requirements.
- Includes all officers, directors and employees and consultants. Excludes self insured plans.
- Performance based incentives and existing contractual obligations exempted.

Failsafe

- Beginning 2012 OMB to certify annually in President’s Budget that the provisions this bill will not increase the budget deficit in the coming year. If it increases the deficit, required to notify Congress and the aggregate amount and the exchange subsidies provided would be automatically adjusted to commensurate with the deficit increase.