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CCH BRIEFING *Special Report*

Progress Report: Health Care Reform at the August Recess

Highlights

- ✔ Mandatory individual coverage
- ✔ Greater employer responsibility with assistance for small businesses
- ✔ Guaranteed issue and renewability requirements
- ✔ Health insurance exchange through which individuals and employers can purchase insurance
- ✔ Subsidies for individuals/families with incomes up to 400% of the federal poverty level
- ✔ Medicare Advantage payments reduced to match Medicare fee-for-service payments by 2013
- ✔ Medicare prescription drug plan coverage gap phased out by 2023
- ✔ Promotion of primary and coordinated care
- ✔ Reduced Medicare payments to hospitals with high levels of readmission related to certain procedures

Inside

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Congressional efforts expand on employment-based options, change Medicare and Medicaid provisions

With President Barack Obama insisting that comprehensive health care reform must be enacted by the end of 2009, lawmakers have labored under increasing pressure to get the job done. The Chairmen of the House Ways and Means, Energy and Commerce, and Education and Labor Committees on July 14 unveiled a draft bill (*America's Affordable Health Choices Act*) that the three committees worked on together (House Tri-Committee proposal). The three House Committees subsequently passed slightly different versions of reform legislation. On July 15, the Senate Health, Employment, Labor, and Pensions Committee (HELP) passed its version of health care reform (*The Affordable Health Choices Act*). The Senate Finance Committee, chaired by Senators Max Baucus (Mont.) and ranking member Charles Grassley (Iowa), has been exploring varied policy options, and, as of Congress' August recess, had not issued a formal proposal.

This briefing provides an overview of provisions particularly of interest to employers in these three major reform proposals being considered in Congress, and highlights changes to the Medicare and Medicaid programs that are contained in the House Tri-Committee proposal (the Senate HELP committee has no jurisdiction over these programs).

Employers and health care reform

According to the Congressional Research Service, the 2009 health care reform effort attempts to address these three key concerns: (1) health care **costs** are rising at an unsustainable rate, both for individual families and the society as a whole; (2) for all the U.S. spends on health care (more than 16 percent of the gross domestic product), by some measures the **quality** of care provided is inferior to the care provided in other developed countries; and (3) the number of Americans who lack insurance **coverage** (more than one-seventh of the population at some point in 2007) is a problem by itself that also exacerbates the cost and quality issues. Although lawmakers are far from reaching a consensus on health care reform legislation, the three major proposals under consideration address these three key concerns with both similar and divergent provisions.

House Tri-Committee proposal

The 1,018-page House Tri-Committee draft includes a public plan, certain limits on health insurance medical loss ratios, and employee and employer

coverage requirements. Several provisions that impact employers and their employees, except for those predominantly tax-related, are discussed below.

Guaranteed coverage and insurance market reforms. Under the House draft, insurance companies would be required to guarantee issue and renewal of coverage regardless of individuals' health status. Insurers would also be prohibited from excluding coverage of treatments for preexisting health conditions and from setting annual and lifetime limits on benefits. Insurers' ability to charge higher rates due to health status, gender, or other factors would be limited, and premiums would be permitted to vary based only on age, geography, and family size. Medical loss ratios would be limited (a certain percentage of medical insurance premiums would be required to be paid out in benefits).

A health insurance exchange. A new health insurance exchange, a marketplace for individuals and small employers to comparison shop among private and public insurers, would set and enforce insurance reforms and consumer protections, facilitate enrollment, and administer credits to help low- and middle-income individuals and families purchase insurance affordably. Over time, the exchange would be opened to all employers as another choice to cover their employees. States could opt to operate the exchange in lieu of the national exchange, provided that they follow the federal rules.

Impact: *This would be a national exchange with guaranteed issue and renewability, and rating variation only based on age, rating area and family status. A loss-ratio minimum, originally set at 85 percent, is now to be determined by the Department of Health and Human Services and the Health Choices Administration, a new independent agency within the executive branch. Loss-ratio limits do not appear in the Senate proposals.*

Impact: *The Senate HELP Committee version provides for geographically based, state or regional exchanges (called health benefit gateways). States would pay plans based on enrollee actuarial risk, using national standard methods.*

Comment: *Among the policy options under consideration by the Senate Finance Committee are national or regional exchanges, with required participation for individual and small group insurers; guaranteed issue and renewability; and rating variation based only on age, tobacco use, family status and geography.*

A public health insurance option. The health insurance exchange would include a public health insurance option along with private insurance options. The public option would be subject to the same market reforms and consumer protections as private plans in the exchange, and it would be self-sustaining – financed only by its premiums.

