

June 26, 2009

SUMMARY OF HOUSE TRI-COMMITTEE HEALTH CARE REFORM LEGISLATION: DISCUSSION DRAFT

Background:

On June 19, House of Representatives Ways & Means Committee Chairman Charles Rangel (D-NY), Energy & Commerce Committee Chairman Henry Waxman (D-CA) and Education & Labor Committee Chairman George Miller (D-CA) released their draft health care reform legislation. It is available at <http://edlabor.house.gov/documents/111/pdf/publications/DraftHealthCareReform-BillText.pdf>.

The Democratic tri-committee proposal would expand health care coverage by enacting an individual mandate and an employer “play or pay” policy. Additionally, it would create a health insurance exchange with a public insurance plan option, expand Medicaid to 133 percent of the federal poverty limit, and enact a number of insurance market reforms. The draft legislation does not specify how expanded coverage would be financed, and the committees have not yet received an official “score” from the Congressional Budget Office (CBO). However, coverage will be financed in part through reductions to provider payments. More information on the financing proposals is expected in coming weeks.

Among the key provisions affecting hospitals, the draft legislation would:

- Permanently reduce the annual market basket update for inpatient, outpatient and post-acute care services to account for “productivity gains” in FY 2010, and beyond that we estimate cut could cut payments for hospital-based services by approximately \$150 billion over 10 years.
- Pay hospitals Medicare payment rates for individuals enrolled in a new public health insurance plan (as part of a national health insurance exchange) for the first two years, after which the Secretary would set payment rates. Over time the public plan would be open to all, in which case consultants at The Lewin Group estimate that Medicare rates would result in an annual revenue loss of \$36 billion to hospitals.
- Implement an aggressive readmissions policy that would reduce payment to hospitals with higher than expected patient readmission rates.

- Reform the physician payment formula by eliminating the accumulated deficits under the existing sustainable growth rate (SGR) formula and by directing higher payments to primary care providers.
- Instruct the Secretary to develop a *plan* to bundle Medicare payments for post-acute care, and determine whether hospital inpatient services and/or physician services should be included.
- *Not* reduce disproportionate share hospital (DSH) or graduate medical education (GME) payments.

Members of the House discussed the draft legislation during the week of June 22, with hearings in the Ways and Means Committee on June 24, the Energy and Commerce Committee on June 23, 24 and 25, and in the Education and Labor Committee on June 23. The House plans to “mark up” the legislation and take it to the floor in July, with the goal of passing legislation by the start of the summer recess on August 1.

Attached is a detailed summary of key proposals affecting hospitals.

What You Can Do:

We urge you to review this advisory carefully and contact your members of Congress to express your concern. The draft legislation would result in significant cuts in Medicare payments to hospitals. Blunt and arbitrary payment cuts do not help patients or communities, and they are not representative of true health care reform.

Further Questions:

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**Summary of House Tri-Committee
Health Care Reform Legislation:
Discussion Draft**

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COVERAGE AND INSURANCE REFORMS

Insurance Market Reforms (Sec. 101-152, 1234)

The draft bill establishes insurance market reforms and standards for qualified plans offered inside and outside a national health insurance exchange (exchange). All plans offered, including plans offered through the insurance exchange, as well as the public plan option, would be required to meet set requirements. The most significant provisions include guaranteed issue and renewal of policies, a prohibition on pre-existing condition exclusions, nondiscrimination in benefits, adequacy of provider networks, rating restrictions, and minimum medical loss ratios. Other provisions address fair marketing practices, benefit package offerings, timely payment of claims, fair grievance and appeals mechanisms and transparency. Also included are changes in the guaranteed issue requirements for Medigap plans that guarantee access to affordable coverage for Medicare beneficiaries.

Immediate Investments (Sec. 501)

The Secretary of Health and Human Services (HHS), before implementing comprehensive health insurance reform, must undertake the following investments to improve efficiency and value of health care:

- *Administrative Simplification.* Health insurance administrative simplification must include: standardizing language, forms and claims attachments; establishing operating rules and companion guides for processing health transactions; increasing consistency of claims edits and code corrections across plans and products; increasing electronic exchange of clinical and administrative data; and standardizing quality reporting.
- *Reinsurance for Early Retirees.* The Secretary would establish a reinsurance program for early retirees.
- *Smart Card.* The Secretary would establish a program that promotes the use of electronic insurance cards to reduce administrative challenges for providers and patients. The Secretary also would encourage the use of smart cards for preventive and wellness services.

Health Choices Administration (Sec. 141-152)

An independent agency, known as the Health Choices Administration, would be established. The Health Choices Administration commissioner (commissioner) would be appointed by the president and confirmed by the Senate. The duties of the commissioner include administering the new insurance market standards, the Health Insurance Exchange, and the affordability credits (low-income subsidies). The commissioner would consult with the National Association of Insurance Commissioners, state agencies

and other federal agencies to establish a Health Insurance Ombudsman. The Commissioner would have the authority to collect data and administer sanctions.

Health Insurance Exchange (Sec. 141, 201-208, 1801-1802)

The commissioner would establish the exchange to facilitate access to qualified health insurance coverage for individuals and employers. The commissioner would certify entities offering qualifying health plans, solicit and negotiate bids and establish standards for certification that include licensure, enrollment process and data reporting. The scope of the commissioner would include managing Medicaid wrap-around benefits for certain exchange-eligible individuals, contracting with essential community providers, managing subsidies for low-income individuals and assuring that services are culturally and linguistically appropriate. The commissioner also would establish a risk-pooling mechanism minimizing the impact of adverse selection of enrollees among the plans offered. Additionally, the commissioner would conduct outreach and education, timely eligibility determinations and a process for open enrollment. The Secretary has oversight and enforcement responsibilities. The exchange would be up and running by year one, which is defined as 2013 or any earlier year so determined by the President.

Exchange-Eligible Individuals and Employers. Eligibility for enrollment through the exchange would be phased over a three-year period.

- Year one: Individuals that are *not* already enrolled in a qualifying health plan or other acceptable coverage would be eligible for the exchange (*Acceptable coverage would include employer-based coverage, Medicare, Medicaid, DOD/Tricare, VA or “grandfathered” health insurance coverage*). Employers with 10 or fewer employees and the self-employed also would be eligible for the exchange.
- Year two: All individuals and employers eligible in year one would continue to be eligible along with an additional group of employers – those with 20 or fewer employees.
- Year three: All individuals and employers eligible in years one and two would continue to be eligible along with large employers. The commissioner would determine the definition and eligibility requirements for large employers and establish a phased-in schedule for entry into the exchange.

Medicaid, Children’s Health Insurance Program (CHIP) and the Exchange. Non-traditional Medicaid beneficiaries, which include those newly eligible for Medicaid up to 133.33 percent of the federal poverty level (FPL) – such as childless-adults and uninsured newborns – would be eligible for the exchange if they were enrolled in a qualified health plan, group health coverage or grandfathered coverage during the six months prior to becoming Medicaid eligible. In year five of the exchange, states may request that some or all Medicaid beneficiaries have access to coverage through the exchange if the state can demonstrate that it will provide wrap-around Medicaid coverage and that the exchange health care plans can manage this new population. The state and the exchange must coordinate coverage for these populations through a memorandum of understanding. All children born in the U.S. who are not covered under an acceptable coverage plan would be considered non-traditional Medicaid and eligible for enrollment in Medicaid and the exchange (see Medicaid Expansion, page 6). CHIP enrollees would be required to obtain coverage through the Exchange.

