



SIDE-BY-SIDE COMPARISON OF KEY MEDICARE PROVISIONS IN 2009 HEALTH REFORM LEGISLATION: H.R. 3200 and Senate Finance Committee Chairman's Mark

This document provides a description of key Medicare provisions of 2009 health reform legislation, including H.R. 3200, America's Affordable Health Choices Act, as introduced July 14, 2009 and amended by the House Committee on Ways & Means and the House Committee on Energy & Commerce¹ and the Senate Finance Committee Chairman's Mark of the America's Healthy Future Act of 2009, as introduced on September 16, 2009 and passed by the Committee on October 13, 2009. The document describes the major provisions relating to Medicare benefit changes, Medicare Advantage, the Medicare Part D prescription drug benefit, physician and other provider payment reforms, and other health system reforms. The summary will be updated to incorporate changes made during the legislative process. For more information about health reform legislation, see www.kff.org/healthreform/sidebyside.cfm. For a one-page summary of key Medicare provisions, see www.kff.org/healthreform/7948.cfm.

H.R. 3200: America's Affordable Health Choices Act of 2009 (as introduced on July 14, 2009 and amended)	Senate Finance Committee Chairman's Mark: America's Healthy Future Act of 2009 (as passed by the Committee on October 13, 2009)
BENEFIT AND PREMIUM CHANGES	
<p>Eligibility, enrollment and benefits for Medicare Savings Program (MSP) and Low Income Subsidies (LIS) under Part D</p> <ul style="list-style-type: none"> Increases the asset limit used to determine eligibility for the Medicare Savings Programs and for Part D low-income subsidy (both full and partial) recipients to \$17,000/individuals and \$34,000/couples effective January 1, 2012, and indexes the asset limit to inflation in subsequent years. Under current law, the asset limit used to determine eligibility is \$4,000/individuals and \$6,000/couples for the Medicare Savings Programs, \$6,600/individuals and \$9,910/couples for the full Part D low-income subsidy recipients and \$11,010/individuals and \$22,010/couples for partial low-income subsidy recipients in 2009. In determining their assets, Part D low-income subsidy applicants are allowed to exclude the value of a life insurance policy. [Sec 1201] Eliminates Part D cost sharing for non-institutionalized full-benefit dual eligibles who would require institutional care if not for provision of home- and community-based care under Medicaid. Effective January 1, 2011. [Sec 1202] Allows individuals to self-certify (with administrative verification) income and assets when applying for LIS under Part D, as of 2010. Allows IRS to disclose information to the Social Security Administration (SSA) to assist SSA in identifying individuals likely to be LIS eligible. [Sec 1203] 	<p><i>No similar provision to increase asset threshold for MSP and Part D LIS.</i></p> <p>Funds outreach and education activities related to MSP and LIS, through 2012. [Title III, Subtitle B, Part III]</p> <p>Requires that the redetermination of eligibility for the surviving spouse of an LIS-eligible couple occur no earlier than one year from the next redetermination that would have occurred after the death of a spouse, beginning in 2011. [Title III, Subtitle B, Part III]</p> <p>Eliminates Part D cost sharing for non-institutionalized full-benefit dual eligibles, similar to the House provision, effective January 1, 2011.</p>

¹ The House Committee on Education & Labor adopted the bill with no amendments to Medicare-related provisions.

BENEFIT AND PREMIUM CHANGES (continued)		
<p>Eligibility, enrollment and benefits for Medicare Savings Program (MSP) and Low Income Subsidies (LIS) under Part D (continued)</p>	<ul style="list-style-type: none"> • Provides for the LIS benefit to be retroactive to the effective date of LIS qualifying assistance. For beneficiaries automatically enrolled into a Part D plan, the effective date is the date on which the individual is entitled to benefits under Medicare and Medicaid. [Sec 1204] • Extends through 2012 the Qualified Individual (QI) program that provides Part B premium assistance to Medicare beneficiaries with incomes between 120% and 135% of poverty, and effective January 1, 2011, eliminates the limit on federal matching funds. [Sec. 1782; Sec 1201-1207; 1801, see Part D LIS plans below] 	
<p>Preventive services</p>	<p>Waives deductible and coinsurance for Medicare-covered preventive benefits, as of January 1, 2011. [Sec. 1305 and 1306]</p> <p>House Energy & Commerce (E&C) amendment to Sec. 1305: Requires the Secretary to report to Congress on beneficiary barriers to preventive services, within 12 months of the date of enactment, and to prioritize patient and physician education about the risk factors for an abdominal aortic aneurysm.</p> <p>House Ways & Means (W&M) amendment to Sec. 1305: Corrects reference to preventive services.</p> <p>W&M amendment to Sec. 1306: Adds reference to waive co-payment and deductibles for beneficiaries undergoing screening colonoscopy and ancillary tissue removal.</p> <p>Provides Medicare coverage for all federally recommended vaccines, as of January 1, 2010. [Sec. 1310]</p> <p><i>No similar provision to cover an annual comprehensive health risk assessment.</i></p>	<p>Waives deductible and coinsurance for Medicare-covered preventive services rated A or B by the U.S. Preventive Services Task Force (USPSTF). [Title II, Subtitle A]</p> <p><i>No similar provision to cover federally recommended vaccines.</i></p> <p>Provides access to and waives coinsurance and deductibles for an annual comprehensive health risk assessment and a personalized prevention plan. Requires the health risk assessment to be completed prior to or during the annual wellness visit. Allows Medicare coverage for either an initial preventive physical examination (IPPE) or the annual wellness visit in the same year. [Title II, Subtitle A]</p> <p>Provides the Secretary the authority to modify coverage of preventive services in accordance with the USPSTF, for any indication or population. Provides funding for the Centers for Medicare and Medicaid Services (CMS) to improve provider education and patient awareness of covered preventive services. Requires GAO studies to assess barriers to use of preventive services and the impact of coverage of immunizations under Part D. [Title II, Subtitle A]</p> <p>Requires the Secretary to establish an initiative providing incentives to beneficiaries for completing a healthy lifestyles program, and submit a preliminary evaluation to the Congress as of January 1, 2014. [Title II, Subtitle A]</p>
<p>Other services</p>	<p>Requires Medicare to cover immunosuppressive drugs indefinitely for kidney transplant recipients. Immunosuppressive drugs are currently covered for 36 months. [Sec. 1232]</p> <p>Requires coverage of consultations for advanced care planning, which may include formulating an order for life-sustaining treatment, for a beneficiary who has not had a consultation within 5 years, effective January 1, 2011. More frequent consultations permitted if there is a significant change in the health of an individual. Consultations may be provided by physician or nurse practitioners and physician assistants with authority under state law to sign order for life-sustaining treatments.</p>	<p>Prohibits federal funds from being used to pay for assisted suicide and offers conscience protections to providers or plans refusing to offer assisted suicide services.</p> <p>Establishes an Elder Justice Coordinating Council within HHS to prevent, detect, treat, understand, intervene in, and, where appropriate, aid in the prosecution of elder abuse, neglect, and exploitation.</p>

BENEFIT AND PREMIUM CHANGES (continued)		
<p>Other services (continued)</p>	<p>Requires the Secretary to include measures on end of life care and advanced care planning in the Physician's Quality Reporting Initiative, to the extent measures have been endorsed or adopted by a consensus-based organization. [Sec. 1233]</p> <p>E&C amendment (new section): Provides coverage for post-mastectomy external breast prosthesis garments regardless of whether garments are supplied prior to or after the breast cancer surgical procedure. [Sec. 1150]</p>	
<p>Disparities and culturally appropriate services</p>	<p>Requires the Secretary to study and report on means to ensure effective communication in Medicare, including appropriate language and interpreter services. Subjects Medicare Advantage plans to sanctions if they fail to provide required language services. Provides funding for providers to improve communication. [Sec. 1221 and 1222]</p>	<p>Establishes uniform categories for collecting data on race and ethnicity, gender, and primary language. Requires CMS to collect data on people with disabilities, focusing on access to care. [Title I, Subtitle H]</p> <p>Requires population surveys to collect sufficient data on racial and ethnic subgroups to generate statistically reliable results. Requires HHS to share health disparities data, measures, and analyses with other relevant agencies and requires the Secretary to ensure that all appropriate privacy and security safeguards are followed for health disparities data collection, analysis, and sharing. [Title I, Subtitle H]</p>
<p>Part B premium</p>	<p><i>No similar provision.</i></p>	<p>Freezes the current income thresholds for higher Part B premiums from 2011 to 2019. Under current law, thresholds are indexed to rise each year with the consumer price index. In 2009, beneficiaries with incomes greater than \$85,000, \$107,000, \$160,000, and \$213,000 pay 35%, 50%, 65%, and 80% of the program's costs per elderly enrollee, respectively. Income thresholds are doubled for married couples. [Title III, Subtitle E]</p>
MEDICARE ADVANTAGE REFORMS		
<p>Payment reforms</p>	<p>Phases in a change in payment for Medicare Advantage plans (except for PACE plans) to 100% of Medicare fee-for-service (FFS) costs using a blended benchmark by 2013:</p> <ul style="list-style-type: none"> • 2011 benchmark = 2/3 local benchmark for the area + 1/3 of FFS costs for the area; • 2012 benchmark = 1/3 local benchmark for the area + 2/3 FFS costs for the area; • 2013 benchmark = 100% of FFS costs for the area. <p>In no case would the blended benchmark be less than 100% of the FFS amount. For all years, the FFS cost amount is adjusted to account for the phase-out in indirect medical education from the Medicare Advantage capitation payment rates. [Sec. 1161]</p> <p>Provides bonus payments to high-quality plans equal to an increase in the blended benchmark amount of 1.0% in 2011, 2.0% in 2012 and 3.0% in 2013 and subsequent years. Provides bonus payments to plans identified as improved quality plans equal to an increase in the blended benchmark amount of 0.33% in 2011, 0.66% in 2012, and 1.0% in 2013 and subsequent</p>	<p>Reduces Medicare Advantage national per capita growth percentage for plan payment by 3 percentage points, for the 2011 plan year. Phases in a change in payment for all Medicare Advantage plans (except regional plans, PACE plans, and cost plans) and bases payment on the enrollment-weighted average plan bid by 2015 for the payment area:</p> <ul style="list-style-type: none"> • 2012 benchmark = 2/3 local benchmark for the area + 1/3 average plan bid for the area; • 2013 benchmark = 1/3 local benchmark for the area + 2/3 average plan bid for the area; • 2014 benchmark = 100% of enrollment-weighted average of 2013 plan bids, increased by the Medicare Advantage growth percentage for 2014; • 2015 benchmark = 100% of enrollment-weighted average of bids in a payment area. <p>Prohibits local benchmarks from exceeding levels that would have existed under current law. Calculates regional plan benchmarks as a weighted blend of the regional bids and the new local benchmarks. Provides plans that bid below the benchmark a rebate equal to 100% of the difference</p>