Impact: *The Energy and Commerce Committee amendment would allow states to establish non-profit cooperatives in lieu of the national public plan.*

Impact: *The Senate HELP Committee version includes a Community Health Insurance option to be offered through each gateway (exchange). Participation in the community health plan (public option) would be voluntary for providers.*

Comment: *Two options were initially proposed by the Senate Finance Committee but have been (reportedly) supplanted by a proposal by Senator Kent Conrad (N.D.) to establish state-based health care cooperatives, although nothing has been released by the committee itself regarding cooperatives. The initial options were: (a) to create a new public plan to be offered through the exchange that will be subject to the same rating and risk adjustment rules as the private plans; or (b) not to create a public plan.*

Essential benefits. A new essential benefits package standard set by a new independent advisory committee, chaired by the U.S. Surgeon General working with practicing providers and other health care experts, would serve as the basic benefit package for coverage in the exchange. Eventually it would become the minimum coverage standard for employer plans. The basic package would include preventive services with no cost-sharing, mental health services, dental and vision care for children, and caps on the amount of money a person or family spends on covered services in a year.

Affordability. Affordability credits – vouchers to help pay for the cost of coverage obtained through the exchange – would be available to low- and moderate-income individuals and families. The credits begin and are most generous for those whose household incomes are just above the proposed new Medicaid eligibility levels and are incrementally lowered until they are completely phased out for household incomes at 400 percent of the federal poverty level (FPL – $43,000 for an individual or $88,000 for a family of four in 2009). The affordability credits would be administered by the exchange together with other federal and state entities,

such as local Social Security offices and state Medicaid agencies. Annual out-of-pocket spending would be capped for all new policies.

Impact: *Under the Senate HELP Committee bill, a credit would be provided to the gateway (exchange), which in turn would provide the credit to the plan in which an eligible individual is enrolled. The eligible individual would then pay a reduced amount for health insurance obtained through the gateway. Affordability credits would not be available to individuals who are eligible for employer-based coverage that meets minimum qualifying criteria and affordability standards, or other public health insurance programs.*

Certain small employers would receive a credit provided by the Secretary of Health and Human Services under the Senate HELP Committee version.

Impact: *Affordability credits under the House Ways and Means Committee markup would operate similarly. An eligible individual would receive a "credit" that is applied against a qualified health plan premium. The actual payment would be made to the qualified health plan by the Commissioner of the new Health Choices Administration.*

Individual responsibility mandate. Except in cases of hardship, once market reforms and affordability credits are in effect, individuals would be responsible for obtaining and maintaining adequate health insurance coverage. Those who choose not to obtain coverage would pay a penalty based on two percent of adjusted gross income above a specified level.

Impact: *The Senate HELP Committee version of the mandate provides that all individuals must have "qualifying health" coverage. There is a penalty of up to a $1,000 fine for failure to comply, with exceptions for individuals in states without a health benefit gateway.*

Comment: *The Senate Finance Committee is considering an option that would require all individuals to have coverage that meets minimum standards, except in cases of financial hardship, with an excise tax penalty for non-compliance.*

Employer responsibility mandate. Under the House Tri-Committee proposal, employers would have the option of providing health insurance coverage for their workers or contributing funds on their behalf. Employers that choose to contribute would pay a fee based on eight percent of their payroll.

Impact: *Employers would be required to pay a minimum share of the premium – 72.5 percent for single and 65 percent for family coverage for the lowest cost essential benefits plan – or pay eight percent of payroll into the exchange trust fund.*

Impact: *Under the Senate HELP Committee proposal, employers with at least 25 employees who do not offer adequate coverage must pay a $750 annual fee per full-time employee and $375 per part-time employee. Employers that offer coverage must pay at least 60 percent of the premium.*

Comment: *The Senate Finance Committee has considered two options:*

(1) Employers with more than a $500,000 annual payroll would be required to offer coverage, pay at least half of the premium or pay an assessment (set fee per employee per month based on annual payroll; or tiered amount percentage of payroll; or greater penalty on firms with annual payroll exceeding $1.5 million).