Benefits Packages. The Health Benefits Advisory Council, which would be a public private advisory committee comprised of medical and other experts, would be charged with recommending covered benefits and the essential benefits package. The four benefit categories that plans would offer through the exchange, as defined by the Health Benefits Council, would be: basic, enhanced, premium, and premium-plus. Participating plans must offer one basic plan for each service area and would be able to offer additional plans that meet certain requirements.

- The basic plan would be the essential benefit package defined by the Health Benefits Advisory Committee. For individuals receiving affordability credits or subsidies, cost sharing would be modified for the basic benefit plan.
- The enhanced benefit plan would be the basic plan with a lower level of cost sharing, set at 85 percent of the actuarial equivalent of the plan.
- The premium plan would include all the basic benefits with a lower level of cost-sharing, set at 95 percent of the actuarial equivalent of the plan.
- The premium-plus plan would add benefits such as adult oral health and vision care.

Health Insurance Exchange Trust Fund. A trust fund would be established to pay the operating expenses of the exchange. The revenue to support the trust fund would come from taxes and excise taxes on individuals and employers that fail to obtain coverage, provide acceptable coverage or fail to meet certain coverage requirements.

State-based Health Insurance Exchanges. A state or a group of states could apply to the commissioner to operate an insurance exchange if it met specified criteria.

Public Health Insurance Plan (Sec. 221-226)

To offer greater choice and affordability of health plans, the Secretary would establish a public health insurance plan. This public plan would be available only through the exchange. The Secretary would enter into administrative contracts with entities similar to Medicare fiscal intermediaries to administer the public plan option. The public plan would be available in year one of the exchange and would have to meet all the requirements of the exchange. Individuals and employers with access to the exchange would have access to the public plan. The benefit levels of basic, enhanced, premium and premium-plus would be the same for the public plan as for the Exchange.

Premiums and Financing. Start-up funds for the public plan would be provided. However, going forward, the Secretary would be required to establish geographically adjusted premium rates that allow the cost of the health benefits and their administrative costs to be fully financed.

Provider Payments. In the first three years of the exchange, the public plan would pay hospitals and other providers based on Medicare Part A and Part B. Hospitals would receive the Medicare rates for the first three years of the exchange.

Medicare practitioners' rates, for this time period, would apply without regard to the sustainable growth rate (SGR) with an update of not less than 1 percent. The public plan would pay physicians and other practitioners incentive payments of the Medicare rate plus 5 percent if they participate in both Medicare and the public plan. Pediatricians and

other practitioners, as determined by the Secretary, who typically do not participate in Medicare, would be eligible for the incentive bonus. This incentive payment of Medicare plus 5 percent would not be available to hospitals participating in the public plan.

Rate-setting Process. Beginning in year four of the exchange, the Secretary would be required to establish a provider rate setting system that would conform to the current federal rule making process.

Modernizing Hospital and other Provider Payment. Beginning in year one of the exchange, the Secretary could utilize innovative payment methods. Such payment methods could include:

Payments for a medical home;

- Care coordination;
- Accountable care organizations;
- Value based purchasing;
- Bundling; and
- Capitation, including the full range of risk from partial to full capitation.

These innovative payments must seek to improve outcomes, reduce health disparities, address geographic variation, manage chronic illness and promote integrated delivery. Cost sharing could be modified to encourage the use of services that promote health and value.

Provider Conditions of Participation. The Secretary would establish conditions of participation for providers including licensure, provider exclusion and prohibition of balance billing.

Individual Affordability Credits/Subsidies (Sec. 241-246)

Subsidies for the purchase of health coverage for low-income individuals and families would be available in the form of affordability credits through the exchange. Individuals and families with incomes up to 400 percent of the FPL would be eligible for affordability credits to be used toward the premium and cost sharing. Affordability credits would be managed by the commissioner of the exchange and either the commissioner or the state Medicaid program would determine eligibility.

Premium credits would be based on the average cost of the three lowest-cost, basic health plans in the area. The credit would be set using a sliding scale so that individuals and families with incomes at or below 133.33 percent of FPL would pay no more than 1 percent of their income toward a premium contribution. Those with incomes at 400 percent FPL would pay, at most, 10 percent of their income.

The cost-sharing credits would be in the form of cost-sharing reductions and are based on a sliding scale for individuals and families at or below 133.33 percent FPL up to 400 percent of FPL. The cost-sharing credit is based on a calculation of the annual-cost sharing limit and a reduction in the cost-sharing amount based on a percentage of the full actuarial value if no cost sharing were imposed. Undocumented immigrants would not be eligible for the affordability credits.

Shared Responsibility (Sec. 301-314)

Individual Responsibility. All individuals would be required to obtain “acceptable health coverage” either through the exchange or through employer-based coverage, Medicare, Medicaid, DOD/Tricare, VA or “grandfathered” health insurance coverage. Individual health insurance policies would not be acceptable unless they qualify under the “grandfathered” insurance option. The individual mandate is enforced through a 2 percent tax on adjusted gross income up to the cost of the average national premium for the basic health plan offered in the exchange. The Secretary, in coordination with the commissioner, would determine the national average premium. Exceptions to the mandate would apply for dependents, non-resident aliens, individuals residing outside of the U.S., those with religious objections and those facing financial hardships.

Employer Responsibility – Play or Pay. Employers would be required to offer and pay a portion of their employees’ health coverage or, in lieu of coverage, pay into the Health Insurance Exchange Trust Fund. This approach works as follows:

- Employers would be required to offer coverage to their employees and their families, contributing financially toward that coverage. If their employees seek coverage through the exchange, they must contribute to the exchange. For full-time employees, employers must contribute 72.5 percent of the lowest-cost plans for individuals and 65 percent for families. The Secretary of HHS, with the exchange commissioner and the secretaries of Labor and Treasury, would set the employer contribution for part-time employees.
- Employers would have the option to pay in lieu of providing coverage. That payment would be equal to 8 percent of the employees’ wages and would be paid into the exchange trust fund.

ERISA Plans. Employers would be allowed to meet the health coverage participation requirements by establishing and maintaining a group health plan that meets certain criteria. Employers would be subject to compliance audits and could face civil penalties for failure to comply. Tax penalties would also apply to these ERISA plans.

Avoiding Adverse Selection. The Health Choices Commission would have the authority to set standards to prevent an employer from steering high-risk employees into the exchange in order to avert adverse selection.

Exception for Small Employers. Under consideration is an exception to the employer responsibility requirements for small employers. The draft legislation does not provide specifics.

Subsidy/Credit for Small Business Employee Health Coverage. A subsidy for small business employers would be a credit equal to 50 percent of the expenses for an employee’s qualified health plan. The credit phases out based on the average compensation of the employees and the number of workers employed.

