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## **SUMMARY**

# **U.S. HOUSE OF REPRESENTATIVES TRI-COMMITTEE DISCUSSION DRAFT ON REFORM OF THE HEALTH CARE SYSTEM**

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# SUMMARY

## U.S. HOUSE OF REPRESENTATIVES TRI-COMMITTEE DISCUSSION DRAFT ON REFORM OF THE HEALTH CARE SYSTEM

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### **DIVISION A: AFFORDABLE HEALTH CARE CHOICES**

Purpose: to provide affordable, quality health care for all Americans through building on the current system, insurance reforms including the creation of an Exchange and assuring that all Americans are covered with an essential benefits package, reforming the health care delivery system to increase quality and reduce costs.

#### *Title I*

#### *Protections & Standards for Qualified Health Benefits Plans*

##### **Subtitle A: General Standards**

Purpose: to establish standards to ensure that new health insurance coverage guaranteed access to affordable coverage.

##### **Requirements for Reforming the Health Care Marketplace**

##### **Protecting the Choice to Keep Current Coverage:**

- Individual coverage pursuant to a group health insurance plan offered and in force and effect before Y1 are grandfathered. No new enrollees after Y1 except dependents.
- *5 year grace period to meet same requirements as apply to QHBP*
- Individual health insurance coverage shall not qualify as acceptable coverage unless grandfathered or offered as an Exchange-participating health benefits plan.

##### **Subtitle B: Standards Guaranteeing Access to Affordable Coverage**

##### **Prohibits Preexisting Conditions Exclusions**

**Guaranteed Issue and Renewal [Individual mandate is the corollary.]**

### **Insurance rating rules**

- Premium rates may not vary except by age (2-1), family enrollment.

**Non-discrimination in Benefits** [Standards set by Commissioner].

**Ensuring Adequacy of Provider Networks** [Standards set by Commissioner].

**Minimal Medical Loss Ratio:** 85% with rebates to enrollees for less.

### **Subtitle C: Standards Guaranteeing Access to Essential Benefits**

#### **Coverage of Essential Benefits Package**

- Choice of Coverage: Qualified Health Benefit Plan (QHBP) (Non-Exchange and Exchange) must offer Essential Benefits Package.
- No annual or lifetime limits on coverage *except may limit coverage based on “clinical appropriateness.”* [Language may tie into CER.]

#### **Essential Benefits Package Defined**

- Hospitalization, outpatient hospital and clinical services, professional services of physician and others, services, equipment, supplies incident to services for professional, prescription drugs, rehabilitative and habilitative services, mental health and substance abuse, preventative services as recommended by Preventative Services Task Force and vaccines as recommended by CDC, maternity benefits, Well Baby care.
- No cost-sharing for preventative services.
- Cost sharing limits for Y1 is \$5,000 (individual) and \$10,000 (family).
- Limits on use of co-payments.

#### **Health Benefits Advisory Committee**

26 members. Surgeon General Chairs.

9 non federal appointed by President.

9 non federal appointed by Comptroller General.

8 federal employees appointed by president.

At least one practicing physician or other health professional  
Advisory to Sec. HHS.

Makes recommendations (within 1 year of enactment) on benefits standards and cost sharing.

Take into account “innovation in health care” and ensure that essential benefits coverage does not lead to rationing of health care.

#### **Process for Adoption of Recommendations: Adoption of Benefit Standards**

- Sec HHS goes through rule making process on essential benefits package.

## **Subtitle D: Additional Consumer Protections**

**Ensuring Fair Marketing Practices by Health Insurers** [Commissioner to establish uniform marking standards for all QHBP.]

### **Requiring Fair Grievance Procedures**

- QHBP must have an internal claims appeal process, external review process according to standards set by Commissioner. State law ok if more protective.

### **Requiring Information Transparency and Plans Disclosure**

- *QHBP shall comply with standards for accurate and timely disclosure of claims payment policies practices and amounts etc.*
- *Assure transparency regarding reimbursement arrangements for providers.*

### **Application to QHBP not offered through the Health Insurance Exchange**

- Provisions of subtitle apply to QHBP not offered through the Exchange to extent specified by Commissioner.

### **Timely Payment of Claims**

- *Prompt payment of claims same as for Medicare Advantage plans or reduced as feasible by Commissioner.*
- Commissioner set standard for coordination of benefits.

## **Subtitle E: Governance**

### ***Health Choices Administration***

- Independent agency of the executive branch.
- Commissioner appointed by the President with the advice and consent of the Senate.
- Duties
  - Establish QHBP standards including enforcement and coordination with other governmental entities.
  - Establishment and operation of the Health Insurance Exchange.
  - Data collection including for the purpose of promoting quality and value and addressing disparities in health care. May share data with HHS
- Sanctions authority including civil monetary penalties, suspension of enrollment.
- Appoints a health insurance ombudsman.

## **Subtitle F: Relation to Other Requirements ; Miscellaneous**

### **Relation to Other Requirements**

- Laws related to genetic information, nondiscrimination of mental health etc apply. State laws related to private rights of action apply. Nothing shall be construed as affecting ERISA.

### **Prohibits Discrimination in Health Care.**

***Title II***  
***Health Insurance Exchange & Related Provisions***

**Subtitle A: Health Insurance Exchange**

**Establishment of Health Insurance Exchange**

- Health Insurance Exchange established within Health Choices Administration and overseen by Commissioner.
- Commissioner shall establish standards for bids from, negotiate and enter into contracts with QHBP.