MEDICARE ADVANTAGE REFORMS (continued)		
<p>Payment reforms (continued)</p>	<p>years. Requires the Secretary to publish the list of high-quality and improved-quality plans on the Medicare website, effective 2011. [Sec. 1162]</p> <p>W&M amendment to Sec. 1162: Modifies which plans are eligible for quality bonus payments, increases bonus payments for high quality plans, and eliminates bonus payments to improved plans. Specifically, it provides bonus payments to eligible plans equal to 2.6% in 2011, 5.3% in 2012, and 8.0% in subsequent years.</p> <p>Extends indefinitely the Secretary's authority to adjust Medicare Advantage plan risk adjustment payments for coding intensity; the authority currently ends in 2010. [Sec. 1163]</p> <p>Requires the Secretary to submit a report to Congress that evaluates the adequacy of the risk adjustment system in predicting costs for dual eligibles, beneficiaries with low incomes, and beneficiaries with chronic conditions. Requires the Secretary to implement any changes in the risk adjustment system by 2012. [Sec. 1167]</p> <p>Eliminates the Medicare Advantage Regional Plan Stabilization Fund; transfers any remaining amounts to the Medicare Supplementary Medical Insurance (SMI) Trust Fund. [Sec. 1168]</p> <p>E&C amendment (new section): Requires CMS to conduct a study (and report to Congress within one year of enactment) to determine potential effects of calculating MA payments rates on a more aggregated geographic basis (e.g., MSAs) rather than using county boundaries. [Sec. 1169]</p>	<p>between the plan bid and the benchmark, beginning in 2014. Maintains requirement for plans to use rebates for additional benefits to the enrollees.</p> <p>Requires the Secretary to establish new payment areas for urban areas that correspond to Metropolitan Statistical Areas (MSAs) and reflect patterns of health care, for plan year 2012. Requires the Secretary to combine one or more rural counties in a state into a single service area, for plan year 2015. Makes bidding and service areas the same as payment areas, beginning in 2012.</p> <p>Beginning in 2014, provides bonus payments for care coordination and management activities, higher than average quality, and improved quality. Plans would be required to use any bonus payments to provide extra benefits to their enrollees. Provides additional quality bonus for prior year achievement (three or more stars) or improvement (for plans that did not receive at least a three-star rating, if their ratings improved over the prior year).</p> <p>Requires PFFS plans not sponsored by employers to establish contracted networks of providers in areas served by two or more organizations, rather than two or more plans, as is currently required.</p> <p>Allows Cost plans to continue to operate, regardless of any other MA plans serving the area, until 2013.</p> <p>[Title III, Subtitle C]</p>
<p>Special Needs Plans (SNPs)</p>	<p>Limits enrollment in chronic care special needs plans (SNPs) to either the annual, coordinated open enrollment period or when an individual is diagnosed with a disease or condition that qualifies them for a SNP, beginning in January 2011. Extends the ability of chronic care or institutional SNPs to restrict enrollment to defined special needs populations from January 2011 to January 2013, and to January 2016 for SNPs serving dual eligibles. Grandfathers plans that had a contract with a state to operate an integrated Medicaid-Medicare program approved by CMS as of January 1, 2004. [Sec. 1176 and 1177]</p> <p>E&C amendment (new section): Creates Medicare Senior Housing plans, similar to the Erickson demonstrations, for individuals residing in a continuing care retirement community that provides onsite primary care services, provides transportation services to providers outside the facility, and uses health information technology. Plans must be offered by a Medicare Advantage organization that offered a plan under the Erickson demonstrations. Payments would be capped at the greater of current Medicare Advantage payments or the costs of care under FFS.</p>	<p>Limits enrollment in SNPs to those who meet the definitions for the plan. Requires all SNPs serving dual eligibles to have contracts with state Medicaid programs by 2013. Provides additional payment adjustment for frailty to SNPs for the dually eligible if the plan fully integrates Medicare and Medicaid benefits and payments, including the provision of long-term care. Applies all changes to payment, payment and service areas, rebates, and bonuses to apply to SNPs in same manner as they apply to Medicare Advantage plans. Requires SNPs to be certified by NCQA beginning in 2012. Permits the Secretary to design the certification criteria in conjunction with NCQA. Requires the Secretary to use a new risk score for new enrollees in SNPs, beginning in 2011. Requires the Secretary to evaluate and revise the methodology for risk adjusting MA payments, for 2011 and thereafter. [Title III, Subtitle C]</p> <p>Creates Erickson SNPs, beginning in 2011. Extends SNP authority until December 31, 2013. [Title III, Subtitle C]</p>

MEDICARE ADVANTAGE REFORMS (continued)		
<p>Enrollment period</p>	<p>Moves up the annual coordinated election period by two weeks (to November 1 through December 15) to provide CMS and plans additional time to process enrollment applications beginning in 2011. Eliminates the one-time change of enrollment option under which new Medicare Advantage enrollees are currently permitted to change their selection one time during the first three months of the year. [Sec. 1164]</p> <p>Allows beneficiaries to select a different Medicare Advantage plan outside of the enrollment period if they are enrolled in a plan in which enrollment is suspended. Permits the Secretary to take into account the health or well-being of the individual in determining other exceptional circumstances in which a beneficiary could change plans outside of the enrollment period. [Sec. 1172]</p>	<p>Changes the annual enrollment period for Medicare Advantage and Part D to October 15 to December 7, effective 2011. Eliminates the open enrollment period of January 1 to March 31. Allows beneficiaries who enroll in Medicare Advantage during the annual enrollment period to choose to disenroll and return to FFS between January 1 and February 15, beginning in 2011. [Title III, Subtitle C]</p>
<p>Benefits, cost sharing and premiums</p>	<p>Limits the cost-sharing that a Medicare Advantage plan may impose to no more than would apply under FFS Medicare, beginning in 2011. Extends current law to prohibit Medicare Advantage plans from imposing cost-sharing requirements that exceed amounts imposed under FFS Medicare or Medicaid for beneficiaries dually eligible for Medicare and Medicaid, including Qualified Medicare Beneficiaries (QMBs). Permits cost sharing under Medicare Advantage plans to take the form of coinsurance, copayments, or per-diem rates. [Sec. 1171]</p>	<p>Prohibits plans from charging cost-sharing greater than FFS Medicare for certain services, including chemotherapy treatment, renal dialysis, and skilled nursing care, and others identified by the Secretary, beginning in 2011.</p> <p>Requires plans to use rebates and bonuses in the following order:</p> <ol style="list-style-type: none"> 1) Meaningfully reduce cost-sharing, defined as copayments, coinsurance, deductibles, and out-of-pocket caps on total beneficiary spending; 2) Add preventive and wellness benefits, such as preventive care visits, smoking cessation programs, and free flu shots; and 3) Add non-covered benefits, such as eye exams and dental coverage. <p>Prohibits rebates and bonuses from being used to reduce premiums. [Title III, Subtitle C]</p> <p>Allows plans to grandfather the extra benefits for their current enrollees in areas of the country where average plan bids are at or below 75% of FFS costs, beginning in 2012. The amount of extra benefits would be reduced by 5% beginning in 2013. The Secretary would be required to provide for transitional extra benefits in 2012 to beneficiaries who enroll in Medicare Advantage plans and experience a significant reduction in extra benefits under competitive bidding in certain areas. Requires the Chief Actuary of CMS to determine within three months after enactment whether beneficiaries currently participating in Medicare Advantage would lose Medicare-covered benefits under competitive bidding and strikes the provisions related to Medicare Advantage competitive bidding and bonus payments if the Actuary affirms a loss of Medicare-covered benefits.</p>