Medicaid Expansion (Sec. 1801-1802)

Medicaid would be expanded to individuals under age 65, both traditional and non-traditional categories, with incomes at or below 133.33 percent of FPL. (Non-traditional Medicaid eligibles could go into the exchange beginning year one.) Children would be covered under Medicaid at birth as non-traditional Medicaid beneficiaries, if they did not have “acceptable” coverage at the time of birth. These new populations would be 100 percent federally financed through the Medicaid Federal Medical Assistance Percentage (FMAP).

Medicare Advantage (Sec. 1161-1179)

There are significant changes Medicare Advantage (MA) plan payment, specifically the gradual reduction in MA plan benchmarks for bids to align more closely with average Medicare fee-for-service (FFS) costs; the elimination of the MA Regional Plan Stabilization Fund; extension of the Secretary’s authority to apply coding intensity adjustments to reduce plan rates; the inclusion of quality bonuses for high quality plans; and improvements to risk adjustment for MA payments. The overall effect of these changes would significantly reduce plan payment levels from the current average of 114 percent per-beneficiary FFS costs. Additional changes would limit beneficiary out-of-pocket costs for individual health services, modify enrollment periods, increase transparency on administrative costs and address other operational aspects.

Medicare Advantage Plans For Special Needs Individuals. These reforms to the MA plans for special needs individuals include placing limits on enrollment periods and extending the authority to restrict enrollment. The enrollment limits would not permit an MA plan to enroll outside of the enrollment period or at the time of diagnosis beginning January 1, 2011. Reforms also would allow MA plans to restrict enrollment beginning January 1, 2013 and January 1, 2016 if the plan is a fully-integrated, dual-eligible special needs plan.

Fully Integrated Dual Eligible Special Needs Plans (FIDESNP). A new designation for MA plans would be created to advance the integration of Medicare and Medicaid benefits for dual eligibles. After the new MA plan – Fully Integrated Dual Eligible Special Needs Plans (FIDESNP) – has been in place for five years, the Secretary must submit a report to Congress on the impact of integrating Medicare and Medicaid services for this population. The report must be submitted by December 2013.

Improve Coordination for Dual Eligibles. Either through a new program or an identifiable office within the Centers for Medicare and Medicaid Services (CMS), the Secretary would be required to improve coordination between the Medicare and Medicaid programs for services provided to the dual eligible population. The program is authorized through 2015.

KEY DELIVERY SYSTEM REFORMS

Hospital Readmissions (Sec. 1151)

Beginning in FY 2011, inpatient prospective payment system (PPS) hospitals with higher-than-expected readmissions rates would experience decreased Medicare payments

for all Medicare discharges. Performance evaluation would be based on the 30-day readmission measures for heart attack, heart failure and pneumonia, currently part of the Medicare pay-for-reporting program and reported on *Hospital Compare* in Summer 2009. The base inpatient payment for hospitals with *actual* readmission rates higher than their Medicare-calculated *expected* readmission rate would be reduced by an adjustment factor that is the greater of:

- A hospital-specific readmissions adjustment factor based on the number of readmissions to the hospital in excess of the hospital's calculated expected readmission rate; or
- 0.99 in FY 2011, 0.98 in FY 2012, 0.97 in FY 2013 and 0.95 in FY 2014 and beyond.

This means the largest potential reduction for a hospital would be 1 percent in FY 2011, 2 percent in FY 2012, 3 percent in FY 2013, and 5 percent in FY 2014 and beyond. This reduction would apply to *all* Medicare discharges.

Beginning in FY 2013, the Secretary would be able to expand the list of conditions to include chronic obstructive pulmonary disorder and several cardiac and vascular surgical procedures. The Secretary could expand the conditions again beginning in FY 2015 with the option to include an “all-cause” readmission rate measure. The Secretary would be directed to seek endorsement from the National Quality Forum for all measures used to assess readmissions performance. However, the Secretary would have the discretion to proceed without receiving endorsement.

Up to 5 percent of the readmissions payment reductions taken from inpatient PPS hospitals would be available to assist hospitals receiving at least \$10 million per year in Medicare DSH payments. Such hospitals would receive funds up to the amount of their readmissions payment reduction. These funds would be used to support transitional care activities designed to address patient noncompliance issues that result in higher-than-normal readmissions rates, such as providing care coordination services to assist in transitions from the hospital to other settings, or increasing the services offered by discharge planners.

Critical access hospitals also would be evaluated for their performance on readmissions.

- Critical access hospitals would be evaluated in the same manner as inpatient PPS hospitals.
- The adjustment factor would be applied to critical access hospitals’ cost-based payments for cost reports beginning in FY 2011 and beyond.

Post-acute providers also would experience reduced payments for readmissions.

- Payments for skilled-nursing facilities, inpatient rehabilitation facilities, home health agencies and long-term care hospitals would be reduced when patients are readmitted to an inpatient PPS or critical access hospital from a post-acute provider within 30 days of the initial discharge.

- Payments would be reduced by 0.4 percent in 2011, 0.6 percent in 2012, and 1.0 percent in 2013.
- The Secretary would be charged with developing measures to assess post-acute care providers' readmission rates and, after FY 2013, applying a policy to post-acute care providers that is similar to the proposed hospital policy.

Post Acute Care Payment Reform Plan for Bundled Payment (Sec. 1152)

No later than three years after the health reform law were enacted, the Secretary would develop a *plan* to reform Medicare payment for post-acute care services, including skilled-nursing facility, inpatient rehabilitation facility, long-term care hospital, hospital-based outpatient rehabilitation facility and home health agency services. The plan should include detailed specifications for bundling payment for post-acute care services and could also include other approaches. The Secretary would need to consider:

- To whom the payment would be made, the activities and services included in the bundle, the time frame of the bundle and whether the bundle should include physician services;
- Whether inpatient hospital services should be included in the bundle and, if so, which inpatient services;
- Whether critical access hospitals should be included in the bundle;
- The extent to which savings could be achieved due to increased efficiencies;
- Whether rates should be determined on a national basis or should differ by area, severity, outliers and other factors;
- Protections needed to ensure beneficiaries receive appropriate, high-quality care and have a choice of provider;
- Legal and regulatory barriers to bundling;
- Quality measures that would be appropriate for reporting by hospitals and post-acute providers;
- Whether and how cost-sharing requirements should be modified;
- Other regulations that may need to be modified or eliminated, such as the post-acute care transfer policy; and
- Other issues the Secretary deems appropriate.

After the report is issued, the Secretary would have the authority to conduct demonstration projects of post-acute bundling or other post-acute payment reforms identified in the report.

In addition, no later than six months after the law is enacted, the Secretary would expand the current Acute Care Episode demonstration to include post-acute care services and may include additional demonstration sites.

Value-Based Purchasing

The House legislation does not propose a Medicare value-based purchasing program. However, the Secretary could adopt such a payment system for the public plan.