**Exchange Eligible Individuals and Employers**

- All individuals are eligible to obtain coverage through enrollment in an Exchange participating plan unless has other acceptable coverage.
- Non Traditional Medicaid Individuals.
- Large employers may meet their obligations under Sec 312 by becoming Exchange eligible employers as early as Y3. Small Employers (20 or less) and Smallest Employers (10 or less) are exempt provided?

**Benefits Package Levels:**

- Commissioner will specify the benefits to be made available through Exchange participating plans.

Exchange-eligible individuals roll onto Medicare when eligible.

QHBP must offer a “Basic plan” and may offer an “Enhanced Plan” and then a “Premium Plan(s).”

**Basic Plan**

- Include Essential benefits package
- Tiered cost sharing reduced for lower income levels.
- Variations established by Commissioner but none more than plus (or minus) 10%
- State mandated benefits apply.

**Contracts for the Offering of Exchange-participating Health Benefits Plans**

- Commissioner to implement standards and certify QHBP.
- Entities bid for inclusion of their plans in the Exchange.
- Commissioner may require data reporting including risk pooling information.
- QHBP must provide for “wrap around” Medicaid coverage.
- Entity shall contract with “essential community providers.” [As determined by the Commissioner.]

- Entity shall provide for culturally and linguistically appropriate services and communications.
- Network adequacy determined by Commissioner and out of network services and cost sharing for Out of Network limited.

**Outreach & Enrollment of Exchange-Eligible Individuals and Employers in Exchange Participating Health Benefits Plan.**

- Commissioner shall establish mechanism for outreach.
- Enrollment process
  - Open enrollment September – November of each year.
  - Special enrollment available.
  - Provides for a process by which individuals who are Exchange-eligible individuals can be automatically enrolled.
- Special duties relate to Medicaid & CHIP
  - Covers all children born in the US, deemed non-traditional Medicaid eligible with affordability credit.
  - CHIP children Exchange eligible unless Medicaid eligible.
  - Individual jointly eligible for Medicaid and Exchange may choose.
- Automatic enrollment in Medicaid (for Medicaid eligible individuals) who do not participate in the Exchange. Presumptive eligibility while Medicaid eligibility established.

**Other Functions**

- Coordinates affordability Credits.
- Coordinates Risk Pooling.
- Special Inspector General established for the Exchange. Appointed by President with advice and consent of Senate.

**Health Insurance Exchange Trust Fund**

- Within the Department of Treasury.
- Commissioner pays in from time-to- time the amounts as the Commissioner determines necessary.
- Deposits include excise taxes paid and penalties imposed on individual and employees pursuant to individual and employer mandates.
- Excise tax on failure to meet coverage requirements.
- Proportional.

**Optional State Based Health Insurance Exchanges**

- State or group of states may apply for approval to operate an Exchange.
- Sets standards for operation of Exchange.

## **Subtitle B: Public Health Insurance Option (PHIO)**

### **Establishment and Administration**

- Not later than Y1 (2013) HHS shall provide for the offering of an Exchange-participating health benefits plan referred to as a Public Health Insurance Option.
- PHIO that ensures choice, competition, and stability of affordable, high quality coverage.
- PHIO shall be made available only through the Exchange.
- Ombudsman and data collections established for all Exchange participating plans.
- PHIO treated as a QHBP in the Exchange.

### **Premiums & Financing**

- HHS establish geographically adjusted premium rates that comply with Exchange rules at a level that fully finances the cost of health benefits and administrative costs.

### **Payment Rates for Items & Services**

- HHS will establish rates for PHIO providers same as Medicare in Y1-Y3.
- Practitioner services shall not be less than Medicare plus 1% Y1.
- Provider participating in both Medicare and PHIO *paid 5% bonus* in Y1-Y3. Pediatricians also eligible.
- HHS negotiates rates for prescription drugs.
- *Beginning with Y4 and subsequent years, HHS may adjust rates in order to promote payment accuracy, to ensure adequate beneficiary access to provider or to promote affordability and the efficient delivery of medical care. [Bootstraps CER?]*
- *Nothing in this subtitle shall be construed as affecting the authority of HHS to establish payment rates to provide for the more efficient delivery of services such as initiatives provided in Sec. 224. [CER?]*
- *No administrative or judicial review of methodology or establishing rates.*

### **Modernized Payment Initiatives and Delivery System Reform**

- HHS may utilize “innovative payment mechanism and policies” to determine payments under the PHIOs (such as medical home, care management payments, value-based purchasing, bundling of services, differential payment rates performance or utilization based payments, partial capitation and direct contracting with providers.)
- *Medical Home, care management payments, accountable care organizations, value based purchasing, bundling of services, differential payment rates, performance or utilization based payments, partial capitation and direct contracting with providers.*
- *HHS shall design and implement payment mechanisms and policies that seek to improve health outcomes, reduce health disparities, address geographic variation in the provision of health services, prevent or manage chronic illness and promote care that is integrated, patient centered, quality and efficient.*

### **Provider Participation**

- HHS to set conditions for provider participation in PHIO.
- *Limitation on Balance Billing to Medicare Rates.* PHIO provider may not impose charges for such items or services (in relation to the payment rate under the option for such items or services) that exceed the charges that may be made for such items or services (in relation to the payment rate for such items or services under Medicare) or for similar items or services (in the case of items and services not covered under Medicare).