(2) No pay-or-play requirement.

Assistance for small employers. Certain small businesses would be exempted from the employer responsibility requirement. A new small business tax credit would be available for those firms who want to provide health coverage to their workers, but cannot afford it.

Impact: *The House Committee on Education and Labor would provide exemptions for employers that would be negatively affected by job losses as a result of the requirement. This version would eliminate or reduce the pay-or-play assessment for small employers with annual payroll of less than $400,000:*

- *Annual payroll less than $250,000: exempt;*
- *Annual payroll more than $250,000 but not exceeding $300,000: two percent of payroll;*
- *Annual payroll more than $300,000 but not exceeding $350,000: four percent of payroll;*
- *Annual payroll more than $350,000 but not exceeding $400,000: six percent of payroll.*

Impact: *Under the Senate HELP Committee version, employers with 25 or fewer employees would be exempt.*

Government responsibility. The federal government would be responsible for ensuring that every American can afford quality health insurance through the new affordability credits, insurance reforms, consumer protections, and improvements to Medicare and Medicaid.

Prevention and wellness. Prevention and wellness measures include expansion of community health centers; requiring benefit packages to cover preventive services with no cost-sharing; creation of community-based programs to deliver prevention and wellness services; a focus on community-based programs and new data collection efforts to better identify and address racial, ethnic, regional and other health disparities; and funds to strengthen state, local, tribal and territorial public health departments and programs.

Quality control. The House Tri-Committee proposal would develop a comparative effectiveness research center to conduct, support, and synthesize research into outcomes, effectiveness, and appropriateness of medical treatments; improve transparency of skilled nursing facilities performance; and establish national priorities for "performance improvement" in the treatment of chronic diseases, and in services that address health disparities, that reduce variations in care, and that decrease medical errors.

Senate Finance Committee

Among the options considered by the Senate Finance Committee as a means of financing health care reform is modification of the exclusion from income for employer-provided heath coverage, including:

A limit based on the value of the plan or the income of the insured, or a combination of both. One option would impose a limit on the exclusion based on the value of the plan or the income of the insured, or a combination of both. Or, the limit could be tied to a percentage of the value of the employer-provided health care coverage. A limit based on value could target the actuarial value of a benchmark plan, such as the value of the Federal Employee Health Benefit Program (FEHBP) standard option. The exclusion also could be limited to a percentage of the total premium for health insurance coverage obtained through the employer for all taxpayers. Exclusion limits could take into account geographic variations in the cost of living, including medical costs. The exclusion could also be reformulated as a tax credit, a tax deduction, or a combination of a tax credit and tax deduction.

Health savings accounts (HSA). Another option would limit HSA contributions to the lesser of the individual's deductible under the high-deductible health plan or the dollar amount of the maximum allowable aggregate HSA contributions. It would increase from 10 percent to 20 percent the additional tax on distributions from an HSA that are not used for qualified medical expenses. HSA distributions would only be excludable from gross income as an amount used for qualified medical expenses if the expenses are substantiated by the employer or an independent third party. If the current exclusion for employer-provided health care coverage is limited, HSA contributions could be counted against the limit.

Employer-provided reimbursement of medical expenses under flexible spending accounts (FSA) and health reimbursement arrangements (HRA). A third option would limit or eliminate the amount of salary reduction contributions to a health FSA or for HRA reimbursements that would be excludible from gross income. If the current exclusion for employer-provided health care coverage is limited, contributions to an FSA or HRA could be counted against the limit.

Senate HELP Committee

The Senate HELP Committee's proposal, the Affordable Health Choices Act (AHCA), includes provisions for American Health Benefit Gateways (insurance exchanges) in which the federal government would provide grants to states to facilitate establishment of these gateways in each state. The gateways would facilitate the purchase of health insurance at an affordable price by qualified individuals and groups (modeled after the Federal Employee Health Benefits Program). There could be more than one gateway per state or one regional gateway for several states.

Prevention and wellness. The AHCA would create a new federal interagency council to develop a national health strategy and funding to support prevention and wellness efforts. The bill would provide coverage of preventive services and eliminate co-payments and deductibles for these services; and would offer grants for community initiatives. Prevention and wellness would be emphasized as one strategy to reduce health care costs.