MEDICARE ADVANTAGE REFORMS (continued)

Oversight and other
consumer protections

Requires the Secretary to publish standardized information on medical loss ratios and other information for each Medicare Advantage plan. Requires plans with medical loss ratios below 85% to give enrollees a rebate of premiums by such amount as would provide for a ratio of at least 85%. Prohibits plans with medical loss ratios below 85% for 3 consecutive years from enrolling new enrollees under the plan for coverage during the second succeeding contract year. Terminates plans that fail to have an 85% loss ratio for 5 consecutive years. [Sec. 1173]

Permits the Secretary to require a periodic audit of information related to data submitted for risk adjustment, and to take actions necessary to address identified deficiencies beginning for the 2011 contract year and years thereafter. [Sec. 1174]

Reinforces the Secretary's authority to not accept every plan bid. [Sec. 1175]

Enhances penalties for MA and Part D plans that provide false information or violate marketing rules. [Sec. 1616 and 1617; scores not available for individual provisions]

E&C amendment (new sections): Requires the Secretary to request that the National Association of Insurance Commissioners (NAIC) develop standardized marketing requirements for Medicare Advantage and Part D plans; authorizes the Secretary to develop regulations establishing and implementing standardized marketing requirements in the absence of NAIC action; gives states authority to enforce standardized marketing requirements. [Sec. 1906] Requires the Secretary to request that the NAIC make recommendations on the establishment of standardized benefit packages for, and the regulation of, Medicare Advantage and Part D plans. [Sec. 1907]

Requires the Secretary to categorize plans in each payment area into two or more categories (such as bronze, silver, and gold) according to plans' share of rebates, bonuses, and supplemental premiums, beginning in 2011. Any marketing materials must reflect categories. [Title III, Subtitle C]

Requires sponsors of Medicare Advantage and prescription drug plans to develop a uniform exceptions and appeals process by 2012.

Requires the Secretary to develop and maintain a complaint tracking system capable of tracking complains made by a Medicare Advantage or Part D eligible individuals through resolution and making reports.

PRESCRIPTION DRUG BENEFIT (PART D) REFORMS

Coverage gap and
rebates for dual eligibles

- Progressively increases the initial coverage limit and decreases the annual out-of-pocket threshold from the amounts otherwise computed, beginning in 2011 until there is continuous coverage; eliminates the coverage gap by 2023. In 2011, the gap is projected to be \$3,778.
- Requires drug manufacturers to provide to Part D plan sponsors, which in turn are required to provide to beneficiaries, a 50% discount off the negotiated price of covered brand-name drugs dispensed to individuals in the coverage gap after December 31, 2010. Provides that the discount amount is counted towards the true out-of-pocket (TrOOP) threshold (which triggers the catastrophic benefit).
- Requires drug manufacturers to provide Medicaid rebates for any covered outpatient drug the manufacturer dispenses after December 31, 2010 to full-benefit dual eligible Medicare Part D enrollees for which payment was made by a Part D plan. [Sec. 1181 and 1182]

No similar provision to increase initial coverage limit and decrease the out-of-pocket threshold to close coverage gap.

Establishes a discount program for beneficiaries who enroll in Part D and have drug spending that falls into the coverage gap; entitles eligible beneficiaries to automatically receive a 50% discount off the negotiated price for brand-name prescription drugs that are covered under Part D and covered by their plan's formulary and allows 100% of the negotiated price of discounted drugs (excluding dispensing fees) to count toward the annual out-of-pocket threshold that determines when catastrophic coverage begins. Discount does not apply to beneficiaries receiving the Part D low-income subsidy and those required to pay the Part B income-related premium. Stipulates that drugs sold and marketed in the U.S. by a manufacturer would not be covered under Part D unless the manufacturer agrees to participate in this discount program. [Title III, Subtitle D, Part III]

PRESCRIPTION DRUG BENEFIT (PART D) REFORMS (continued)		
<p>Coverage gap and rebates for dual eligibles (continued)</p>	<p>Counts the costs that are incurred by AIDS Drug Assistance Programs (ADAP) and the Indian Health Service (IHS) in providing prescription drugs to a beneficiary enrolled in a Part D plan toward the calculation of the enrollee's true out-of-pocket (TrOOP) costs. Effective January 1, 2011. [Sec. 1184]</p>	<p><i>No similar provision to provide Medicaid rebates.</i></p> <p>Counts the costs that are incurred by AIDS Drug Assistance Programs (ADAP) and the Indian Health Service (IHS) in providing prescription drugs to a beneficiary enrolled in a Part D plan toward the calculation of the enrollee's true out-of-pocket (TrOOP) costs, similar to House provision. Effective January 1, 2011.</p>
<p>Drug price negotiation</p>	<p>E&C amendment (new section): Requires the Secretary to negotiate with pharmaceutical manufacturers the prices (including rebates, discounts, and other price concessions) that may be charged to Part D plan sponsors, beginning with prices for the 2011 plan year. Permits plan sponsors to obtain discounts or price reductions below the price negotiated by the Secretary. Requires the Secretary to report to Congress on negotiations and prices achieved as a result. [Sec. 1186]</p>	<p><i>No similar provision to negotiate with pharmaceutical manufacturers.</i></p> <p>Requires pharmacy benefit managers (PBMs) to share information with the Secretary and with plans with which PBMs contract, including: the percent of all prescriptions provided through mail order, and generic dispensing and substitution rates by location, and the aggregate amount and type of rebates, discounts and price concessions the PBM negotiates on behalf of the plan and the aggregate amount of these that are passed through to the plan sponsor, and the average aggregate difference between the amount the plan pays the PBM and the amount the PBM pays the retail and mail order pharmacy. The information would be treated as confidential.</p> <p>Requires the Inspector General to study prescription drug prices paid by Part D insurers to those negotiated by state Medicaid plans, including rebates and discounts received, and report to Congress by October 1, 2011.</p>
<p>Benefit changes for LIS recipients</p>	<p>Requires that the calculation of the low-income benchmark premium exclude the Medicare Advantage (MA) rebate amounts from the Medicare Advantage Prescription Drug plan premiums, effective January 1, 2011. Under current law, regional benchmarks are calculated based on the average premium, weighted by low-income enrollment, for basic benefits for both stand-alone prescription drug benefits and Medicare Advantage drug plans [1207].</p> <p>Allows the Secretary to use an "intelligent assignment" process for automatic enrollment of full-benefit dual eligibles who do not enroll in a Part D plan, taking into account the coverage of drugs used by the individual, prior authorization requirements, and the overall quality rating of the plan; effective for contract years beginning in 2012. Directs the Secretary to use an "intelligent assignment" process to facilitate the enrollment of LIS-eligible individuals who do not enroll in a Part D plan during the special enrollment period after LIS eligibility is determined; effective for determinations made in January 2011 and thereafter. Individuals may decline or change such enrollment. [Sec 1206]</p>	<p>Requires that the calculation of the low-income benchmark premium exclude the Medicare Advantage (MA) rebate amounts from the Medicare Advantage Prescription Drug plan premiums, effective January 1, 2011. Under current law, regional benchmarks are calculated based on the average premium, weighted by low-income enrollment, for basic benefits for both stand-alone prescription drug benefits and Medicare Advantage drug plans. [Title III, Subtitle B, Part III]</p> <p>Establishes a voluntary de minimus policy authorizing Part D plans to qualify as low-income subsidy benchmark plans if their bids are nominally above the benchmark amount and they absorb the difference between their bid and the benchmark. [Title III, Subtitle B, Part III]</p> <p>Requires Part D plans losing status as benchmark plans for low-income subsidy enrollment to transmit recent drug utilization data to new plans for LIS enrollees being assigned to other plans; requires the new plans to provide information about formulary differences between the new and old plans. [Title III, Subtitle B, Part III]</p>

PRESCRIPTION DRUG BENEFIT (PART D) REFORMS (continued)

Enrollment and other
consumer protections

Permits a Part D enrollee to make a mid-year change in their enrollment if coverage is reduced or the cost sharing is increased for a drug they currently take under their Part D plan. Effective January 1, 2011 [Sec. 1185]

E&C amendment (new section): Restricts the circumstances under which the Secretary may waive the requirement that entities seeking to offer a Part D plan in a state be licensed in that state, beginning with the 2010 plan year, by only allowing the requirement to be waived if the entity has a substantially complete application pending in the state. [Sec. 1176]

Creates a 45-day period (January 1 – February 15) beginning in 2011 in which beneficiaries who enroll in a Part D plan during the annual period could disenroll.