Accountable Care Organizations (Sec. 1301)

The draft legislation would permit pilot projects to test the success of accountable care organizations (ACOs) in coordinating and improving care provided to patient

populations. Only physician groups, working with hospitals and other providers of care, would be permitted to form an ACO, and the physician groups would be rewarded for providing high-quality, efficient care. The physician group would have to have a legal structure, include sufficient primary care physicians, report on quality measures selected by the Secretary and use patient-centered processes. The total payment to the ACOs would be determined by the Secretary, but would be based on prior history of payment for Medicare patients in that area adjusted for an estimated savings to create a target performance amount. ACOs with high scores and with costs below the targeted amount would be eligible for an incentive payment. The pilot projects could also test a partial capitation model or other payment models. The pilot programs would begin on or before January 1, 2012 and last for three to five years.

Extension of Gainsharing Demonstration (Sec. 1703)

The gainsharing demonstration project enacted in the Deficit Reduction Act of 2005 would be extended from December 31, 2009 to September 30, 2011. Since the awarding of those projects was significantly delayed, this extension would provide the projects with approximately the same amount of time as would have been available if they had been awarded on a timely basis.

Physician-Owned Hospitals and Self-Referral (Sec. 1156)

The House legislation would eliminate the exception for physician-owned hospitals under the whole hospital and rural provider exceptions under the Stark law, but would grandfather those physician-owned hospitals with a Medicare provider agreement in place by January 1, 2009 and would limit the percentage of physician ownership to no more than the level on the date of enactment. These provisions incorporate long-sought AHA policies. Grandfathered facilities would be required to meet several types of requirements to maintain their grandfathered status. Those include:

- A variety of disclosures to patients about physician ownership and reports to HHS and public availability of physician ownership information on the HHS Web site, as well as those of any physician-owned hospital.
- Patient safety requirements related to emergencies and patient disclosures regarding onsite physician availability.
- Adherence to a set of rules that ensure bona fide ownership and investment, including:
 - Aggregate physician ownership or investment could not exceed the level in place on the date of enactment.
 - Ownership or investment could not be conditioned, directly or indirectly, on physicians making or influencing referrals to the hospital.
 - Any ownership interest offered to a physician owner or investor could not be offered on more favorable terms than those offered to an individual who is not a physician owner.
 - The hospital could not provide loans or financing for physician investments in the hospital.

- The hospital could not directly or indirectly guarantee a loan, make a payment toward a loan, or otherwise subsidize a loan to any individual or group of physician owners or investors related to acquiring an ownership interest in the hospital.
 - Ownership or investment returns to physician owners or investors would be distributed to them in an amount directly proportional to the interest they hold in the hospital.
 - Compensation of and returns to physician owners or investors could not include the guaranteed receipt of, or an exclusive right to purchase, other business interests related to the hospital, including the purchase or lease of any property under the control of other owners or investors.
 - The hospital could not offer a physician owner or investor the opportunity to purchase or lease any property under hospital control on more favorable terms than offered to an individual who is not a physician.
- No expansion of the number of operating rooms, procedure rooms or beds on or after the date of enactment could be made unless the hospital obtained HHS approval to do so. Any approved increase in capacity would be limited to facilities on the main campus of the hospital and could not exceed 200 percent of the number of operating rooms, procedure rooms, or beds on the date of enactment. An opportunity for public input on an expansion application would be required and applications could not be submitted more often than once every two years. The qualification requirements for growth exceptions would be that the hospital must:
 - Be located in a county with high population growth (i.e., where the population increased during the most recent five-year period at a rate that is at least 150 percent of the state's population increase);
 - Have a Medicaid inpatient admission percentage equal to or greater than the average percentage for all hospitals located in the county;
 - Not discriminate against beneficiaries of federal health care programs and not permit physicians practicing at the hospital to discriminate against such beneficiaries;
 - Be located in a state with a state average bed capacity less than the national average; and
 - Have an average bed occupancy rate that is greater than the state average bed occupancy rate.

Medical Home Pilot Program (Sec. 1302)

The legislation would establish a medical home pilot program in Medicare to evaluate the feasibility and advisability of reimbursing qualified, patient-centered medical homes that provide service to high-need beneficiaries. Two models of medical homes would be evaluated – the independent, patient-centered medical home model and the community-based, medical home model.

The independent, patient-centered medical home must be a physician- or nurse practitioner- directed practice that would be certified by the Secretary. It must provide targeted, high-need beneficiaries with direct and ongoing access to a primary care or

principal care physician or nurse practitioner, coordinate care to the beneficiary across care settings, integrate clinically-relevant patient data into patient care and apply evidence-based guidelines. A prospectively paid monthly fee would be paid for medical home services on a per-beneficiary basis.

The community-based, medical home model must be a nonprofit, community-based or state-based organization that is certified by the Secretary. The organization must provide high-need beneficiaries with medical home services under the supervision of a primary care or principal care physician or nurse practitioner. The organization must employ community health workers that assist in chronic care management activities. Two separate monthly payments would be made on a prospective basis for each high-need beneficiary, including one payment to the community-based organization and one payment to the primary or principal care practice.

The Secretary would evaluate the pilot program to determine the extent to which medical homes result in the following:

- Improved quality and coordination of care;
- Reductions in health disparities;
- Reductions in preventable hospitalizations;
- Prevention of readmissions;
- Reduction in emergency department visits;
- Improved health outcomes;
- Improved patient satisfaction; and
- Improved efficiency of care and reductions in healthcare expenditures.

A report to Congress on the findings of the evaluation must be submitted and, depending on these findings, the Secretary could expand the program on a permanent basis. In order to expand the program, the chief actuary of CMS must certify that expansion would not result in additional spending under Medicare.

The legislation provides \$6 million annually for FYs 2010-2014 for the administration of the program; \$200 million annually for FYs 2010-2014 for medical home services provided in the independent, patient-centered medical home model; and \$125 million annually for FYs 2012-2016 for medical home services provided in the community-based medical home model. An additional \$2.5 million for FYs 2010-2012 is provided for initial implementation activities.

MEDICARE AND MEDICAID PAYMENT CHANGES

Disproportionate Share Hospitals (Sec. 1112, 1804)

The House draft does not propose any reductions to Medicare or Medicaid DSH payments. However, by July 1, 2016, the Secretary would be required to submit two reports to Congress – one on the continued role of Medicare DSH and another on the continued role of Medicaid DSH – taking into account the impact of health care reform on reducing the number of uninsured individuals. The Secretary would be required to recommend the appropriate amount of Medicare DSH payments, the eligible hospitals

and the distribution of payments given hospitals' uncompensated care costs, if any, and costs associated with serving low-income beneficiaries. The Secretary also would be required to recommend the appropriate targeting and distribution of Medicaid DSH payments among the states.

340B Drugs (Sec. 2501-2502)

The draft legislation would expand eligibility for the 340B program to include freestanding children's hospitals, critical access hospitals, Medicare-dependent hospitals, sole community hospitals, rural referral centers, and certain maternal and child health, comprehensive mental health, and substance abuse treatment providers. Currently, eligible entities include community health centers, certain children's hospitals, hemophilia treatment centers and public and nonprofit disproportionate share hospitals that serve low-income and indigent populations. The draft legislation does not, however, expand the 340B program to inpatient drugs.