Reducing costs. Cost reductions would be attained not only through disease prevention measures, but also by improving health care quality, applying information technology, and reducing fraud, abuse and unnecessary procedures. Disease prevention would be promoted by giving individuals information on how to take care of themselves, including healthy nutrition and promotion of early diagnosis of heart disease, cancer and depression.

Common elements

The three major reform proposals from the Senate Finance Committee (a framework rather than a formal proposal), the Senate HELP Committee (the Affordable Health Choices Act as amended July 2), and the House Tri-Committee, share the following elements:

- an individual mandate;
- a health insurance exchange through which individuals and businesses (small businesses in the two Senate committees proposals) can purchase health insurance;
- subsidies for individuals/families with incomes of up to 400 percent of the federal poverty level;
- new rules for the individual and small group insurance markets;
- guaranteed issue and renewability requirement for individual and small group insurers; limited rate variation only for family status, age and geography;
- state involvement in some way, primarily administrative;
- targeting of fraud, waste and abuse to reduce costs;
- promotion of prevention and wellness;
- support of comparative effectiveness research;
- strengthening of primary care and chronic care management, including expanding the primary care medical professional workforce; and
- Medicaid expansion.

The HELP Committee's exchanges are "state-based [and state established] American Health Benefit Gateways." The House Tri-Committee and the Senate HELP Committee proposals include an employer play-or-pay mandate, except for "certain small employers," and credits for small employers to offset the cost of coverage. The HELP Committee and Tri-Committee proposals both would prohibit preexisting condition exclusions.

Public option. A public health insurance option, a feature that President Obama considers essential to keep private health insurance companies "honest," is included in the Senate HELP Committee's proposal, and in the House Tri-Committee proposal. The Senate Finance Committee appears to have dropped such an option, presumably in the interest of bipartisanship. The public option would be offered through the exchange along with private plans and the public and private plans must meet the same requirements for benefits levels, provider networks, cost-sharing and consumer protections. The HELP Committee would have the federal Department of Health and Human Services (HHS) run the public option.

Payment rates. The House Tri-Committee proposal sets out public plan payment rates at Medicare rates with bonus payments for providers who participate both in Medicare and the public plan. The HELP Committee would have HHS negotiate rates and premiums, with rates up to the local average private rates.

Modernization. Health care system "modernization" would be achieved through investment in training of medical personnel, including doctors, nurses, and other professionals, and focusing on improved care coordination. Long-term care and services would enable the elderly and disabled to live at home by providing access to affordable home adaptive measures, as well as caregivers and other support personnel.

President's reform principles

"The most significant driver by far of our long-term debt and our long-term deficits is ever-escalating health care costs," President Barack Obama noted after a meeting in May with House Democratic leaders. "And if we don't reform how health care is delivered in this country, then we are not going to be able to get a handle on that."

"In addition to the implications for the federal budget, obviously we're also thinking about the millions of American families out there who are struggling to pay premiums that have doubled over the last decade – rising four times the rate of their wages – and 46 million Americans who don't have any health insurance at all," he added.

"Businesses are using money to pay their rising health care costs that could be going to innovation and growth and new hiring," Mr. Obama pointed out. "Far too many small businesses are dropping health care altogether. In fact, you've got small business owners who can't afford health care for themselves, much less for their employees. And ... pressures on Medicare are growing, which only underscores the need for reform."

President Obama has identified the following eight principles to which comprehensive health care reform should adhere:

1. Protect families' financial health through reduced insurance premiums and related costs for individuals and businesses.
2. Make health care more affordable by reducing high administrative costs, unnecessary tests and services, waste, fraud and abuse, and other "inefficiencies."
3. Aim for coverage "universality" and put the United States "on a clear path to cover all Americans," not necessarily to cover all Americans within ten years.
4. Ensure portability of coverage so that workers are not tied to their jobs in order to have health insurance coverage and so that individuals with preexisting health conditions are not precluded from obtaining and keeping coverage.
5. Guarantee choice of health care plans and of medical providers with the option of keeping employment-based coverage.
6. Invest in prevention and wellness through public health services and through insurance access to "proven" preventive treatments. The American Recovery and Reinvestment Act (ARRA), enacted on February 17, 2009, includes $1 billion for prevention and wellness initiatives.
7. Improve care quality and patient safety with implementation of proven patient safety measures, and incentives to reduce the great variations in treatments across areas and providers, and promote use of health information technology, and development and dissemination of treatment effectiveness data. The ARRA includes $1.1 billion for comparative effectiveness research**.**
8. Maintain long-term fiscal sustainability by ensuring that the reform pays for itself through cost-growth reduction and improved productivity.