### **Fraud and Abuse Provisions**

- Medicare provisions apply to PHIO. Other provisions other than criminal provisions identified by HHS in consultation with IG that impose sanctions shall also apply.

### **Subtitle C: Individual Affordability Credits**

#### **Availability Through Health Insurance Exchange**

- Two types of Credits: Affordability Premium Credit & Affordability Cost Sharing Credit.
- All Credits paid to the entity that offers the QHBP.
- Exchange-eligible individuals may apply for credits.
- Affordability Credit only available in Y1 and Y2 for basic plan. Y3? The Commissioner shall establish process to all affordability credits to be used for enhanced and premium plans but limits to the amount available under the Basic Plan.
- No cash rebates.

#### **Affordable Credit Eligible Individual**

- Before Y5, lawfully present in US, enrolled in Exchange and not as an employee of an employer who uses the Exchange.
- Family income below 400% of FPL.

#### **Affordable Premium Credit**

- Commissioner shall establish sliding scale within in a range so that individuals with income at or below 133% of FPL the premium percentage limit is 1% and for individuals with income levels at 400% of FPL, the premium percentage is 10%.

#### **Affordability cost Sharing Credit**

- Cost sharing reductions: 6 tiers on a sliding scale (individuals and families) below 133% FPL, the actual value of coverage with cost sharing in an amount equal to 98% of full actual value and 400% of FPL equal to 70%.
- No Affordability Credits for individual who are not lawfully present in the US.

## **Income Determinations**

- Most recent tax return.
- Verification though request for information from Treasury and other information (not specified). Alternative process shall be established to verify income.
- Family income for CHIP is maximum.
- Study geographic Variations in application of FPL.
- Provides for penalties for misrepresentation.
- No payment for undocumented alien.

## ***Title III*** ***Shared Responsibility***

### **Subtitle A: Individual Responsibility**

See Sec. 59B of IRS Code

### **Subtitle B: Employer Responsibility**

#### **Part 1: Health Coverage Participation Requirements**

- Offer coverage under a QHBP to employee.
- Employee accepts and employer makes timely contributions toward coverage
- Y5, if employee declines but obtains coverage through the Exchange, employer makes contribution to Exchange.

#### **Employer Responsibility to Contribute Towards Employee and Dependent Coverage**

- Employer pays an amount not less than the employer required contribution of
  - An individual: 72.5% of the lowest cost plan
  - Family: 65% of lowest cost plan
- Part time employees : pro rata

#### **Employer Contributions in lieu of Coverage:**

- 8% of wages paid to employee
- \$100 per day penalty for non-compliance as well as other tax consequences.

#### **Improper Steering**

- Grants authority to set standards for determining whether employers are acting to affect the risk pool within the Exchange.

#### **Part 2: Satisfaction of Health Coverage Participation Requirements**

##### **Group Health Plan Coverage to Meet Requirements**

- Employer may make election to HHS to be subject to health coverage participation requirements. Sets rules for employer's termination.
- Failure to elect or to substantially comply subject to excise tax consequences.

***Title IV***  
***Amendments to Internal Revenue Code***

**Subtitle A: Shared Responsibility**

**Part 1: Individual Responsibility**

**Tax on Individuals Without Acceptable Health Care Coverage**

- 2% of excess of AGI over threshold amount.

**Part 2: Employer Responsibility**

**Election to Satisfy Health Coverage participation Requirements**

- Excise tax of \$100 per day per employee.
- Reasonable diligence exception.

**Responsibility of Nonelecting Employers**

- Employers Electing to Not Provide Health Benefits 8% of wages.
- Exception for Small Employers. [Section left blank]
- Effective date January 1 2013.

**Subtitle B: Credit for Small Business Employee Health Coverage Expenses**

- Small Business Credit equal to 50% of coverage expenses but scales down based on overall employee compensation. Credit not available to highly compensated individuals (\$125,000).
- Small employer =25.

**Subtitle C: Disclosure to Carry out Health Insurance Exchange Subsidies.**

- Treasury may share with Health Choices Administration tax information only for purposes and to extent necessary to verify appropriate amount of affordability credit.

**Subtitle D: Other Revenue Provisions [To Be Provided]**

***Title V***  
***Immediate Investments***

**Immediate Investments**

- Administrative simplification including, standardized claims form and standards for claims attachments.
- Establishing operating rules for processing health care transactions.

- Increasing consistency of claims edits.
- Increasing electronic exchange of administrative and clinical data.
- *Standardizing quality reporting data.*

Ensuring Value: Implementing minimum loss ratio of not less than 85%.

## **DIVISION B: MEDICARE AND MEDICAID IMPROVEMENTS**

### ***Title I Improving Health Care Value***

#### **Subtitle A: Provisions Related to Medicare Part A** [Not Reviewed]

#### **Subtitle B: Provisions Related to Medicare Part B**

##### **Sustainable Growth Rate Reform**

- 2010 Medical Economic Index.
- Rebases SGR using 2009 as the base year.
- Establishes separate conversion factors for service areas and multiple conversion factors. [Effect unclear: bundling?]
- Application to Accountable Care Organizations (pilot program).
  - 2012 rules that allow ACOs to have its own expenditure targets and updates.