MEDICARE

Market Basket Updates (Sec. 1103, 1131-1155)

For 2010 and beyond, the draft legislation would reduce the annual inpatient, outpatient, inpatient rehabilitation facility, long-term care hospital, psychiatric hospital, skilled-nursing facility, hospice and home health agency market basket updates by the full estimate of "productivity growth" (currently estimated at 1.3 percent for FY 2010). Beginning in FY 2012, the annual market basket for renal dialysis facilities also would be reduced for productivity growth.

The draft legislation describes the productivity adjustment as the change in the 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity. For inpatient acute hospitals, this productivity adjustment is in addition to and would interact with the existing market basket incentives/penalties tied to hospital quality reporting and requirements for becoming a "meaningful user" of health information technology.

For FY 2010 through FY 2014, the full market basket update would be reduced by the full productivity adjustment.

- During these years, if a hospital does not report data on the required quality measures, the market basket remaining after the productivity adjustment would be reduced by an additional 2.0 percentage points, but not below zero.

In FY 2015 and 2016, the full market basket would continue to be reduced by the productivity adjustment.

- During these years, if a hospital does not report data on the required quality measures, the market basket remaining after the productivity adjustment would be reduced by 75 percent and 50 percent, respectively.
- Also during these years, if a hospital is not a "meaningful user" of health information technology, the market basket would be reduced by 25 percent and 50 percent.

In FY 2017 and beyond, the full market basket would continue to be reduced by the productivity adjustment.

- If a hospital does not report data on the required quality measures, the market basket remaining after the productivity adjustment would be reduced by 25 percent.
- Also during these years, if a hospital is not a “meaningful user” of health information technology, the market basket would be reduced by 75 percent.

Payments to Skilled Nursing Facilities (Sec. 1101-1111)

The draft legislation would eliminate the FY 2010 market basket update for skilled nursing facilities (SNF) for the final three quarters of FY 2010. This cut would be in addition to CMS’ proposal to cut SNF payments by \$1 billion in FY 2010 to adjust for greater-than-expected utilization of the new payment categories added in 2006.

Additionally, the Secretary would be required to compare SNF payments under the prior RUG-44 model and the current RUG-53 model to assess budget neutrality of SNF payments for 2006. In 2006, CMS moved to the RUG-53 system, which added nine new payment categories for complex patients requiring rehabilitation. Based on the analysis, the Secretary would adjust payment, if warranted by the findings, to ensure budget neutrality between both systems.

The legislation also would create a SNF PPS payment add-on for non-therapy ancillary services and an outlier payment methodology for therapy and non-therapy ancillary services. These two budget-neutral changes would be required by FY 2011.

Inpatient Rehabilitation Facility Payment Update (Sec. 1102)

The draft legislation proposes to freeze rates for inpatient rehabilitation facilities (IRF) for the final three quarters of FY 2010 at the FY 2009 level.

Payments to Home Health Agencies (Sec. 1153-1154)

The draft legislation would eliminate the home health market basket update for calendar year 2010, and directs the Secretary to reduce payments for FY 2011 by an additional 5.5 percent to reflect coding changes identified by CMS. The legislation would require the Secretary to conduct an analysis to rebase the home health prospective payment system before 2011 or, if unable to do so, implement a 5 percent cut in 2011.

Payments to Psychiatric Facilities (Sec. 1311)

Currently, there is a 190-day lifetime cap on Medicare inpatient psychiatric services provided in an inpatient psychiatric hospital. The legislation would eliminate this cap for services provided on or after January 1, 2010.

Payments to Physicians (Sec. 1121-1124, 1303-1304)

Sustainable Growth Rate (Sec. 1121). Under current law, physician fees in Medicare are slated to be reduced by 21 percent in January 2010 and by about 5 percent for the subsequent four years. This legislation would reform fundamentally and permanently the SGR formula that updates reimbursement for physician services in Medicare.

The proposal would eliminate accumulated deficits under the existing SGR and rebase the system to 2009. It would provide a conversion factor update for 2010 based on the Medicare Economic Index (MEI) in order to allow a new system to be developed.

The SGR would be replaced with a new “target growth rate” formula that:

- Removes items, such as drugs and laboratory services, not paid under the Medicare physician fee schedule from the computation of the target growth rate;
- Retains limits on volume growth, but establishes two separate target growth rates – one for primary and preventive care services and one for other services;
- Provides a higher target growth rate for primary care and preventive care services than for other services. That is, the volume of primary and preventive care services is allowed to grow at the annual rate of Gross Domestic Product (GDP) plus 2 percent and other services are allowed to grow at GDP plus 1 percent; and
- Allows ACOs to have individual target growth rates and payment updates.

Mis-valued Codes Under the Physician Fee Schedule (Sec. 1122). The draft legislation would require the Secretary to periodically identify mis-valued codes under the physician fee schedule and review and make adjustments to the relative values for these codes, including consolidation of individual services into bundled codes for payment. It also would require the Secretary to establish a process to validate relative value units of codes identified as mis-valued. It would provide CMS with \$20 million annually to carry out this section. These provisions would not be subject to law related to federal information policy or to the requirements of the Federal Advisory Committee Act. They could be implemented through program instruction (meaning they would not be subject to public notice and comment). This section also would repeal the Practicing Physician’s Advisory Council.

Payments for Efficient Areas (Sec. 1123). In 2011 and 2012, the legislation would provide a 5 percent increase in payments for physician fee schedule services furnished in areas identified by the Secretary as “efficient areas.” Efficient areas are defined as those counties in the lowest fifth percentile of utilization based on annual per-capita spending for services, standardized for geographic differences in payment rates.

Modifications to the Physician Quality Reporting Initiative (PQRI) (Sec. 1124). The legislation would require the Secretary to establish a mechanism by 2011 that would provide timely feedback to physicians who report data under the PQRI and would establish an appeals process for physicians with PQRI payment disputes. The Secretary would need to develop a plan by 2012 that integrates clinical reporting on quality measures with reporting requirements related to the meaningful use of electronic health records. Quality reporting incentive payments would be extended for two years, through 2012.

Rate Increase for Selected Primary Care Services (Sec. 1303). Starting in 2011, the legislation would provide a 5 percent bonus (or 10 percent if furnished in a health professional shortage area) to primary care practitioners for whom primary care services make up at least 50 percent of their total allowed charges.

Increased Reimbursement Rate for Certified Nurse-midwives (Sec. 1304). The legislation would increase reimbursement for certified nurse-midwives by removing the statutory

language limiting their reimbursement to 65 percent of a physician's reimbursement for the same service.

Primary Care Bonus Payment. For physicians and other health care professionals who provide primary care services, Medicaid reimbursement would be increased to 80 percent of the Medicare rate in 2010, 90 percent in 2011 and 100 percent in 2012. The additional cost to the state Medicaid programs would be fully financed by the federal government through FMAP increases.

Payments to Ambulatory Surgery Centers (Sec. 1144)

The draft legislation would require CMS to develop a cost report for use by ambulatory surgery centers (ASCs) within two years of enactment and would require ASCs to begin to report their costs to CMS as a condition for coverage. In 2012, it would require ASCs to report quality data such as data on health care-associated infections and other data as required by the Secretary.