Medicare and Medicaid

Three House committees have approved slightly different versions of *America's Affordable Heath Choices Act* (H.R 3200). As of late August, there was no complete legislative text for each of these three versions, so this analysis will focus on HR 3200 as it was introduced on July 17th.

Comment: *One of the many underreported aspects of the House health care reform bill – over 600 of the 1,000 pages of this legislation would enact changes to the Medicare or Medicaid programs.*

Medicare Part A

Inpatient hospitals. A productivity adjustment is incorporated into the market basket update for inpatient hospitals, skilled nursing facilities, inpatient rehabilitation hospitals, psychiatric hospitals and hospice care, starting in 2010.

Impact: *Hospitals already face possible reductions to their Medicare payments if they do not report certain quality measures or do not adapt meaningful use of electronic medical records. This provision would set a floor for the market basket update so that it would not go below zero in any given year.*

Skilled nursing facilities: The market basket update would be frozen for second, third and fourth quarters of fiscal year (FY) 2010. The recalibration factor for the FY 2010 prospective payment system update would be codified. The Secretary of Health and Human Services (HHS) would be directed to analyze payments for non-therapy ancillary services, and an outlier payment would be created for these services.

Report on disproportionate share hospitals. The Secretary of HHS would be required to submit a report to Congress by January 1, 2016 on disproportionate share hospital (DSH) payments.

Comment: *If more people are covered by health insurance either under a public option or private insurance plan, hospitals may see a drop in patients who are either Medicaid-eligible or who receive uncompensated care because they are uninsured. Consequently, hospitals may be eligible for lower DSH payments.*

Hospices: The phase-out of the Medicare hospice budget neutrality adjustment factor (BNAF) would be extended through fiscal year 2010.

Impact: *The hospice BNAF increases payments to hospices that would otherwise experience a payment reduction by raising hospice payments by amounts that would make overall payments budget neutral to the levels they would have been at had the wage adjustment data from the Bureau of Labor Statistics (BLS) been used. The Centers for Medicare and Medicaid Services (CMS) stopped using BLS data in 1997.*

Medicare Part B

Physician services: The sustainable growth rate (SGR), the formula used to adjust Medicare physician

payments each year, would be reformed. The reformed SGR would not reduce physician pay rates to offset increases in spending on pharmaceuticals or lab services.

Physicians who practice in areas of the country that are identified as being the most cost-efficient would receive incentive payments. Incentive payments also would be extended through 2012 under the Physician Quality Reporting Initiative.

Impact: *Primary care physicians would likely see annual payment increase grow at a higher rate than other physicians.*

Miscellaneous Part A Provisions: CMS would no longer have the option to purchase power-driven wheelchairs with a lump-sum payment at the time that a chair is supplied, but could only make payments over a 13-month period. The rule providing for payment at cost for brachytherapy services would be extended through the end of 2011. HHS would be required to study the development of a cost report for ambulatory surgical centers (ACS) within two years; ASCs would be required to submit quality data starting in 2012. Payments for practice expense units for imaging services would be increased to reflect a presumed utilization rate of 75 percent instead of 50 percent.

Medicare Part A and B

Hospital readmissions. Starting in FY 2012, hospitals would face adjustments in payments based on the dollar value of each hospital's percentage of potentially preventable Medicare readmissions for three specific conditions or procedures that are high volume or high expenditure in nature. The policy may be expanded to cover more conditions in future years. Hospitals could face further payment adjustments based on the hospital's performance in readmissions compared to a national ranking of hospitals.

Comment: *In the spring of 2009, CMS started a pilot program aimed at reducing readmissions. A CMS study concluded that one in five patients who leave a hospital will be readmitted within a month and that more than three-quarters of these readmissions are potentially preventable.*

Post-acute care payments: HHS is directed to develop a plan to create a bundled payment plan for post-acute care services aimed at: (1) improving the coordination, quality, and efficiency of such services; and (2) reducing the need for readmission to hospitals from post-acute care providers.