Authorizes the Secretary to identify drug classes of clinical concern, as defined by the Secretary, for Part D formularies; codifies the current six classes of clinical concern as they are currently specified through sub-regulatory guidance until the Secretary issues a rule regarding classes of clinical concern to be protected on plan formularies. [Title III, Subtitle B, Part III]

Requires the Secretary to establish two or more categories of prescription drug plans offered by Part D sponsors based on ranges of the actuarial values of the prescription drug benefits provided under the plans and to ensure that there are meaningful differences between the benefit categories. Requires the Secretary to develop standardized nomenclature, definitions, and language to describe and present the benefit categories on the Part D plan finder and other relevant beneficiary communications. [Title III, Subtitle B, Part III]

Limits removal or change of coverage (including increasing cost sharing or applying utilization management tools) of covered Part D drugs under Part D plan formularies under Part D plans to the date on which plans may begin marketing for the upcoming year; makes exceptions for new generic drugs or safety concerns. Requires plan sponsors to provide each enrollee notification of formulary changes or restrictions on coverage for the upcoming plan year. [Title III, Subtitle B, Part III]

Requires the Secretary to develop a complaint tracking system and a uniform exceptions and appeals process by 2012 for Part D plans, monitor retroactive payments made to full benefit dual eligibles enrolled in a plan under Part D, and report annually on expenditures, access to care, and health outcomes for dual eligibles. Requires the Office of the Inspector General of HHS to report annually on the inclusion of drugs commonly used by dual eligibles on Part D plan formularies.

Allows Part D sponsors to waive copayments for first fills of generic drugs, effective no sooner than 2011.

Requires Part D plans to employ utilization management techniques when dispensing medication to beneficiaries in long-term care facilities.

Requires the Office of the Inspector General to report annually on the inclusion of drugs commonly used by dual eligibles on Part D plan formularies.

PRESCRIPTION DRUG BENEFIT (PART D) REFORMS (continued)		
Part D premiums	<i>No similar provision.</i>	Reduces the Part D premium subsidy for higher-income beneficiaries, similar to the current income-related premium for Part B premiums, beginning in 2011. Inflates the income thresholds by the consumer price index (CPI), but freezes these updates for the period between 2010 and 2019. Expands the current authority for IRS to disclose income information to SSA for purposes of adjusting the Part B subsidy to include the Part D subsidy adjustments and related appeals. [Title III, Subtitle B, Part III]
Retiree drug subsidy	<i>No similar provision.</i>	Repeals the deduction from income currently allowed for Medicare Part D retiree drug subsidy payments received by employers for qualified retiree prescription drug expenses. [Title VI]
PHYSICIAN PAYMENT REFORMS		
Physician fee schedule	Updates the physician fee schedule conversion factor in 2010 by the percentage increase in the Medicare Economic Index (MEI). Annual updates beginning in 2011 determined according to new sustainable growth rate (SGR) methodology with two categories of physician services, each with separate allowed expenditure targets, update adjustment factors, and conversion factors: (1) evaluation and management services and Medicare-covered preventive services; and (2) all other services not described in (1). Allows the revised formula to be updated by the gross domestic product (GDP) plus 2% for evaluation and management services and GDP plus 1% for all other services. [Sec. 1121]	<p>Updates the physician fee schedule conversion factor in 2010 by 0.5%. The conversion factor for 2011 and thereafter would be computed as if the increase in 2010 had never applied. [Title III, Subtitle B]</p> <p>Extends the floor for the geographic index for physician work through December 2012. [Title III, Subtitle B]</p> <p>Requires the Secretary to identify and adjust misvalued physician services, in a budget neutral manner, using specific criteria. [Title III, Subtitle B]</p> <p>Extends the exceptions process for therapy caps through December 31, 2011. [Title III, Subtitle B]</p> <p>Requires the Secretary of HHS to apply a new budget-neutral payment modifier to the fee-for-service payment formula to replace the Geographic Adjustment Factor, and pay physicians or groups of physicians based on the quality of care provided relative to the cost of care. Requires the formula to adjust for beneficiaries' demographics and health status, and for the quality metric to be based on beneficiaries' health outcomes or health status, and promote systems-based care. Requires the Secretary to take into account special conditions of rural and other underserved communities. Requires the formula to be phased in between 2015 and 2017.</p>
Other physician payment reforms	Provides for a 5% payment bonus, effective January 1, 2011, for evaluation and management services and other services associated with ensuring accessible, continuous, coordinated, and comprehensive care when provided by a physician or other practitioner who specializes in family medicine, general internal medicine, general pediatrics or geriatrics and has allowed charges for primary care services that account for at least 50% of the practitioner's total allowed charges. Applies another 5% bonus if a practitioner predominantly furnishes such services in a health professional shortage area. [Sec. 1303]	Provides a 10% payment bonus, effective January 1, 2011, for evaluation and management services provided by a physician or other practitioner specializing in family medicine, internal medicine, pediatrics or geriatrics (or are an advanced practice nurse or physician assistant) and has allowed charges for primary care services that account for at least 60% of the practitioner's total allowed charges. Applies another 10% bonus if a practitioner predominantly furnishes such services in a health professional shortage area. Provides 10% bonuses for eligible general surgeons serving in a health professional shortage area. Offsets 50% of

PHYSICIAN PAYMENT REFORMS (continued)

<p>Other physician payment reforms (continued)</p>	<p>E&C amendment to Sec. 1303: Clarifies that physician assistants are eligible for primary care incentive payments.</p> <p>W&M amendment to Sec. 1303: Clarifies that a physician supervises physician assistants.</p> <p>Provides a 5% add-on to payment for services provided under the physician fee schedule in 2011 and 2012 rendered in counties or equivalent areas in the lowest fifth percentile of utilization (based on Part A and Part B per capita spending standardized to eliminate the effect of geographic adjustments). [Sec. 1123]</p> <p>Extends payments to physicians under the Physician Quality Reporting Initiative (PQRI) through 2012. [Sec. 1124]</p> <p>Increases the payment rate for psychiatric services by 5% through 2011. [Sec. 1309]</p> <p>Prohibits certain referrals made by physicians to hospitals in which they have a direct financial interest. [Sec. 1156]</p> <p>Reduces payment for advanced diagnostic imaging services. [Sec. 1147]</p> <p>E&C amendment (new section): Permits certified diabetes educators to be providers of Medicare diabetes outpatient self-management training. [Sec. 1311]</p> <p>E&C amendment (new section): Excludes prompt pay discounts in excess of 2% of the wholesale acquisition cost (WAC) from the calculation of the average sales price (ASP), for drugs and biologicals sold under Medicare Part B between January 1, 2011 and January 1, 2016. [Sec. 1149A]</p> <p>E&C amendment (new section): Prohibits payment rates for specified pain management procedures from decreasing below rates in effect as of January 1, 2007. This prohibition affects payments between January 1, 2010 and January 1, 2012. [Sec. 1150]</p>	<p>the costs of the bonuses by reducing payments for all other codes, except for physicians primarily serving health professional shortage areas. [Title III, Subtitle B, Part IV]</p> <p>Establishes new PQRI for physicians who complete Maintenance of Certification (MOC) and a MOC practice assessment, as of 2011. Extends payments to physicians under the existing PQRI beyond 2010. Provides a 1% bonus for eligible professionals who report in 2010, beginning in 2011, and a 0.5% bonus for those who report in 2011. Applies a 1.5% payment penalty for eligible professionals who fail to participate successfully in the program by 2012, beginning in 2013. Requires CMS to develop a plan to integrate PQRI into electronic health records. Reduces payments by 5% to physicians whose resource use is at or above the 90th percentile, beginning in 2014. Requires the Secretary to coordinate the physician feedback program with other relevant reforms. [Title III, Subtitle A, Part I]</p> <p>Increases the payment rate for psychiatric services by 5% through January 1, 2012. [Title III, Subtitle B, Part I]</p> <p>Specifies conditions under which a physician may refer beneficiaries to hospitals in which they have a financial interest. [Title IV]</p> <p>Requires physicians to inform beneficiaries that they may obtain imaging services from another physician, and to provide beneficiaries with a list of other providers in the area furnishing the service, beginning 2010. [Title IV]</p> <p>Permits certified diabetes educators to be providers of Medicare diabetes outpatient self-management training. [Title III, Subtitle B, Part I]</p> <p>Requires manufacturers to annually report to the Secretary payments or other transfers of value made to physicians, group practices, or hospitals with residency programs, as of March 31, 2012. Manufacturers and group purchasing organizations (GPOs) must also report any ownership or investment by physicians in the manufacturer or GPO. [Title IV]</p>
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OTHER PROVIDER PAYMENT REFORMS