##### ***Potentially Misvalued Codes***

- *Secretary to identify, review and make appropriate adjustments to relative value targeting fastest growth codes and codes affected by new technology etc.*
- *Establish process to validate RVU.*

##### **Payments for Efficient Areas**

- 5% bonus to those counties in the lowest 5<sup>th</sup> percentile of utilization based on per capita spending. 2011 and 2012.

##### **Modification to PQRI**

- Develop survey on current PQRI practices.
- 2012 develop a plan to integrate clinical reporting on quality measures with reporting requirements relating to meaningful use of electronic health records and shall consist of development of measure the reporting of which demonstrate

meaningful use of an electronic health record and clinical quality of care furnished to an individual and the collection of health data to identify deficiencies in the quality and coordination of care of individuals.

- Incentive payments extended to 2012.

**Adjustment to Medicare Payment Localities** [Adjusts geographic fee schedule area in California.]

## **Part 2: Market Basket Updates**

**Incorporating Productivity Adjustment Into Market Basket Updates That Do Not Already Incorporate Such Adjustment.** [Not Reviewed.]

## **Part 3: Other Provisions**

### **Rental and Purchase of Power Driven Wheelchairs**

#### **Require ASCs to Submit Cost Data and Other Data**

Cost data similar to Hospital within 2 years.

Quality data as the Secretary may specify in 2012.

#### **Treatment of Certain Cancer Hospitals**

To the extent the cost are higher, Secretary may adjust payments.

#### **Payments for Imaging Services**

- Change practice expense RVU to 75 percent (from 50 percent) presumed rate of utilization.
- Increase the reduction in expenditures attributed to multiple procedure payment reduction applicable to the technical component of imaging from 25% to 50%.

## **Subtitle C: Provisions Related to Medicare Parts A & B**

### **Reducing Potential Preventable Hospital Readmissions**

- Base DRG reduced by the adjustment factor.
- Expand beyond 3 the conditions for which measures have been endorsed. By 2013, an additional 4 and by 2015 all causes for readmission.
- No administrative or judicial review.
- Secretary shall develop appropriate performance measures on readmission rates for post acute care providers to be implemented in 2013.
- Conduct a study as to how to apply to physicians with approaches such as applying payment reductions for physician who treat patient during the initial admission that results in readmission.

### **Post Acute Care Payment Reform Plan**

- HHS to develop a detailed plan to reform payment for post acute care.

- Goals of reform is to improve coordination, quality and efficiency, improve outcomes.
- Provide for bundled payments for SNF, inpatient rehab facilities, hospital based outpatient facility home health.
- *Consider whether physician payments should be bundled.*
- Demonstration projects should be included.

**Home Health Payment Update:** [Not reviewed]

**Payment Adjustments for Home Health Care.** [Not reviewed.]

**Limitations on Medicare Exception to the Prohibition on Certain Physician Referrals**

- Report detailed description of the identity of physician owner or investor.
- Required disclose to patient ownership interest in time for individual to make a meaningful decision.
- Disclose hospital is wholly or mostly owned by physicians.
- \$10,000 per day penalty for failing to report or disclose.
- Freeze on increased investment, operating and procedure rooms.
- Limits on loans for hospital to physicians.
- May not condition ownership on influencing referrals.
- Prohibits expansion of facilities beyond 200% of baseline.

**Subtitle D: Medicare Advantage Programs** [Not Reviewed.]

**Subtitle E: Improvements to Medicare Part D**

**Require Drug Manufacturers to Provide Drug Rebates for Certain Full Premium Subsidy Eligible Patients and Medicaid Patients**

**Phased in Elimination of Coverage Gap.**

- Beginning 2011 HHS will progressively increase initial coverage limit and decrease annual out of pocket threshold by 13% and 5% thereafter for years 2012-2015. [Reduce and eliminate Donut Hole.]

**Subtitle F: Medicare Rural Access Protections**

**Telehealth Expansion and Enhancements:** Mandates HHS to expand services.

**Extension of Outpatient Hold Harmless Provision** [Impact Unknown]

**Extension of Sec. 508 Hospital Reclassifications** [2009to 2011.]

**Extension of Geographic Floor of Work** [2009-to 2012.]

**Extension of Payment for Technical Component of Certain Physician Pathology Services.** [2009 to 2009,2010,2011.]

**Extension of Ambulance Ad-Ons** [2010-2012.].

## ***Title II*** ***Medicare Beneficiary Improvements***

### **Subtitle A: Improving and Simplifying Financial Assistance for Low Income Medicare Beneficiaries**

**Improving Asset Tests For Medicare Savings program and Low-Income Subsidy Program.**

**Elimination of Part D Cost-Sharing for Non- institutionalized Full Benefit Dual Eligible Individuals.**

#### **Eliminating Barriers to Enrollment**

- Individual allowed to apply based on self-certification of income and resources.
- Subject to appropriate methods of verification without need for individual to do so.
- Automatic reenrollment.
- Facilitates low income people eligible for assistance under Prescription Drug Program.