Physician referrals: Physicians would be prohibited from having an ownership interest in hospitals that are new as of January 1, 2009. It also would increase the reporting and disclosure requirements regarding physicians with ownership interests in any Medicare –participating hospital.

Medicare Advantage (Part C)

Fee-for-service payment rates. Medicare Advantage (MA) payments would be reduced to match fee-for-service payments by 2013.

Comment: *Studies have shown that private insurance companies that offer Medicare Advantage plans are paid an average of 114 percent of what Medicare pays for fee-for-service Medicare for similar services. Reducing payments for Medicare Advantage is seen as one of the biggest cost saving measures under any health care reform legislation.*

The legislation also provides for bonus payments to high quality Medicare Advantage plans; greater authority for CMS to adjust risk scores in MA plans for differences in coding patterns as compared to fee-for-service payments; and the elimination of the MA regional plan stabilization fund.

MA beneficiary protections. MA beneficiaries would not face higher cost-sharing than beneficiaries under traditional fee-for-service Medicare. CMS would be required to publish standardized information on medical loss ratios for MA plans. Plans that had medical loss ratios below 85 percent would be required to provide rebates to enrollees. Special needs plans (SNP) that cover beneficiaries with chronic conditions would only be able to enroll them during the beneficiaries' eligibility periods. The SNP program would be extended through 2012.

Medicare Part D

Eliminating the "donut" hole. The existing coverage gap, or "donut" hole, in prescription drug plans would be phased out by 2023.

Comment: *The donut hole was put in place when Medicare Part D was created in 2003. Its purpose was political, not practical. Congress had to make the legislation that enacted Medicare Part D budget neutral and*

requiring a large "gap" in prescription drug coverage, where the government paid nothing and the beneficiary shouldered the entire cost of prescription drugs, was one of the ways that the legislation could pass scrutiny by the Congressional Budget Office.

Drug discounts. Drug manufacturers would be required to provide discounts of up to 50 percent for brand-name drugs used by Part D enrollees who have fallen into the "donut" hole, while it is being phased out.

Formulary changes. Part D enrollees would be allowed to change Part D plans mid-year if the plan makes a change to its drug formulary that either increases the cost to enrollees or reduces coverage.

Rural health care

Telehealth benefits are extended to beneficiaries receiving care from freestanding dialysis centers. The floor on geographic adjustments to the work portion of the physician fee schedule would be extended through the end of 2011.

Impact: *Payments to physicians under the physician fee schedule are adjusted based on the variation in costs in different parts of the country. This change is designed to increase physician fees in rural areas.*

Medicare beneficiary improvements

Low-income beneficiaries. The assets test for eligibility for the Part D low-income subsidy would be increased to $17,000 for individuals and $34,000 for couples in 2012. Part D cost-sharing would be eliminated for beneficiaries receiving care under a home- and community-based waiver who would otherwise receive care in an institution.

Reducing health disparities. HHS would be required to conduct a study on how well Medicare providers use language services for beneficiaries with limited English proficiency. A demonstration program would be created to provide Medicare reimbursement for culturally and linguistically appropriate services.

Advance care planning. Every five years, Medicare would cover consultations between a beneficiary and his or her providers on options regarding advance care planning. Measures on advance care planning also would be incorporated into the physician's quality reporting initiative.

Comment: *This provision is what led to some commentators to wrongly state that the federal government was advocating "death panels" for the elderly. This benefit is an optional one. However, since it would be available every five years once a beneficiary enrolled in Medicare at age 65, it could be very beneficial for beneficiaries and their families. It would help beneficiaries to establish conditions for "end of life" care when they were relatively healthy, and then review that plan on a regular basis as they got older.*

Miscellaneous improvements. Exceptions to statutorily set limits on physical and occupational therapy have been extended to the end of 2011. The 36-month limitation on Medicare coverage of immunosuppressive drugs for kidney transplant patients would be deleted. A demonstration program would be established that uses patient decision aids to help beneficiaries better understand their medical treatment options.

Promoting primary & coordinated care

Accountable care organizations. An accountable care organization (ACO) pilot program would be established, creating an alternative payment model for physician-led organizations that take more responsibility for the costs and quality of care provided to their patients. Qualifying ACOs would receive incentive payments if expenditures for applicable beneficiaries are less than a target spending or growth level.