<p>Inpatient hospital payments</p>	<p>Requires the Secretary to report to Congress on Medicare disproportionate share hospital (DSH) payments, taking into account the impact of health care reforms in reducing the number of uninsured individuals, and to make adjustments beginning in 2017 to reflect the empirically-justified DSH adjustment and to make an additional payment for uncompensated care costs as well as the higher Medicare costs associated with serving low-income beneficiaries. [Sec. 1112]</p> <p>W&M amendment to Sec. 1112: Makes technical corrections to the payment adjustment.</p>	<p>Establishes a Hospital Value-Based Purchasing (VBP) program in Medicare that would provide value-based incentive payments to acute care hospitals that meet certain quality performance standards, beginning in 2012/2013. Measures would focus on heart attack, heart failure, pneumonia, surgical care activities, patient perceptions of care and infections associated with health care. Adjusts hospital payments based on performance under the VBP program. Generates funding through reducing Medicare payments to acute care hospitals, phased-in as follows: 1.0% in 2013; 1.25% in 2014; 1.5% in 2015; 1.75% in 2016; and 2.0% in 2017 and beyond. Requires the Secretary to ensure that all funds reduced from hospital payments to fund the VBP program in a given year be returned to hospitals in the form of</p>
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OTHER PROVIDER PAYMENT REFORMS (continued)		
Inpatient hospital payments (continued)	E&C amendment (new section): Requires States to require hospitals to disclose information on hospital charges, including Medicare reimbursement for services.	value-based incentive payments in that same year (i.e., the program would be budget neutral to the Medicare program). [Title III, Subtitle A, Part I] Makes DSH payments equal to 25% of the payments that would otherwise be made, beginning in 2015, taking into account the reductions in the number of uninsured individuals; makes additional payments to reflect hospitals' continued uncompensated care costs. [Title III, Subtitle D] Requires acute care hospitals to make public, and available upon request to any patient, their charges for each Medicare diagnostic related group (DRG), beginning in 2011. [Title IV] Requires the calculation of the Medicare hospital wage index floor for each all-urban and rural state to be budget neutral on a national basis.
Skilled nursing facility (SNF) and rehabilitation facility payments	Sets SNF payment rates in 2010 to equal 2009 rates, effective for care provided after January 1, 2010. [Sec. 1101] Applies budget neutrality factor for change in the patient classification system (RUG 44 to RUG 53). Revises payments to non-therapy ancillary services. [Sec. 1111] W&M amendment to Sec. 1111: Clarifies the items to be analyzed for the SNF case mix classification system and terms of implementation.	Allows a physician assistant who does not have an employment relationship with a SNF, but is working with a physician, to certify the need for Medicare covered post-acute care services. [Title III, Subtitle B, Part I] <i>See market basket changes below.</i>
Inpatient rehabilitation facility payments	Sets inpatient rehabilitation facility payment rates in 2010 equal to 2009 rates, effective for care provided after January 1, 2010. [Sec. 1102]	<i>See market basket changes below.</i>
Market basket updates and productivity adjustments	Updates market basket to incorporate productivity improvements for inpatient hospitals, skilled nursing facilities, long-term care hospitals, inpatient rehabilitation facilities, psychiatric hospitals, and hospice care. [Sec. 1103] Changes annual update to incorporate productivity improvements for outpatient hospitals, ambulance services, ambulatory surgical center services, laboratory services, and certain durable medical equipment. [Sec. 1131] E&C amendment to Sec. 1131: Decreases payments for certain durable medical equipment by an additional 0.5%. Updates home health payments for 2010 at 0%, subject to a 2% reduction for failure to report quality data; implements in 2010 case-mix adjustments currently scheduled for 2011. Updates market basket to account for productivity improvements, effective in 2010. [Sec. 1153 and 1154] W&M amendment (new section): Extends through 2010 the moratorium on phasing out the budget neutrality adjustment factor in the Medicare hospice wage index. [Sec. 1113]	Implements a full productivity adjustment for inpatient hospital services beginning in 2012. [Title III, Subtitle E] Implements a full productivity adjustment for outpatient hospital services beginning in 2012. [Title III, Subtitle E] Implements a full productivity adjustment for skilled nursing facilities beginning in 2012. [Title III, Subtitle E] Implements a full productivity adjustment for inpatient psychiatric facilities beginning in 2012. [Title III, Subtitle E] Implements a full productivity adjustment for inpatient rehabilitation facilities beginning in 2012. [Title III, Subtitle E] Implements a full productivity adjustment for long term care hospital services beginning in 2012. [Title III, Subtitle E] Implements a full productivity adjustment for durable medical equipment beginning in 2012. [Title III, Subtitle E] Implements a full productivity adjustment for hospice providers beginning in 2013. [Title III, Subtitle E] Implements a full productivity adjustment for home health providers beginning in 2015. [Title III, Subtitle E]

OTHER PROVIDER PAYMENT REFORMS (continued)		
<p>Market basket updates and productivity adjustments (continued)</p>		<p>Provides a full productivity adjustment for the clinical laboratory test fee schedule beginning 2011. Reduces the laboratory test fee schedule an additional 1.75 percentage points for 2011 through 2015 and includes an additional reduction in the clinical laboratory test fee schedule equal to \$100 million.</p> <p>All other productivity adjustments for all other Part B providers (except physicians) begin in 2011.</p>
<p>Home health payment</p>	<p>Rebases prospective payment system (PPS) rates in 2011 to reflect changes in the average number and types of home health visits in an episode, the change in intensity of visits in an episode, growth in cost per episode, and other factors. [Sec. 1154]</p> <p>Requires physicians to have face-to-face (or telemedicine) encounter with beneficiary prior to certifying need for home health services or durable medical equipment. [Sec. 1639]</p>	<p>Rebases payments to reflect the number and mix of home health services, level of intensity of services, and the average cost of providing care. [Title III, Subtitle D]</p> <p>Requires the Secretary to establish a provider-specific cap on revenues from outlier payments. [Title III, Subtitle D]</p> <p>Directs the Secretary to provide for a 3% add-on payment for rural home health providers. [Title III, Subtitle D]</p> <p>Requires the Secretary to conduct a study regarding the development of home health payment reforms to ensure access to care and quality services. [Title III, Subtitle D]</p>
<p>Hospice provider payment</p>	<p><i>No similar provisions.</i></p>	<p>Allows physician assistants to establish and periodically review a hospice written plan of care for Medicare-covered hospice services, as of 2010. [Title III, Subtitle B, Part I]</p> <p>Requires the Secretary to collect certain data in order to revise the payment methodology for hospice care. [Title III, Subtitle D]</p> <p>Creates a 3-year demonstration program, called the Medicare Hospice Concurrent Care (HCC) program, that allows patients who are eligible for hospice care to receive all other Medicare covered services during the same period of time.</p>
<p>Graduate medical education</p>	<p>Reallocates residency positions to support training of primary care physicians and directs the Secretary to redistribute residency slots from hospitals that close to others in the same state. Modifies rules governing when hospital can receive IME and direct graduate medical education (DGME) funding for residents who train in non-provider settings. [Sec. 1501-1505]</p> <p>W&M amendment to Sec. 1501: Corrects a drafting error.</p>	<p>Redistributes currently unused residency training slots as a way to encourage increased training, particularly in the areas of primary care and general surgery. Provides increased flexibility in laws and regulations governing Medicare's graduate medical education funding. Directs the Secretary to establish a process to reallocate residency slots in hospitals that close to others in the same area, state, or region. Requires 50% of the unused GME slots to be provided to hospitals in rural states and hospitals in the ten states with the largest ratio of the population living in a health professional shortage area. Allocates an additional number of new residency training slots to hospitals located in the ten states with the lowest resident-to-population ratios. Sets the IME adjustment for the resident positions equal to the full IME adjustment factor. [Title III, Subtitle A, Part IV]</p>