Payments for Imaging Services (Sec. 1147)

Beginning January 1, 2011, the legislation would reduce payments for imaging services under the physician fee schedule by adjusting their practice expense relative value units to reflect higher presumed utilization of imaging equipment. Beginning January 1, 2011, the draft legislation would increase the discount applied to the technical component for multiple imaging procedures performed during the same encounter under the physician fee schedule from 25 to 50 percent. Savings generated from this change would not be budget neutral.

Medicare Part D (Sec. 1181-1185)

The draft legislation includes several changes to the Medicare Prescription Drug Program under Part D including:

- Beginning in 2011, filling in the Part D coverage gap – referred to as the “donut hole” – over a period of 15 years by progressively increasing the initial coverage limit and decreasing the annual out-of-pocket threshold.
- Establishing a drug manufacturer rebate for any covered outpatient drug the manufacturer dispensed after December 31, 2010, to any full premium subsidy Medicare drug plan enrollee for which payment was made by a drug plan sponsor or a MA organization.
- Repealing a provision that currently allows pharmacies located in or contracting with long-term care facilities between 30-90 days to submit claims to a drug plan sponsor or to a MA organization for reimbursement.
- Allowing prescription drug costs incurred or paid under a state pharmaceutical assistance program, under an AIDS drug assistance program or by the Indian Health Service to count toward the annual out-of-pocket threshold under Part D.
- Permitting individuals enrolled in a Part D drug plan or a MA organization to make mid-year changes in their enrollment for formulary changes that adversely impact them.

Medicare Extenders (Sec. 1142, 1192-1196, 1231)

The draft legislation would extend several Medicare provisions. They include:

- Extending cost-based payment for brachytherapy and therapeutic radiopharmaceuticals for two additional years.
- Extending for two additional years outpatient hold harmless payments for certain hospitals in rural areas with 100 or fewer beds and for certain sole community hospitals with 100 or fewer beds.
- Extending section 508 wage index reclassifications for the inpatient PPS through September 30, 2011.
- Under the physician fee schedule, extending by two years the provision increasing the work geographic index to 1.0 for localities in which the work geographic index is less than 1.0.
- Extending for two years grandfathering that allows independent laboratories to continue to directly bill, under the physician fee schedule, for anatomic pathology technical component services provided for certain hospitals' inpatients and outpatients.
- Extending the existing add-on payment for ground ambulance services – a 3 percent add-on for rural areas and a 2 percent add-on for urban areas.
- Extending the outpatient therapy caps exceptions process for an additional two years.
- Extending for two years the 5 percent increase in physician payment for certain psychiatric therapeutic procedures furnished in office or other outpatient facility settings or in inpatient hospital, partial hospital or residential care facility settings.

Repeal of the “45 percent Medicare Trigger” (Sec. 1701)

Current law requires the annual Medicare Trustees’ report to include an estimate of the year in which general revenues will account for more than 45 percent of Medicare funding. If two consecutive trustees’ reports project that this portion will exceed 45 percent within the next six years, then the President must submit legislation to reduce the portion to less than 45 percent. The draft legislation would eliminate this requirement.

MEDICAID (Sec. 1803-1872)

Medicaid and CHIP Maintenance of Effort

A maintenance of effort (MOE) for eligibility would be imposed on states for both their Medicaid and CHIP programs. States could not fall below their eligibility standards as of June 16, 2009, to meet the MOE requirement.

Medicaid Managed Care Organization (MCO) Minimum Loss Ratio

The legislation would establish a minimum loss ratio for Medicaid MCOs at a minimum of 85 percent. This requirement would be effective July 1, 2010.

Puerto Rico and Territories

The draft legislation would increase the Medicaid cap and the FMAP calculation for Puerto Rico and the Territories by amounts specified by the Secretary so that the total amount would not exceed \$10.35 billion between the years 2011 and 2019.

Health Care-Acquired Conditions

State Medicaid programs would be required to include policies that would not result in higher payments to hospitals should a patient have a health care-acquired condition during the hospital stay similar to the Medicare hospital-acquired-conditions policy.

Access Improvements

Improvements in access to services would include a medical home pilot program, improvements in translation services and optional coverage for freestanding birth centers.

Coverage Improvements

The Transitional Medicaid Assistance (TMA) program would be extended for those moving from welfare to work without health coverage. States could, at their option, cover low-income HIV infected individuals and expand outstation eligibility enrollment sites. The Qualified Individual (QI) program, which extends Medicaid coverage to certain low-income elderly, would be made permanent.

Medicaid Integrity Program

The legislation would require evaluations and reports for state Medicaid Integrity programs intended to reduce overpayment, waste fraud and abuse. It would extend the 60-day rule, which governs the time period for repayment by the state to the federal government when an overpayment is discovered to one year, allowing more time for review and appeals.

GRADUATE MEDICAL EDUCATION AND WORKFORCE

GRADUATE MEDICAL EDUCATION (Sec. 1501-1505, 1844)

Indirect Medical Education (IME)

The draft legislation does not propose any changes in Medicare IME payments to teaching hospitals.

Redistribution of Unused Residency Positions (Sec. 1501)

The legislation would redistribute “unused” residency training slots as a way to encourage increased training of primary care physicians. With limited exceptions, the Balanced Budget Act of 1997 capped the number of residents that Medicare will recognize for direct graduate medical education (DGME) and IME at a teaching hospital’s 1996 level. The Medicare Prescription Drug Improvement and Modernization Act of 2003 authorized a redistribution of resident cap positions effective July 2005.

Under the draft legislation, hospitals would lose 90 percent of their unfilled residency positions (based on cost reports over the past three years) and qualifying hospitals would be able to request up to 20 new slots. Priority for the new slots would be given to:

- Hospitals that had a reduction in resident training positions;
- Hospitals with three-year primary care residency training programs, such as family practice and general internal medicine;

- Hospitals that emphasize training in federally qualified health centers, rural health clinics, off-campus provider-based outpatient departments and other non-provider settings;
- Hospitals that emphasize training in health professional shortage areas; and
- Hospitals in states with low resident-to-population ratios.

Hospitals receiving additional slots would be required to maintain at least their current level of primary care residents in their training programs permanently. The redistributed slots would receive full IME (i.e., 5.5 percent) payments and DGME payments at the Medicare current law policy.

Training in Non-Provider Settings / Non-Patient Care Activities (Sec. 1502-1503)

Under certain conditions, hospitals have been allowed to count toward hospital DGME and IME payments the time residents spend training in sites that are not part of the hospital. Currently, hospitals may receive Medicare payments only if residents spend their time in patient care activities (as opposed to didactic conferences and seminars) and only if there is a written agreement between the hospital and the non-provider entity, and if the hospital incurs “all or substantially all” of the costs involved in the offsite training.

Effective July 1, 2009, the draft legislation would allow all non-research time spent by a resident in an offsite setting to count toward DGME and IME payments if the hospital incurs the costs of the salary and benefits of the resident during this time. The draft legislation also calls for an Office of Inspector General (OIG) study to determine whether there is an increase in time spent by medical residents in non-provider settings due to this provision.