Comment: *An ACO might include a group of physicians in one hospital; an independent practice association; or a group practice. ACOs could include nurse practitioners and physician assistants.*

Medical home pilot program. A medical home pilot program would be established for the purpose of evaluating the feasibility of reimbursing qualified patient-centered medical home services to high-need beneficiaries. A medical home could be either an independent patient-centered model or a community-based model.

Primary care physicians. The payment rate for physicians providing primary care would be increased five percent. Eligible practitioners practicing in health shortage areas would receive an additional five percent. Nurse-midwives would receive the same payment rate as physicians for performing the same services;

currently, nurse-midwives receive 65 percent of what physicians are paid. All beneficiary cost-sharing for preventive services would be waived. The payment rate under the physician fee schedule for mental health services would be increased five percent for two years, through the end of 2011.

Quality

Comparative effectiveness research. HHS would establish a Center for Comparative Effectiveness Research and Quality to conduct, support, and synthesize research on the outcomes, effectiveness and appropriateness of health care services and procedures. Among the Center's duties would be to encourage the development of clinical registries and the development of clinical effectiveness research data networks from electronic health records, post-marketing drug and medical device surveillance efforts, and other forms of electronic health data.

Nursing home transparency. Skilled nursing facilities (SNF) and nursing facilities (NF) would be required to disclose information on facility ownership and organizational structure. SNFs and NFs also would be required to establish compliance and ethics programs. Date would be added to the Nursing Home Compare website regarding SNF and NF staff and summary information on complaints filed against SNFs and NFs.

HHS would be able to impose civil money penalties for a facility deficiency that results in the death of a resident. HHS and the HHS Inspector General would be directed to establish a pilot program to develop an independent monitor to oversee interstate and large intrastate SNF and NF chains.

Quality measurements. HHS would be required to establish and regularly update national priorities for performance improvement.

Comment: *Priority is to be given to health care services that: (1) address health care provided to patients with prevalent, high-cost chronic diseases; (2) have the greatest potential to decrease morbidity and mortality; (3) have the greatest potential for improving the performance, affordability, and patient-centeredness of health care; (4) address health disparities across groups; and (5) have the potential for rapid improvement due to existing evidence or standards of care.*

HHS also is charged with developing, testing, and updating new patient-centered and population-based quality measures for the assessment of health care services. Each year a multi-stakeholder group would provide recommendations for the adoption of specific quality measures on a timely basis.

Physician payments sunshine provision

Financial relationships between providers and suppliers. Manufacturers or distributors of covered drugs, biologicals, or medical supplies would be required to report any payments above $5 to a "covered recipient," which includes a physician, physician group practice, a pharmacy or pharmacist, a health insurance company, pharmacy benefit manager, hospital, medical school, sponsor of a continuing education program, a patient advocacy or disease specific group, an organization of health care professionals, a biomedical researcher, or a group purchasing organization. Hospitals or other entities that bill Medicare would be required to report any ownership share by a physician. Failure to report this information is subject to civil money penalties.

Medicare graduate medical education

Unused residency positions. HHS is directed to redistribute residency positions that have been unfilled for the prior three cost reports; the redistributed slots would go to training primary care physicians. HHS also would be required to redistribute residency slots from closed hospitals to other hospitals in the same state.

Nonprovider settings. Any time spent by a resident in a non-provider setting will count toward a hospital's indirect and direct Medicare graduate education if the hospital pays the costs of the resident's stipends and fringe benefits.

Impact: *The goal here is to increase the number of primary care services that can be provided in non-hospital settings, such as rural health clinics and federally qualified health centers.*

Program integrity

Fraud and abuse. An additional $100 million would be provided for the Health Care Fraud and Abuse Control Fund. New and expanded penalties would be provided for a variety of health care fraud and abuse actions. The penalties apply to such things as false statements made on provider or supplier enrollment applications; submission of false statements related to a false claim; delaying inspections requested by the

Inspector General; actions by individuals excluded from Medicare participation; providing false information by Medicare Part C or D plans; and obstruction of program audits.

CMS authority. CMS would receive enhanced authority to prevent waste, fraud and abuse. Screening procedures for new providers would be implemented, including licensing board checks, background checks, screening lists of individuals excluded from other federal and state health programs, and unannounced pre-enrollment site visits.