OTHER PROVIDER PAYMENT REFORMS (continued)		
Graduate medical education (continued)		<p>Establishes and provides funding for community based, ambulatory patient care centers, known as Teaching Health Centers, which operate primary care residency programs. [Title III, Subtitle A, Part IV]</p> <p>Establishes a graduate nurse education demonstration program in Medicare. [Title III, Subtitle A, Part IV]</p>
Other providers	<i>No similar provision.</i>	<p>Removes the sunset in current law to allow Indian tribes, tribal organizations, and urban Indian organizations to continue to receive payment for certain Medicare Part B covered items and services when furnished in Indian hospitals and ambulatory care clinics. [Title 1, Subtitle G, Part X]</p> <p>Requires the Secretary to establish a prospective payment system for Medicare-covered services furnished by Federally-Qualified Health Centers (FQHCs). [Title III, Subtitle A, Part IV]</p> <p>Requires the Secretary to convene a public meeting on payment systems for new clinical laboratory diagnostic tests and submit a report to Congress with recommendations to reform the reimbursement mechanisms for new clinical lab diagnostics. [Title III, Subtitle B, Part I]</p> <p>Increases the Medicare payment rate for nurse-midwives for covered services from 65% to 100% of the physician fee schedule rate.</p>
OTHER HEALTH SYSTEM REFORMS		
Reducing potentially preventable hospital readmissions	<p>Reduces Medicare payments to PPS and critical access care hospitals based on each hospital's ratio of actual risk-adjusted readmissions to risk-adjusted expected readmissions for specified clinical conditions effective in 2012, reduction limited to 1% in 2012, 2% in 2013, 3% in 2014, and 5% beginning in 2015 and subsequent fiscal years. When the readmission is from a post-acute care provider (SNF, inpatient rehabilitation facility, home health agency, or long-term care hospital), the payment to that provider would be reduced 0.4% in 2012, 0.7% in 2013, and 1.0% in 2014. [Sec. 1151]</p>	<p>Requires CMS to calculate national and hospital-specific data on the readmission rates of Medicare participating subsection (d) hospitals and for hospitals paid under section 1814 (b)(3) for eight conditions that the Secretary selects based on spending and readmission rates. Requires the Secretary, starting in 2012, to share these data with hospitals, and publicly report data on the Hospital Compare website. Starting in 2013, reduces payments to hospitals with readmission rates above a certain threshold by 20% if a patient with a selected condition is re-hospitalized with a preventable readmission within 7 days and by 10% if a patient with a selected condition is re-hospitalized with a preventable readmission within 15 days. [Title III, Subtitle A, Part III]</p>
Bundling and other post-acute care services payment reforms	<p>Directs the Secretary to develop a detailed plan to bundle payments for post-acute care services delivered by SNFs, inpatient rehabilitation facilities, long-term care hospitals, hospital-based outpatient rehabilitation facilities, and home health agencies after discharge from a hospital, with the goal of improving the coordination, quality, and efficiency of such services; and improve outcomes for individuals such as reducing hospital readmissions. Requires the Secretary to convert the acute care episode (ACE) demonstration to a pilot program and to include post-acute</p>	<p>Requires the Secretary to develop, test and evaluate alternative payment methodologies, including bundled payments, through a national, voluntary pilot program designed to provide incentives for providers to coordinate patient care across the acute and post-acute care continuum and to be jointly accountable for the entire episode of care. Requires the Secretary to work with the Agency for Healthcare Research and Quality (AHRQ) to develop episode of care quality measures. Requires the Secretary to submit an implementation plan to Congress on making the pilot a</p>

OTHER HEALTH SYSTEM REFORMS (continued)		
<p>Bundling and other post-acute care services payment reforms (continued)</p>	<p>services. The Secretary may expand the pilot program to additional sites or conditions. Authorizes demonstrations of post-acute bundling or other payment reforms included in the plan. [Sec. 1152]</p> <p>E&C amendment to Sec. 1152: Instructs the Secretary to adopt bundled payments for inpatient and post-acute care services on a large scale geographically, to the extent that payments are found to be successful in reducing costs and improving quality. Requires the Secretary to attempt to attract 10% of all eligible providers to act as acute and post-acute bundling sites. Requires the Secretary to implement bundling reforms if they are found to be successful in improving quality and reducing costs.</p> <p>W&M amendment to Sec. 1152: Clarifies the types of bundled payments included, requires an evaluation of the pilot program, and adds a study on bundling of payments for outpatient services.</p>	<p>permanent part of the Medicare program if the pilot program achieves goals of improving patient outcomes, reducing costs and improving efficiency. [Title III, Subtitle A, Part III]</p>
<p>Geographic payment adjustments</p>	<p>Requires the Institute of Medicine (IOM) to conduct a study and provide recommendations on the accuracy of the geographic adjustment factors used by Medicare (e.g., wage index). Requires the Secretary to take recommendations into account in proposed rules published to implement changes to Medicare payment systems for physicians and hospitals. Prohibits the Secretary from changing payment rates to be less than they would have been had this section not been enacted, and allocates up to \$4 billion per year for two years for payment increases. [Sec. 1157 and 1158]</p> <p>E&C amendment to Sec. 1158: Incorporates technical corrections to ensure payment adjustments can be executed as intended.</p> <p>W&M amendment to Sec. 1158: Incorporates technical corrections to the revision of payments rates.</p> <p>E&C amendment (new section): Instructs CMS to develop a tool for measuring physicians' resource use relative to their local and national peers, and confidentially deliver the reports in significant scale beginning in 2011. [Sec. 1126]</p> <p>W&M amendment (new section): Initiates a study by the IOM on geographic variation in health care spending, and directs the Institute to make recommendations on how to create incentives for providers to deliver high-value care. [Sec. 1159]</p>	<p>Requires the Medicare Payment Advisory Commission (MedPAC) to review payment adequacy for rural health care providers serving the Medicare program and provide a report to Congress by January 1, 2011 analyzing beneficiaries' access to care in rural communities, adequacy of Medicare payments to rural providers and quality of care and recommending appropriate modifications to rural payments. [Title III, Subtitle B, Part II]</p>
<p>Comparative effectiveness research</p>	<p>Establishes a Center for Comparative Effectiveness Research within AHRQ to conduct, support, and synthesize research on outcomes, effectiveness, and appropriateness of health care services and procedures. An independent Commission will oversee the activities of the Center. [Sec. 1401]</p> <p>The research will be funded through transfers from the Medicare Hospital Insurance (HI) and SMI Trust Funds and fees on health plans. [Sec. 1802]</p>	<p>Establishes a private, non-profit corporation, the Patient-Centered Outcomes Research Institute, which conducts and disseminates research comparing the clinical effectiveness, risk and benefits of treatments, services, and items. Makes the Institute tax exempt for Federal tax purposes. Requires the research to take into account differences in outcomes among subpopulations. Creates a Board of Governors to oversee the duties of the Institute. Prohibits denial of Medicare coverage based</p>

OTHER HEALTH SYSTEM REFORMS (continued)		
<p>Comparative effectiveness research (continued)</p>	<p>E&C amendments to Sec. 1401:</p> <ul style="list-style-type: none"> • Prohibits the federal government from using comparative effectiveness research to deny or ration care. • Prohibits CMS from using the research to make Medicare coverage determinations on the basis of cost. • Requires the research to be based on evidence-based medicine and to not violate best practices as determined by physician specialty colleges and academies of medicine. 	<p>solely on the research conducted by the Institute. Prohibits the Institute from using cost-effectiveness analysis (or dollars per value-adjusted year of life) and prohibits the Secretary from using such a measure to determine coverage, reimbursement, or incentives programs. Funds the research through transfers from the Medicare Trust Funds, appropriations for comparative effectiveness research in the American Recovery and Reinvestment Act of 2009 (ARRA), and fees on health plans. [Title III, Subtitle F]</p>
<p>Delivery system pilot programs</p>	<p>Mandates an accountable care organization (ACO) pilot project, beginning no later than January 1, 2012, to test performance target and partial capitation payment models (and other payment models at the Secretary's discretion). Defines an ACO as "a group of physicians" meeting specified criteria. Authorizes the Secretary to promulgate regulations expanding the use of successful ACO models if the CMS Chief Actuary certifies that such expansion would produce savings. [Sec. 1301]</p> <p>E&C amendment to Sec. 1301: Instructs the Secretary to adopt the ACO model on a large scale geographically to the extent that it is found to be successful in reducing costs and improving quality.</p> <p>W&M amendment to Sec. 1301: Clarifies that physicians from various specialties can be the primary point of care for beneficiaries in ACOs.</p> <p>Mandates a medical home pilot project to test the independent patient-centered medical home model and the community-based medical home model, targeted at high-need beneficiaries. Provides for evaluation of the pilot program by the Secretary and expansion if the CMS Chief Actuary determines that spending would not increase by doing so. [Sec. 1302]</p> <p>E&C amendments to Sec. 1302:</p> <ul style="list-style-type: none"> • Instructs the Secretary to adopt the medical home model on a large scale geographically to the extent that it is found to be successful in reducing costs and improving quality. Clarifies that physician assistants are eligible to participate in both the independent and community-based medical home models. • Includes individuals with cognitive impairment that leads to functional impairment in the definition of high-need beneficiaries. • Requires the Secretary to implement the pilot program in one of the territories. • Requires the Secretary to seek to eliminate racial, gender, and geographic health disparities when selecting sites for the pilot. 	<p>Allows groups of providers to be recognized as accountable care organizations (ACOs) and to be eligible for an incentive bonus based on the cost-savings they achieve for the Medicare program, beginning 2012. Eligible providers include: groups, networks, partnerships, or hospitals employing practitioners, such as physicians, nurse practitioners, physician assistants, clinical nurse specialists, and others as determined by the Secretary. All physicians, regardless of specialty, may be members of ACOs. Specifies that ACOs may coordinate care through the use of telehealth, remote patient monitoring, and other such enabling technologies. [Title III, Subtitle A, Part III]</p> <p>Establishes a pilot program, called the Community Care Transitions Program, beginning in 2011, to fund eligible hospitals and community-based partnership organizations to provide patient-centered, evidence-based care transition services to Medicare beneficiaries at the highest risk of preventable re-hospitalization. [Title III, Subtitle A, Part III]</p> <p>Requires the Secretary to conduct a pilot project to bring primary care services to high-cost Medicare beneficiaries with multiple chronic conditions in their home. Interdisciplinary teams of professionals would be eligible for shared savings if they achieve quality outcomes, patient satisfaction, and cost savings. [Title III, Subtitle A, Part III]</p>