The draft legislation would authorize a demonstration project to allow approved “teaching health centers” to be reimbursed directly for its own DGME costs associated with training primary care residents. Approved teaching health centers would include federally qualified health centers or rural health centers. They would be required to contract with teaching hospitals for the inpatient portion of the primary care residency program.

Resident Cap Positions from Closed Hospitals (Sec. 1504)

Currently, if a teaching hospital closes, the resident cap positions associated with it are eliminated. The draft legislation would allow the residency caps from closed hospitals to be distributed to other hospitals in the state according to a methodology determined by the Secretary. This provision would be retroactive to incorporate residency positions from hospitals that closed within the past two years.

Improving Accountability for Medical Residency Training (Sec. 1505)

The draft legislation would authorize a Government Accountability Office (GAO) study to evaluate residency training programs and determine whether certain educational goals are being met and whether medical schools have the faculty and expertise necessary to achieve the goals for approved medical residency training programs. These goals include:

- Working effectively in various health care delivery settings (including non-provider settings);
- Coordinating patient care within and across settings;
- Understanding the relative costs and value of various diagnostic and treatment options;
- Working in inter-professional and multi-disciplinary team-based models to enhance safety and improve quality;
- Understanding and preventing errors; and
- Becoming meaningful users of electronic health records.

Medicaid Graduate Medical Education (GME) (Sec. 1844)

The Medicaid statute would be amended to explicitly include payments for the cost of GME, both inside and outside the hospital, as legitimate Medicaid payments. States would report GME expenditures to the Secretary. The Secretary would be directed to issue a rulemaking on the Medicaid program goals for Medicaid GME payments by December 31, 2011.

WORKFORCE

Public Health Investment Fund (Sec. 2002-2003). The House legislation would authorize \$33.7 billion over five years to establish a “Public Health Investment Fund” within the Public Health Service Act to provide increased support for community health centers, workforce development, prevention and wellness and implementing best practices. Of this amount, \$9.4 billion would be specifically appropriated to community health centers.

Primary Care and Nursing Workforce (Sec. 2201-2235). The draft legislation proposes a number of policies to improve the primary care workforce including:

- Investing in the National Health Service Corps program by increasing funding to over \$400 million from FY 2010 through 2014, and increasing the amount of loans per individual from \$35,000 to \$50,000 for FY 2011 and beyond.
- Creating new “Health Professional Needs Areas,” defined as those geographic areas that have insufficient health professionals to deliver primary care services given the area’s population.
- Providing scholarships and loan repayment programs to physicians and other health professionals who agree to practice in high-needs areas.
- Providing low-interest medical school loans to certain individuals who practice in primary care.
- Providing \$200 million in grants from FY 2010 through FY 2014 to certain entities – including public and nonprofit hospitals – to develop and support primary care training programs and dental training programs.
- Providing \$1.1 billion in grants and loans from FY 2010 through FY 2014 to train advanced education nurses who will practice in health professional shortage areas.
- Establishing a new “Public Health Workforce Corps” to ensure an adequate supply of public health professionals and to eliminate critical public health workforce shortages.
- Providing scholarships (educational expenses plus a stipend) and a loan repayment program for individuals who enroll in a program of public health, health

administration, management or policy, preventive medicine or other graduate school and who become commissioned officers and who agree to provide services in a workforce shortage area.

- Providing \$250 million in grants from FY 2010 through FY 2014 for eligible entities to provide graduate medical resident training in preventive medicine specialties.
- Authorizing grants to qualifying health care entities to address the projected nursing shortage through the development of comprehensive programs to provide education to nurses and to create a pipeline to the nursing profession.

Advisory Committee on Health Workforce Evaluation and Assessment

The draft legislation would establish an Advisory Committee on Health Workforce Evaluation and Assessment that would make recommendations to the Secretary on the adequacy and appropriateness of the nation's health workforce.

National Center for Health Workforce Analysis

The proposal would establish a National Center for Health Workforce Analysis to evaluate the effectiveness of federal workforce programs.

QUALITY, DISPARITIES AND COMPARATIVE EFFECTIVENESS

Stand for Quality (Sec. 2401)

The draft legislation provides for the development of national priorities for quality improvement and for measures to assess success in improving care. Seven million dollars would be given to an organization, presumably the National Quality Forum (NQF), to bring together various stakeholders to set national goals, similar to the NQF's current efforts convening the national priority partners. As described in the draft, these priorities would be turned over to the Secretary for determination and development of new measures that track progress and the development of information and strategies that support provider's efforts to improve care.

Quality and Surveillance / Implementing Best Practices (Sec. 2401)

The draft legislation would establish a Center for Quality Improvement within the Agency for Healthcare Research and Quality (AHRQ). The center would identify and develop quality improvement activities based on the national priorities and the potential impact on patient outcomes and satisfaction of the candidate activities, the relevant key health indicators, and the adaptability of the activities to the work of other providers. The center would work directly with provider organizations to implement successful improvement strategies and to measure the effect on patient outcomes and satisfaction. The center also would support research to facilitate continuous medical practice improvement, the design of health care delivery systems and support regional efforts to improve care through collaborative projects. To jump start the work of the center, the draft legislation would mandate that initial work focus on health care-associated infections, safe surgery, improved flow of patients through the emergency room and improved obstetrics and neonatal care.

Assistant Secretary for Health Information (Sec. 2402)

This section would amend title XVII of the Public Health Service Act to establish a new Bureau of Health Information headed by an Assistant Secretary for Health Information within HHS, who would have a duty to ensure the collection, “collation,” reporting and publishing of “full and complete statistics” on:

- key health indicators on the Nation's performance in delivering health care, and
- any other information the Secretary would determine.

Comparative Effectiveness Research (Sec. 1401)

The draft legislation would create a center within AHRQ to conduct, support and synthesize comparative effectiveness research. It also would establish an independent comparative effectiveness research commission to oversee and evaluate the activities carried out by the center, and determine national priorities for comparative effectiveness research. The commission would:

- consist of 15 members serving four-year terms;
- include the director of AHRQ and the chief medical officer of CMS;
- appoint a clinical perspective advisory panel for each research priority;
- contract with the Institute of Medicine (IOM) to determine standards of evidence;
- employ an executive director and staff;
- ensure transparency, stakeholder input and public access to information; and
- ensure that the research takes into account potential differences for subpopulations.

The commission and the center would not be permitted to “mandate coverage, reimbursement or other policies for any public or private payer.”

Additionally, the legislation would create a Comparative Effectiveness Research Trust Fund (CERTF). This fund would allocate \$300 million for comparative effectiveness research through 2012. It also would allocate \$26 million to the commission to conduct its activities through 2012. For 2013 and beyond, the CERTF would be financed in a public/private manner based on a per-capita tax. HHS would pay an amount per Medicare beneficiary and private insurers would pay an amount per number of lives covered in the plan.

Reducing Health Disparities (Sec. 1221-1224, and Titles II and III of Division C)

The draft bill includes a variety of provisions in several locations throughout the legislation that would reduce health disparities, including:

- A one-year HHS study on Medicare payment for language services for all Medicare service providers and the extent to which state Medicaid programs are paying for such services.
- An HHS demonstration program for no fewer than 24 three-year grants to Medicare providers to improve effective communication with limited English proficiency (LEP) beneficiaries and test different payment methodologies for language services.
- An IOM study and report on the impact of language access services on the health and health care of LEP populations.
- A variety of provisions regarding workforce expansion, increased National Health Service Corps funding, increased scholarships and loan repayment for individuals

from disadvantaged backgrounds as well as improved diversity and cultural competency in training health professionals.