Medicare Integrity Program. MIP contractors would be required to conduct periodic self-evaluations and report on the effectiveness of their activities.

Deadline for submission of claims. The period of time by which Medicare providers would have to file claims would be reduced from 36 months to 12 months.

Comment: *Congress is concerned that the existing 36-month period for filing Medicare claims presents opportunities for fraud schemes in which processing patterns of CMS can be observed and exploited. Congress claims that reducing the maximum claims submission period to 12 months after services are provided will not overburden providers and will reduce fraud and abuse.*

Physician requirements. Physicians who order durable medical equipment (DME) or home health (HH) services billable to Medicare would be required to be Medicare-enrolled physicians. Physicians also would be required to meet face to face with a patient before certifying DME or HH services.

Overpayments. Medicare providers or suppliers would be required to report and return Medicare overpayments within 60 days of becoming aware of the overpayment.

Registering with HHS. Any agent, clearinghouse or other alternative payee that submits claims on behalf of a Medicare or Medicaid health provider would be required to register with HHS.

Access to information. The Department of Justice would have access to Medicare and Medicaid claims data. Duplication between the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank would be eliminated.

Medicaid and CHIP

Expanded eligibility. Effective in 2013, non-disabled, childless adults under age 65 and parents and individuals with disabilities with incomes at or below 133 percent of the federal poverty level ($14,400 per year for an individual); and newborns up to the first 60 days of life who are not otherwise covered by health insurance would be eligible for Medicaid. The federal government would pay 100 percent of the cost of coverage.

CHIP program. States would be prohibited from adopting eligibility standards in their Children's Health Insurance Programs (CHIP) that are more restrictive than those in effect as of June 16, 2009.

Medicaid DSH. HHS would be required to report to Congress by January 1, 2016 on the continuing role of Medicaid disproportionate share hospital payments.

Preventive services. Effective July 1, 2010, state Medicaid programs would be required to cover preventive services not otherwise covered, as determined by HHS. States would be required to cover smoking cessation programs. States would have the option, as of January 1, 2010, to cover home visits by trained nurses to families with a first-time pregnant woman or child under age two eligible for Medicaid. States also would have the option of providing coverage for family planning services and supplies for low-income women who are not pregnant.

Access. Primary care payments under Medicaid would increase to no less than 80 percent of Medicare rates in 2010; 90 percent in 2011; and 100 percent in 2012. A five-year pilot program to test the medical home concept with high-need beneficiaries would be established. A 75-percent federal matching rate for costs if translating or interpretive services would be provided. State Medicaid programs would be allowed to cover services provided in free-standing birthing centers.

Coverage. For three years, state Medicaid programs would be allowed to cover individuals with HIV with incomes and resources below state eligibility levels for individuals with disabilities. The transitional Medicaid program, which provides health coverage for families leaving cash assistance for work would be extended two years, through the end of 2012.

Financing. Extends existing rules for Medicaid payments to pharmacists for multiple-source drugs through the end of 2010; then, Medicaid payments for such drugs would be limited to 130 percent of the weighted average manufacturer price (AMP). The minimum manufacturer rebate for brand-name drugs purchased by state Medicaid programs would be increased from 15.1 percent of AMP to 22.1 percent of AMP.

Waste, fraud and abuse. Federal matching payments would be prohibited for the cost of health care-acquired conditions that are determined to be non-covered services under Medicare. Providers and suppliers (other than physicians and hospitals) participating in Medicaid would

be required to adopt programs to reduce waste, fraud and abuse. State Medicaid programs would have up to one year to return the federal share of overpayments to providers due to fraud. States would be required to terminate from their Medicaid programs, entities or individuals who have been terminated from Medicare, other federal health programs, or other Medicaid programs.

Miscellaneous provisions. The "45-percent" trigger provision of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) would be repealed.

Comment: *The MMA requires the President to submit legislation to Congress, and Congress to act swiftly on it, if, in two consecutive years, general revenue Medicare funding expressed as a percentage of total Medicare outlays is in excess of 45 percent. The legislation would be designed to eliminate excess general revenue Medicare funding for the next seven years. Although the "funding warning" has been issued by the Medicare trustees the last three years, Congress has always voted to delay considering any legislation to address the issue.*