**Enhanced Oversight Relating to Reimbursements for Retroactive Low Income Subsidy Enrollment.**

### **Subtitle B: Reducing Health Disparities**

**Ensuring Effective Communication in Medicare.**

- Study payments for language services

**Demonstration To Promote Access For Beneficiary With Limited English Proficiency By Provide Reimbursement For Culturally And Linguistically Appropriate Services.**

- 24 three-year grants up to \$500,000 each
- Requires IOM Report on Impact of language access services

**Extended Months of Coverage For Immunosuppressive Drugs For Kidney Transplants And Other Renal Dialysis Provisions.**

**Part B Premium:** Excludes capital gains from sale of primary residence excluded from income.

**Requiring Guarantee Issue For Certain Individuals Under MediGap.**

**Consultation regarding End of Life Planning.**

**Part B Special Enrollment Period and Waiver of Limited Enrollment Penalty for Tricare Beneficiaries.** [12 month after 65].

### *Title III*

#### *Promoting Primary Care, Mental Health Services and Coordinated Care*

##### **Accountable Care Organization Pilot Program**

- HHS shall conduct a pilot program to test different payment incentive models to reduce growth of expenditures and improve health outcomes.
- Promote accountability for patient populations and coordinated services.
- Encourage investment in infrastructure to accomplish.
- Reward physician practices for providing high quality and efficient health care services.
- Qualifying ACO means a group of physicians and may include other entities such as hospital or other provider services.
- Several other criteria including bonus sharing arrangements, sufficient number of PCPs, quality reporting.
- *HHS may issue regulations to implement, on a permanent bases, the components to the pilot program that are beneficial to the program as determined by the Secretary provided they result in less spending.*

##### **Medical Home Pilot Program**

- HHS shall establish a medical home pilot program for evaluation of the feasibility of reimbursing qualified patient-centered medical home services to high need beneficiaries.
- Evaluate each of the following medical home models: independent patient centered Medical Home; Community Based Medical Home.
- Nothing in this code section shall be construed to prevent a nurse practitioner from leading a patient centered medical home.
- Patient Centered Medical Home Model Services
  - Direct access to PCP or NP who accept responsibility for providing first contact, continuous comprehensive care.
  - Coordinates care by a team of individuals at the practice level, institution and home settings led by a PCP or NP.
  - Provide for all the patient health care needs or take responsibility for arranging care with other qualified providers for all stages of life.
  - Provides continuous access to care.

- Integrates readily accessible clinically useful information on patients that enables the practice to treat comprehensively and systematically.
  - Implements evidence-based guidelines.
  - Primary care means a physician or NP who practices in the field of family medicine, internal medicine, geriatric medicine or pediatric medicine.
  - Principle care means integrated, accessible health care that is provided by a physician who is a subspecialist that addresses the majority of the personal health care need of patients with chronic conditions and for whom the subspecialist assumes care management.
- Individually based Medical Home Model designed to target chronically ill.
  - Prospective per patient/per month payment.
  - Community Based Medical Home Model is a non-profit that provides services supervised by physician or NP that assists them in chronic care management activities.
  - HHS to study the extent to which MH models improve quality, reduce disparities, prevent readmissions, improve outcomes and patient satisfaction reduce duplicative tests recue health care expenditures.

**Rate Increase for Selected Primary Care Services**

- For primary care services rendered on or after January 1, 2011.
- Amount paid to the practitioner or to employer or facility 5% increase (10% of services furnished in a health professional shortage area.)
- PCP defined as physician or other practitioner who specializes in family medicine, general internal medicine or geriatrics.

**Increase Reimbursement for Certain Nurse Midwives** [Unknown Impact: but may allow payment to midwives for services previously had to be performed by “physician.”]

**Coverage and Waiver of Cost-Sharing for Preventative Services**

- A host of preventative services covered at 100%.
- Diagnostic mammograms and colorectal cancer screening also covered. No coinsurance may be applied.

**Waiver of Deductible for Colorectal Cancer Screening Tests Regardless of Coding, Subsequent Diagnosis or Ancillary Tissue Removal.** [Effective January 1, 2011.]

**Coverage of Marriage and Family Therapist Services and Mental Health Counselor Services.** [Paid at 75% of amount paid to psychologist.]

**Extension of Physician Fees Schedule Mental Health Add-Ons through 2011.**

**Expanding Access to Vaccines.** [For adults, vaccine recommended by Advisory Committee on Immunization Practices, and for children, vaccines on the list referred to in 1928(e).]

## **Elimination of 190 Day Lifetime Limit on Psychiatric Hospital stays.**

### ***Title IV*** ***Quality***

#### **Subtitle A: Comparative Effectiveness Research**

##### **Comparative Effectiveness Research**

- HHS shall establish within the Agency for Health Care Research and Quality a Center for Comparative Effectiveness Research to conduct, support, and synthesize research with respect to the outcomes, effectiveness and appropriateness of health care services and procedures in order to identify the manner in which diseases, disorders and other health conditions can most effectively and appropriately be prevented, diagnosed, treated and managed clinically.
- Oversight by Comparative Effectiveness Research Commission. HHS will establish an independent Comparative Effectiveness Research Commission to oversee and evaluate activities. Commission shall determine national priorities, identify highly credible research methods and standards of evidence.
- 17 members appointed by Secretary HHS
- Disseminate information to providers and the public including developing protocols and strategies for the appropriate dissemination of research findings in order to ensure effective communication of findings and the use and incorporation of such findings into relevant activities for the purpose of informing higher quality and more effective and efficient decisions regarding medical items and services.

##### **Health Care Comparative Effectiveness Research Trust Fund**

- Created in Treasury initially funded with \$90 Million and \$110 Million in each year 2011 and 2012 plus other revenue mechanisms. Including a “fair share per capita amount on health insurance policies that equals \$375 Million.