- Emphasis in targeting a significant portion of new wellness and prevention initiatives to reduce disparities.
- Emphasis on better information to assess and address health disparities by a new Bureau of Health Information charged with collecting, collating, reporting and publishing a broad range of health indicators.

WELLNESS AND PREVENTION

Coverage and Waiver of Cost-sharing for Preventive Services (Sec. 1305)

The draft would codify a comprehensive list of all Medicare-covered preventive services as of January 1, 2011. This provision would eliminate the application of cost-sharing and deductibles for preventive services, including eliminating co-insurance for screening flexible sigmoidoscopies and screening colonoscopies. Covered preventive services furnished in the hospital outpatient department would not be paid through the outpatient PPS but would be paid at 100 percent of the applicable physician fee schedule rate.

Prevention (Sec. 1811-1815)

States would be required to provide Medicaid coverage for preventive services recommended by the United States Preventive Services Task Force and vaccines recommended by the Centers for Disease Control and Prevention. States, at their option, could cover tobacco cessation programs, nurse home visiting services, family planning services and certain school-based clinic services.

Expanding Access to Vaccines (Sec. 1310)

As of January 1, 2011, the draft legislation would expand coverage under Medicare to all federally recommended vaccines and their administration. Federally recommended vaccines are those that are recommended by the CDC's Advisory Committee on Immunization Practices.

Prevention and Wellness Trust (Sec. 3011)

The draft legislation would create a \$15.2 billion "Prevention and Wellness Trust" with allocations from FY 2010 through FY 2014 as follows:

- \$150 million for prevention task forces;
- \$1.0 billion for prevention and wellness research;
- \$7.0 billion for delivery of community-based prevention and wellness services;
- \$5.4 billion for core public health infrastructure and activities for state and local health departments; and
- \$1.75 billion for core public health infrastructure and activities for CDC.

REGULATORY OVERSIGHT AND REFORM

Increased Funding to Fight Waste, Fraud, Abuse (Sec. 1601-1653)

The draft legislation would add a number of new prohibitions and penalty provisions that would allow the OIG and CMS greater discretion to impose penalties and significant

penalty amounts on providers. Most of these provisions would be enforced by the OIG under its authority to impose civil money penalties (CMPs). New provisions of particular interest for hospitals include:

- Making a false statement or misrepresenting a material fact in an application to participate in a federal health program or in any data submitted to support a claim. A \$50,000 penalty could be imposed for each false statement or misrepresentation. For violations related to an application, damages could also be assessed of not more than three times the amount claimed as a result of the false statement or misrepresentation. This conduct is already prohibited and subject to penalties under other laws.
- Failure to grant the OIG timely access for purposes of audits, investigations, evaluations or other statutory functions. A penalty of \$15,000 per day could be imposed. The OIG already can enforce compliance through a process involving oversight by the court. This legislation would enable OIG to enforce compliance independently under threat of a penalty.
- Failure to have a compliance program that meets certain specifications could receive a \$50,000 penalty per violation. The Secretary would be directed to establish core elements of a program in consultation with the OIG. Corrective action plans could also be imposed as well as monitoring. This legislation suggests elements for the Secretary to consider that match the core elements of the OIG's current recommendations for compliance programs. The Secretary would have unlimited discretion to add or modify.

Overpayments

The draft legislation would create a duty to report overpayments and a deadline for repaying them. Repayment would be made no later than 60 days from the date the overpayment is identified or the date on which payment is required by the applicable claims appeal or reconciliation process. A known overpayment held longer than these time frames would be subject to enforcement under the False Claims Act (FCA). A recent amendment to the FCA created liability for the improper retention of an overpayment. This provision would define the timeframes for determining when an overpayment is improperly retained.

Other provisions

- The maximum time period for submitting claims would be shortened to 12 months instead of the current 36 months. The rationale is to minimize the opportunity for fraud schemes based on observing and exploiting processing patterns of CMS.
- Any person (e.g. a physician) excluded from a federal health care program that orders or prescribes an item or service while excluded, who knows or should know that a claim for such item or service will be presented to the program, could be subject to a \$50,000 penalty for each violation.

Transparency of Information on Skilled Nursing Facilities and Nursing Facilities
(Sec. 1411-1416, 1421-1423, 1431-1432)

These sections would require that SNFs and nursing homes disclose the following ownership information: 1) the governing board; 2) each officer, director, member, partner, trustee or managing employee; and 3) other “disclosable entities.” Such information shall be shared upon request and its availability posted in each facility’s lobby. The Secretary would issue regulations within two years of enactment.

Within three years of enactment, SNFs and nursing homes would implement a compliance and ethics program to prevent and detect criminal, civil and administrative violations and promote quality of care. By December 31, 2011, the Secretary would implement the Quality Assurance Program Improvement (QAPI) program, which includes standards and technical assistance on implementing best practices. Within the following year, SNFs and nursing homes would submit to the Secretary a plan to meet the QAPI standards; and the *Nursing Home Compare* Web site would include related data.

Within two years of enactment, SNF cost reports would be modified to separately report expenditures for wages and benefits for direct care staff, including registered and licensed professional nurses, certified nurse assistants and other medical and therapy staff. Within two years of enactment, SNFs and nursing homes would be required to electronically submit staffing information.

Within one year of enactment, SNFs and nursing homes would be required to use a common resident complaint form and states would establish a complaint resolution process. A whistleblower protection program for employees also would be established.

Targeting Enforcement (Sec. 1421-1423). The draft legislation would allow CMPs to be applied to SNFs and nursing homes in certain circumstances and with limits. For SNFs, the penalties would be: for any case where the deficiency is a direct cause of death, from \$3,050 to \$100,000; for a deficiency causing harm or immediate jeopardy, between \$3,050 and \$25,000; and for any other deficiency, between \$250 and \$3,050.

The Secretary, in consultation with the OIG, would establish a pilot program to implement an independent monitor to oversee interstate and large intrastate chains of SNFs and nursing facilities. Within one year of enactment, the Secretary would require SNFs and nursing homes to report a facility closure within 60 days of closure, and to include a plan for relocating patients.

Improving Staff Training (Sec. 1431-1432). If deemed appropriate by the Secretary, training on dementia and abuse prevention could be required of a SNF or nursing home. Within two years of enactment, the Secretary would report to Congress on the findings of a study on training for certified nurse aides and supervisory staff for SNFs and nursing homes. The report would include recommendations on whether the quantity and content of such training should be increased.

Physician Payments Sunshine Provision (Sec. 1451)

Beginning in 2011, the draft legislation would require manufacturers and distributors of drugs, devices, biologicals, or supplies that provide payment or other “transfers of value”

(such as gifts, trips to research findings, and consulting fees) either directly or indirectly to physicians and other providers to report these payments annually to the Secretary or face penalties.