OTHER HEALTH SYSTEM REFORMS (continued)		
<p>Delivery system pilot programs (continued)</p>	<p>W&M amendment to Sec. 1302: Adds physician assistants to the definition of primary care for purposes of the medical home pilot program and clarifies that physician assistants are eligible to participate in both the independent and community-based medical home models.</p> <p>E&C amendment (new section): Requires the Secretary to conduct a pilot program that tests a home-based primary care model designed to reduce expenditures and improve health outcomes for home care for qualifying beneficiaries, beginning no later than January 1, 2012. Permits qualifying practices to receive 80% of the program's savings in excess of 5%. No qualifying practice may receive more in Medicare payment than what otherwise would have been provided in the absence of the pilot program. [Sec. 1303]</p>	
<p>Nursing home quality reforms</p>	<ul style="list-style-type: none"> • Requires reforms to increase the transparency of skilled nursing facilities' finances and quality. Authorizes civil monetary penalties for deficiencies. • Requires the Secretary to develop, test, and implement a two-year pilot program on the use of an independent monitor to oversee chains of SNFs. • Requires 60-day notification before facility closure. Allows the Secretary to require dementia and abuse prevention training, and requires a study on training content. (Conforming changes for nursing facilities under Title XIX). <p>[Sec. 1411-1432]</p>	<p><i>Similar to House provisions.</i> [Title IV]</p>
<p>Quality improvement</p>	<p>Requires the Secretary to establish and update national priorities for performance improvement, and solicit and consider recommendations from outside entities, including a consensus-based entity and other stakeholders. Lists considerations in setting national priorities. [Sec. 1441]</p> <p>Requires the Secretary to contract with qualified entities to develop patient-centered and population-based quality measures and determine areas in which quality measures are needed. Secretary may contract with qualified public, non-profit or academic institutions with technical expertise in health quality measurement to test proposed measures. [Sec. 1442]</p> <p>Requires public reporting by hospitals (including critical access hospitals) and ambulatory surgical centers on health care-associated infections. Requires the Secretary to produce an annual report to Congress on the number and types of health care-associated infections, the increase or decrease in health care costs, and best-practices recommendations. [Sec. 1461].</p> <p>E&C amendment to Sec. 1442: Requires quality measures to assess the presence of impairment in addition to other factors.</p>	<p>Applies a new payment adjustment to hospitals ranked in the top quartile of national, risk-adjusted hospital acquired condition (HAC) rates. Requires CMS to calculate national and hospital-specific data on the HAC rates of hospitals. Starting in 2013, requires the Secretary to share these data with hospitals, and public reporting on the Hospital Compare website. Starting on October 1, 2014, hospitals in the top quartile of national HAC rates (based on prior year's performance) would receive 99% of their otherwise applicable Medicare payments. [Title III, Subtitle A, Part I]</p> <p>Requires the Secretary to establish quality-reporting programs for inpatient rehabilitation facilities, long term care hospitals, and hospices; reduces annual market basket update by 2% for failure to report quality measures. [Title III, Subtitle A, Part I]</p>

OTHER HEALTH SYSTEM REFORMS (continued)		
<p>Quality improvement (continued)</p>	<p>E&C amendment (new section): Requires the Government Accountability Office (GAO) to evaluate the five star quality rating system used by CMS to provide information to beneficiaries on the quality of certain Medicare facility providers and plans. [Sec. not specified]</p>	<p>Requires the Secretary to establish a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health through a transparent and collaborative process; to identify and fill gaps where no quality measures exist, or where existing quality measures need improvement; and to set forth a process to disseminate measures and incorporate measures, where applicable, in workforce programs, training curricula, federal health programs, and other areas deemed appropriate by the Secretary. Allows the Secretary to contract with an organization that has the requisite experience with developing and implementing quality improvement strategies. [Title III, Subtitle A, Part II]</p>
OTHER PROVISIONS		
	<p>Eliminates the Medicare Improvement Fund. [Sec. 1146] <i>No similar provision to establish a Medicare Commission.</i></p> <p>Repeals the Medicare Solvency Trigger, established under the Medicare Modernization Act of 2003. [Sec. 1901]</p> <p>Creates an office within CMS to improve coordination between Medicare and Medicaid for dual eligibles. [Sec. 1905]</p> <p>E&C amendment (new section): Creates a Center for Medicare and Medicaid Payment Innovation within CMS to test and evaluate models for provider payment that affect the cost and quality of care received under Medicare and Medicaid. All models must improve the quality of care without increasing spending; reduce spending without reducing quality; or improve the quality of care and reduce spending. Authorizes the Secretary to expand the duration and scope of models that meet these criteria. [Sec. 1906]</p> <p>E&C amendment (new section): Requires the proportion of members on MedPAC who represent the interests of rural areas to be no less than the proportion of beneficiaries who reside in rural areas. [Sec. 1197]</p> <p>E&C amendment (new section): Requires all Medicare payments after January 1, 2015 to be paid electronically. [Sec. 164]</p> <p>E&C amendment (new section): Allows beneficiaries to elect to take ownership of certain durable medical equipment after the end of the 13-month rental period. [Sec. 1141A]</p> <p>W&M amendment (new section): Clarifies Medicare Secondary Payer statute with respect to those who may bring an action and the associated rules around such action. [Sec. 1620]</p>	<p>Eliminates the Medicare Improvement Fund. [Title III, Subtitle B, Part I]</p> <p>Establishes a new, independent 15-member Medicare Commission to make proposals to Congress to extend the solvency of Medicare, slow Medicare cost growth and improve quality of care. Prohibits the Commission from presenting proposals that would ration care, increase revenues, or change Medicare Part A or B premiums, cost sharing, benefits, or eligibility. Allows the Commission to present proposals that reduce expenditures under Part C and Part D, including reducing federal premium subsidies to plans. Prior to 2020, prohibits the Commission from recommending spending reductions for hospitals and hospice providers. Requires the CMS Office of the Actuary to calculate a new measure of Medicare excess cost growth in each annual report, and if the growth rate exceeded growth in the CPI and the CPI for medical care (CPI-M), requires the Commission to submit a proposal to Congress that would reduce excess cost growth by a certain amount, with the first set of recommendations due to Congress by January 1, 2014. Requires the Secretary to submit proposals if the Commission fails to act. Requires Congressional consideration and action in response to proposals; if Congress does not act, proposals take effect automatically. Sets the growth target beyond 2019 at GDP per capita plus 1%. Does not sunset the Commission; allows the Commission to continue past 2019 unless Congress votes to terminate it. Grants the Commission authority to advise the Secretary on priorities for health services research. Establishes the Consumer Advisory Commission to advise the Medicare Commission on the impact of Medicare payment policies on consumers. Requires the GAO to study the effect of the Commission's proposals by July 1, 2015. [Title III, Subtitle E]</p>

OTHER PROVISIONS (continued)

W&M amendment (new section): Requires the Administrator of CMS to (1) conduct an assessment of the diseases and conditions that are most cost-intensive for the Medicare program, and (2) review and update that assessment. Creates a fund for research into such diseases and conditions. [Sec. 1906]

Establishes the Federal Coordinated Health Care Office (CHCO) within CMS. The purpose of the Office would be to bring together officials from the Medicare and Medicaid programs and improve coordination of care for dual eligible beneficiaries. [Title I, Subtitle G, Part VII]

Requests National Association of Insurance Commissioners to create new model plans for Medigap C and F that include nominal cost sharing so as to encourage the use of Part B physician services, by 2015. [Title III, Subtitle C]

Requires the Secretary to create an Innovation Center within CMS, similar to the House E&C amendment. Requires the CMS Innovation Center to consider testing salary-based payment models for primary care and groups of providers and suppliers, and to promote care coordination between providers that transitions providers away from fee-for-service based reimbursement and toward salary-based payment. Requires the Center to consider testing a model that develops collaborative of high-quality, low-cost health care institutions that develop, document, disseminate, and implement best practices. Requires that in selecting models for testing, the Secretary consider the extent to which a model maintains a close relationship with care coordinators, primary care practitioners, specialist physicians and other health care providers. Medicaid and CHIP programs would be within the scope of the Center. Requires the Center to be established by January 1, 2011. [Title III, Subtitle A, Part III]