#### **Subtitle B: Nursing Home Transparency** [Not Reviewed]

#### **Subtitle C: Quality Measurements**

##### **Establishment of National Priorities and Performance Measure for Quality Improvement.**

- HHS to establish and periodically update every three years national priorities for performance improvement.
- Shall solicit recommendations.
- Ensure priority is given to areas in the delivery of health care services in the US that contribute to a large burden of disease, have the greatest potential to decrease morbidity and mortality have the greatest potential for improving performance

- affordability and patient centeredness health care including those due to variations in care, address health disparities and have the potential for rapid improvement due to existing evidence, standards of care or other reasons.
- Quality measure means a national consensus standard for measures of performance and improvement of ...physicians...in the delivery of health care services.
  - Standards developed through Agency for Health Care Research & Quality AHRQ.
  - Quality measures shall be designed to assess outcomes an functional status of patients, asses continuity and coordination of care, assess patient experience, assess safety effectiveness and timelines of care the efficiency and resources used in the provision of care, collation of date through HIT, and access.
  - Available for pubic review and comment.
  - HHS may use funds to test and update measures.
  - GAO to conduct periodic evaluations of the implementation of the data collection process for quality measures.

#### **Subtitle D: Physician Payment Sunshine Provision**

##### **Reports on Financial Relationships Between Manufacturers and Distributors so Covered Drugs, Devices Biologicals or Medical Supplies Under Medicare, Medicaid, CHIP And Physicians and Other Health Care Entities and Between Physician and Other Health Care Entities.**

- Requires manufacturers and distributors that provide payment or “anything of value” (more than \$5), directly or indirectly to a “covered recipient” to annually report the recipients identity and value transferred to the OIG of HHS. “Covered entity” includes physician, physician groups, medical associations and CME providers.
- Drug samples are included as things of value.
- Requires hospitals and health care entities to report physician ownership interests.
- Civil monetary penalties for failing to report up to \$10,000 per violation and up to \$150,000 max. (up to \$1 Million for knowing failure to comply.)

#### ***Title V Medicare Graduate Medical Education***

##### **Distribution of Unused Residency Positions**

- Gives HHS authority to grant applications for additional residency up to estimated unused residency slots.
- Hospital must maintain the number of primary care residents at base level.
- Hospital must assign all additional residence slots to primary care.

### **Increased Training in Non-Provider Settings**

- Time spent by a resident without regard to setting shall be included in cost reports.

### **Rules for Counting Resident Time for Didactic and Scholarly Activities and Other Activities.**

- Time spent by intern or resident in approved residency training program in a non-provider setting that is primarily engaged in furnishing patient care shall be counted toward the determination of full-time equivalency.

## *Title VI* *Program Integrity*

### **Subtitle A: Increased Funding to Fight Waste, Fraud & Abuse.**

- In amounts appropriated by Congress.

### **Subtitle B: Enhanced Penalties for Fraud and Abuse**

#### **Enhanced Penalties for False Statements on Provider Enrollment Applications**

- Knowingly makes or caused to be made a false statement or material misrepresentation of fact on application to participate or enroll in health care program including managed care organizations.
- \$50,000 fine
- Effective January 1, 2010.

#### **Enhanced Penalties for Submission of False Medicare, Medicaid or CHIP Claims Data.**

- Knowingly makes or causes to be made any false statement or material misrepresentation of a material fact in any data or information submitted to support a claim for payment.

#### **Enhanced Penalties for Delaying Inspector General Investigations.**

- Failure to grant timely access, upon reasonable request, to the Inspector General for the purpose of audits, investigations, evaluations and other statutory functions. \$50,000 fine plus \$15,000 for each day of failure to comply.

#### **Enhanced Hospice Program Safeguards.**

- If HHS determines that hospice program has demonstrated substandard quality of care and deficiencies are not corrected after notice \$10,000 per day.

#### **Enhanced Penalties for Individuals Excluded From Program Participation**

- Increase penalties for billing on behalf of person excluded from the program.

#### **Enhanced Penalties for Provision of False Information by MA Plan**

3 Times amount paid to such plan or plan sponsor.

## **Enhanced Penalties for MA and Part D Marketing Violations.**

**Enhanced Penalties for Obstruction of Program Audits.** [Not clear due to technical drafting of bill]

## **Subtitle C: Enhanced Program and Provider Protections:**

### **Enhanced Program and Provider protections in the Medicare, Medicaid and CHIP Programs.**

- Upon a determination of significant risk of fraudulent activity with respect to a category of provider including in a geographic area, HHS may screen provider, require enhanced oversight and/or impose a moratorium on enrollment of new providers.

### **Enhanced Medicare, Medicaid, and CHIP Program Disclosure Requirements Related to Previous Affiliations.**

- Applicant or renewing provider must disclose affiliation within previous 7 years with a provider that has uncollected debt or with a person or entity that has been suspended or excluded from such program.
- HHS may apply enhanced safeguards or deny participation to such person with affiliations.

### **Required Inclusion of Payment Modifier for Certain E&M Services**

- *Allows HHS to create modifiers for E&M services to help identify services that result in ordering additional services such as lab tests to enable better monitoring.*

### **Evaluations and Reports Required Under Medicare Integrity Program.**

- Reports on periodic evaluations on the effectiveness of activities.

### **Require Providers and Suppliers to Adopt Programs to Reduce Waste, Fraud and Abuse.**

- Authorizes the establishment of a compliance program that contain core elements
- HHS will establish a timeline on which a provider of services (other than physicians) shall be required to have established such programs.

### **Maximum Period for Submission of Medicare Claims Reduced to Not More than One Year.**

- Reduced from 3 years to 1 year, effective January 1, 2010.

**Physicians who Order Durable Medical Equipment or Home Health Care Required to be Medicare Participating Physicians.** Inserts term “participating” in front of physician in the statute. [Effect unknown.]

**Requirement for Physicians to Provide Documentation on Referrals to Programs at High Risk of Waste and Abuse.**

- HHS may disenroll physician who fails to maintain and provide access to documentation relating to written orders or requests for payment for DME, certifications for HHC or referral for other items or services specified by Secretary.

**Face To Face Encounter With Patient Required Before Physician May Certify Eligibility For Home Health Services Under Medicare.**

**Extension of Testimonial Subpoena Authority to Program Exclusion Investigations.**

**Required Repayments of Medicare and Medicaid Overpayments.**

- *If a person knows of an overpayment the person must report and return the overpayment and notify HHS that overpayment was returned within 60 days of overpayment being identified.*

**Subtitle D: Access to information Needed to Prevent Fraud & Abuse.**

**Access to Information Needed to Prevent Fraud & Abuse**

- Give HHS access to any claims database that can facilitate HHS OIG.

**Elimination of Duplication Between the Healthcare Integrity and Protection Data Bank and The National Practitioner Data Bank.**

- HIPDB merged into NPDB.

**HIPAA Privacy And Security Standard Applied To The Subtitle.**

***Title VII  
Miscellaneous Provisions***

Repeals certain MMA provisions, repeals Comparative Cost Adjustment Program, extends Gainsharing Demonstration Program and grants for Quality Home Visitation Program.

***Title VIII  
Medicaid and CHIP***

**Part 1: Medicaid & Health Care Reform**

**Eligibility for Individuals with Income Below 133% of FPL**

- Expands eligibility to those who are 65 year of age or older who are in families whose income does not exceed 133 1/3% of FPL.
- 100% FMAP.

**Requirements And Special Rules For Certain Medicaid Enrollees and for Medicaid Eligible Individuals Enrolled in Non-Medicaid Exchange-Participating Health Benefits Plan.**

- State required to enter into MOA with Health Choices Commissioner with respect to coordination of enrollments.
- State shall accept without further determination the enrollment of and individual determined by the Commissioner to be a non-traditional Medicaid eligible individual.
- State shall accept without further determination the enrollment of and individual determined by the Commissioner to be a traditional Medicaid eligible individual.
- Presumptive eligibility.
- Traditional Medicaid individuals who enroll in Exchange continue to have wrap around services i.e. coverage for services offered by Medicaid but not included in Exchange Plan.
- State match on proportion of affordability credits.
- Flexibility for states with 5th percentile of uninsured.

**CHIP Maintenance of Effort**

- Y1 State cannot have CHIP or Medicaid eligibility standards more restrictive than eligibility standards under the minimum plan.

**Medicaid DSH Report:** Requires that an analysis of impact on reforms to DSH.

**Part 2: Prevention**

**Required Coverage of Preventative Services**

- Grade A or B services recommended by US Preventative Services Task Force.
- Vaccines recommended by CDC.
- No cost sharing.

**Tobacco Cessation**

- Provides for counseling on tobacco cessation for pregnant women.

**Optional Coverage for Nurse Home Visitation Services**

- Increased FMAP to promote coverage.

**State Eligibility Option for Family Planning Services**

**Payment for Services Furnished by Certain School-Based Health Clinics**

- Prepaid capitation available if service would have been furnished by a physician's office.

### **Part 3: Access**

#### **Payments to Primary Care Practitioners**

- *Increases Medicaid payment rates to primary care services to 80% of Medicare in 2010, 90% Medicare in 2011 and 100% of Medicare in 2012.*
- Increase FMAP to include these increased payments

**Medical Home Pilot Program:** Established

**Translation Services** [Applies translation services amendment to CHIP.]

**Optional Coverage for Freestanding Birth Centers.**

### **Part 4: Coverage:**

#### **Optional Medicaid Coverage for Low-Income HIV Infected Individuals**

- Coverage and enhanced match.

#### **Extending Transitional Medicaid Assistance (TMA)**

- Provisions of AARA are extended 2 years.

#### **Upgrading Electronic Eligibility Systems.**

- 2010-2012: 90% of sums expended during the quarter as attributable to the design development or installation of an electronic eligibility system.
- 2013 75% attributable to the operation of such system.
- HHS must have approve the system.
- Must meet several criteria.

### **Part 5: Financing**

#### **Payments to Pharmacists**

- 130% of weighted average of AMP.

#### **Prescription Drug Rebates**

- Rebate imposed on newly formatted drug such as an extended release version.

#### **Extension Of Prescription Drug Discounts To Enrollees Of Medicaid Managed Care Organizations.**

#### **Payments for GME**

- Term “medical assistance “ includes cost of GME consistent with this subsection whether provided within or outside hospital.

## **Part 6: Waste, Fraud & Abuse**

### **Health-Care Acquired Conditions**

- *Medicaid will ensure that higher payments are not made for services related to the presence of a condition that could be identified by a secondary diagnostic code and non-payment for any health care acquired condition as defined by HHS.*

### **Evaluations and Reports Under Medicaid Integrity Program**

- Entities must agree to provide periodic evaluations.