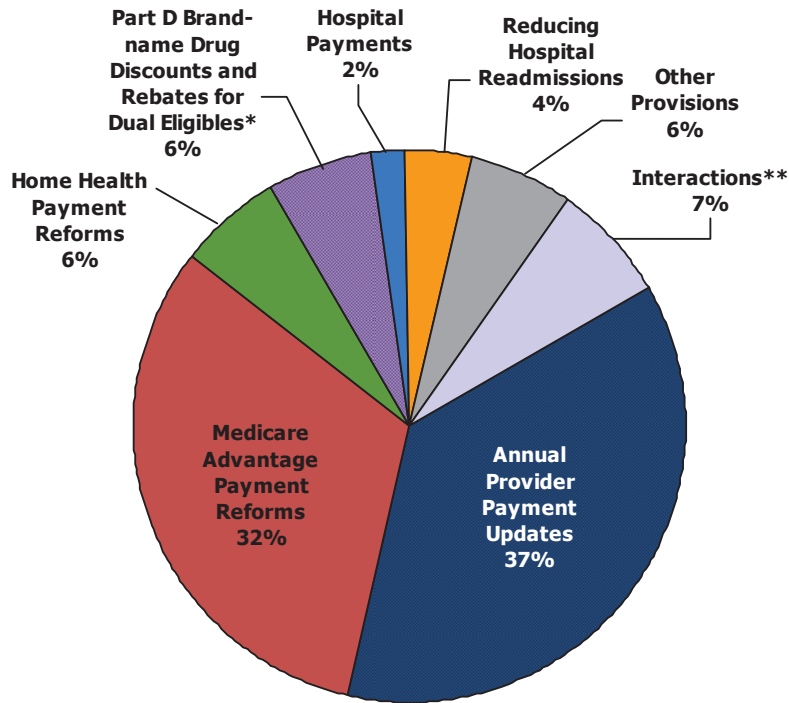
Provides a 12-month special enrollment period for those eligible for TRICARE and entitled to Part A based on disability or ESRD, but who have declined Part B. [Title III, Subtitle B, Part I]

This summary was prepared with the assistance of Health Policy Alternatives.

Medicare Savings and Spending in House Bill (H.R. 3200) "America's Affordable Health Choices Act of 2009"

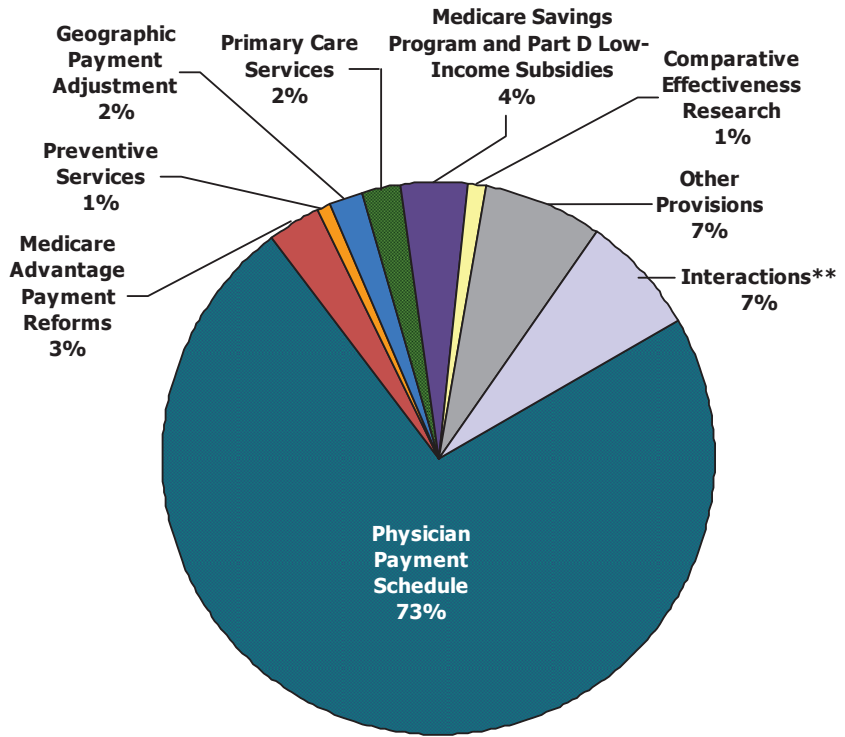
Based on CBO 10-Year Estimates (2010-2019)

Medicare Savings



Ten-Year Savings = \$538.5 Billion

Medicare Spending



Ten-Year Spending = \$320.4 Billion

Source: Kaiser Family Foundation analysis of Congressional Budget Office (CBO) cost estimates as provided on July 17, 2009, and Joint Committee on Taxation (JCT) estimates as provided on July 14, 2009 for H.R. 3200.

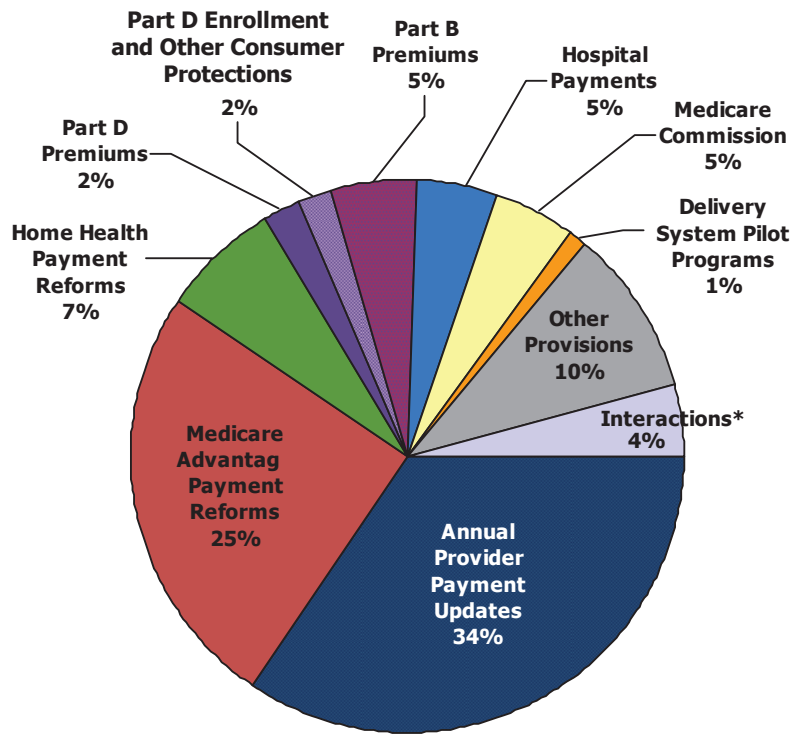
Notes: *Medicare savings for the Part D coverage gap and rebates for dual eligibles includes the spending to close the coverage gap; CBO does not display these estimates separately.

**Savings include interactions with premiums, Medicare Advantage, and 340B; Spending includes interactions with TRICARE and Medicaid.

Medicare Savings and Spending in Senate Finance Committee Chairman's Mark "America's Healthy Future Act of 2009"

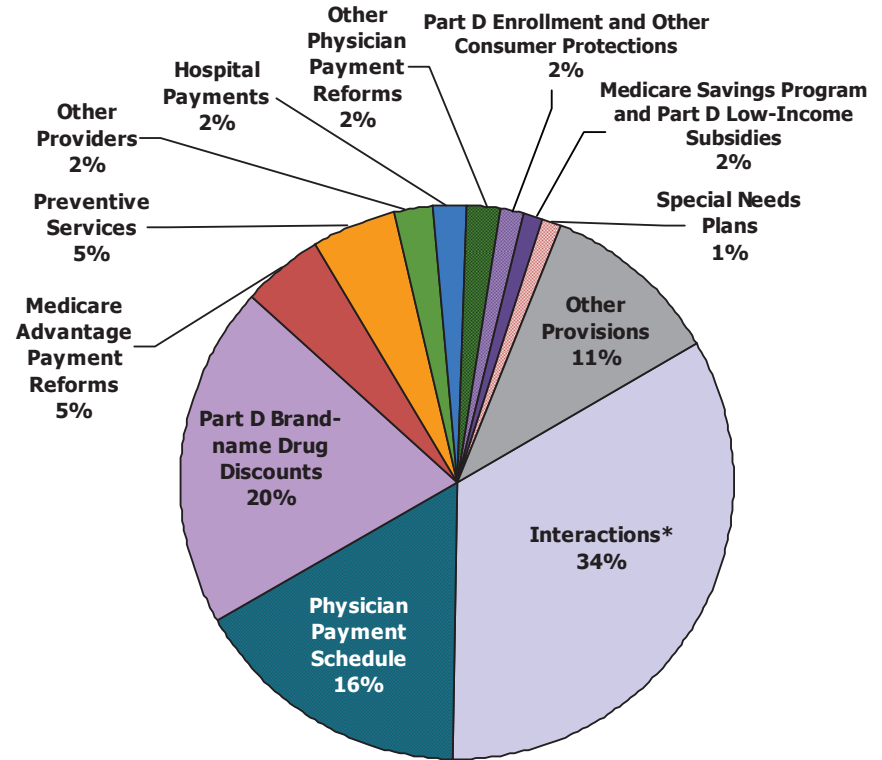
Based on CBO 10-year Estimates (2010-2019)

Medicare Savings



Ten-Year Savings = \$470.2 Billion

Medicare Spending



Ten-Year Spending = \$91.3 Billion

Source: Kaiser Family Foundation analysis of Congressional Budget Office (CBO) cost estimates as provided on October 7, 2009.
Notes: *Savings include interactions with premiums and Medicaid; spending includes interactions with Medicare Advantage and TRICARE.

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