### **Require Providers & Suppliers to Adopt Programs to Reduce Waste, Fraud and Abuse.** [Cross referenced earlier provision for Medicaid]?

### **Overpayments** [Cross reference Medicare -provision]

### **Minimum Medical Loss Ratio to MCOs**

- 85%.

## **Part 7: Puerto Rico and the Territories.** [Payments increased by a cross-referenced percentage.]

# **DIVISION C** **PUBLIC HEALTH AND WORKFORCE DEVELOPMENT**

## *Title I* *Community Health Centers*

**Increased Funding:** [Community Health Centers Funding increased to \$1 Billion in 2010 to \$1.5 Billion in 2011, \$2.5 Billion in 2012, \$3 Billion in 2013 and \$4 Billion in 2014.

## *Title II* *Workforce*

### **Subtitle A: Primary Care Workforce**

#### **Chapter 1: National Health Service Corps**

- Service may be fulfilled by part time Service.
- \$75 Million per year thorough 2014.
- \$300 Million for Loans.

## **Chapter 2: Frontline Health Providers**

- Applicable to physicians and other health professional providing primary care services in health shortage are not addressed by National Health Service Corps.
- Scholarships up to 4 years with commitment to practice in such area 1 year for each year of scholarship not less than 2 years.
- 90% of funds available shall be for primary care providers.

### **Primary Care Training & Enhancement**

- HHS shall make grant or enter into contracts with certain hospitals and medical schools to develop & operate accredited professional training programs (including residencies) and to improve clinical teaching.

### **Training in General, Pediatric and Public Health Dentistry**

- HHS shall make grant or enter into contracts with certain hospitals and dental schools to develop & operate accredited professional training programs (including residencies) and to improve clinical teaching.

## **Subtitle B: Nursing Workforce**

### **Amendments to Public Health Service Act**

- Creates definition of “nurse managed health center” which means a nurse-practice arrangement, managed by an advanced practice nurse that provides primary care or wellness services to underserved or vulnerable populations.
- Promotes funding, loans and education for nurses.

## **Subtitle C: Public Health Workforce**

### **Public Health Workforce Corps.**

- Established and staffed to ensure an adequate supply of public health professionals to eliminate critical public health workforce shortages.
- Achieved through scholarship and loan repayment program.

## **Subtitle D: Adapting Workforce to Evolving Health System Needs**

## **Chapter 1: Health Professionals Training For Diversity**

### **Centers for Excellence**

- Nomenclature changes such as replacing “underrepresented minorities” with “racial and ethnic minority groups.”
- Enhance funding.
- Scholarships and loan Repayment programs for fellowships regarding faculty positions and educational assistance for individuals with disadvantaged backgrounds.

## **Chapter 2: Interdisciplinary Training Programs**

- Shall award grants to eligible entities to address health disparities by promoting cultural and linguistic competency.

## **Chapter 3: Advisory Committee on Health Workforce Evaluation & Assessment**

- Creates Advisory Committee to evaluate and advise Secretary on adequacy and appropriateness of nation's health workforce.

## **Chapter 4: National Center for Health Workforce Analysis**

- Center created to collect and analyze data describing the health care workforce, develop and publish benchmarks, maintain registry of grants.

# *Title III* *Prevention & Wellness*

## **Subtitle A: Prevention & Wellness Trust**

- Substantial sums appropriated to the trust.

## **Subtitle B: National Prevention & Wellness Strategy**

### **National Prevention & Wellness Strategy**

- Secretary shall develop and every 2 years submit to Congress a strategy to improve nation's health through evidence-based clinical and community based prevention and wellness activities.
- Specific national goals and priorities.

## **Subtitle C: Prevention Task Force**

- Creates two task forces: Clinical Preventative Services and Community Preventative Services.

## **Subtitle D: Prevention & Wellness Research**

- CDC to take into account national strategy.

## **Subtitle E: Delivery of Community-Based Prevention & Wellness Services**

- CDC to establish grant program to provide evidence-based, community-based prevention and wellness services in priority areas.

## **Subtitle F: Core Public Health Infrastructure and Activities.**

- CDC to award grants to each state health department and may award other grants on a competitive basis to address through supplemental funding its highest priority core public health infrastructure needs.

*Title IV*  
*Quality & Surveillance*

**Part D: Implementation of Best Practices in the Delivery of Health Care**

**Center For Quality Improvement**

- Established and headed by Director of AHRQ to prioritize quality improvement activities, including clinical, managerial and health care delivery best practices for implementation based on SSA, impact patient outcomes and satisfaction.
- Center work with hospital clinical practices and facilities in implementation of quality improvement activities.
- Will measure patient outcome and satisfaction.
- Initial focus on reducing hospital acquired infections, increasing perioperative patient safety including reducing surgical site infections and surgical errors (wrong site foreign bodies), improving emergency department care and improving provision of neonatal and obstetrical care.
- Assistant secretary to report key health indicators.

*Title V*  
*Other Provisions*

**Expanded Participation in 340 B Program**

- Children's hospitals, critical access hospitals and others added.

**Establishment of Nurse Grant Program**

- Grant program through Dept. of Labor to award grants to carry out comprehensive program to provide educational to nurses and create a pipeline to nursing for incumbent ancillary healthcare workers.

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