Medicare Program Changes in H.R. 3962, Affordable Health Care for America Act

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Summary

Containing scores of provisions affecting Medicare payments, payment rules, and covered benefits, H.R. 3962, as passed by the House on November 7, 2009, treats the Medicare program as both a funding source for health insurance reform and a tool to shape future changes in the way that health services are paid for and delivered. Estimates from CBO on the bill indicate that, absent interaction effects, net reductions in Medicare direct spending may approach $128.1 billion from 2010 to 2014 and $460.8 billion from 2010 to 2019. Major savings are expected from constraining Medicare's annual payment increases, linking payments for Medicare Advantage plans to fee-for-service payments, and requiring drug manufacturers to provide drug rebates for certain low-income Medicare beneficiaries. These savings would be offset by increases related to payment incentives for primary care services, expanded assistance for low-income beneficiaries enrolled in the Medicare prescription drug program, expanded coverage of preventive care services, and higher payments for various types of providers in rural areas.

With respect to reshaping health care delivery, H.R. 3962 would provide financial incentives to acute care and critical access hospitals to reduce potentially preventable readmissions and to improve care coordination starting in FY2012. These policies would be extended to post-acute care providers starting in FY2015. Another provision would require the Secretary to develop a detailed plan to bundle payments for post-acute care services within three years of enactment. Also, by January 1, 2011, the existing physician-hospital bundled payment demonstration would be converted to a pilot program and expanded to include post-acute services.

H.R. 3962 would also alter Medicare payments to a range of providers, physicians, practitioners, and suppliers. Certain provisions address more systemic issues, such as increasing physician payments for preventive services. Other provisions are time-limited extensions of existing payment policies, such as two-year extensions to Section 508 hospital reclassifications, the physician geographic floor, and rural ambulance add-ons. H.R. 3962 would also change the regulation of providers. For instance, Medicare providers would be subject to enhanced screening and oversight in areas designated as high risk for fraud and abuse. Additionally, the Stark whole hospital and rural exceptions for physician-owned hospitals would be eliminated, except for those existing physician-owned hospitals that qualify for an exception.

Finally, provisions in H.R. 3962 would improve Medicare benefits provided to individuals. For instance, the Medicare Part D coverage gap for prescription drugs (the "doughnut hole") would be eliminated, certain low-income subsidies would be amended by changing Medicare's asset test, and copayments would no longer be required for certain preventive care services.

Contents

Appendixes

Contacts

Introduction

This report describes changes to the Medicare program made in H.R. 3962, the Affordable Health Care for America Act, as passed by the House on November 7, 2009. H.R. 3962 contains numerous provisions affecting Medicare payments, payment rules, and covered benefits, and treats the Medicare program as both a funding source for health reform and a tool to shape future changes in the way that health services are delivered. Estimates from the Congressional Budget Office (CBO) on the bill indicate that, absent interaction effects, net reductions in Medicare direct spending may approach $128.1 billion from 2010 to 2014 and $460.8 billion from 2010 to 2019.

The legislation includes four divisions; Division B contains the changes to the Medicare and Medicaid programs. This report discusses all of the proposed changes included in Titles I, III, and VI and selected provisions in Titles II and IX of Division B in H.R. 3962 concerning payment and program modifications to Medicare's fee-for-service program, its prescription drug benefit, and the Medicare Advantage (MA) program; efforts to reform Medicare's payment methods, program integrity changes to address fraud waste and abuse, and other miscellaneous Medicare changes. Provisions that would modify Medicare's graduate medical education payments to teaching hospitals, its preventive care benefits, its quality measurement efforts, and other public health initiatives are not covered.[1] The body of this report includes a discussion of the financial impact on the Medicare program by H.R. 3962 that the CBO established (the CBO score), then provides an overview of Medicare changes by provider type and program, followed by a brief discussion of the program integrity changes.[2] The **Appendix** provides a brief current law description, explanation of the proposed change, and, where possible, the CBO score for most of the Medicare-related provisions in H.R. 3962.

Congressional Budget Office (CBO) Score

On November 6, 2009, the CBO issued an analysis of H.R. 3962, as introduced on October 29, 2009, incorporating the November 3, 2009 manager's amendment.[3] Similarly, the Joint Committee on Taxation issued its analysis of H.R. 3962, including the manager's amendment, on November 7, 2009.[4] Their analyses provide estimates of the direct spending and revenue effects of H.R. 3962. The estimates do not, however, include certain administrative costs that would be incurred by the government to implement the changes or H.R. 3962's impact on other federal programs.

CBO estimates that the provisions in H.R. 3962 that would affect the Medicare, Medicaid, Children's Health Insurance and other federal programs would reduce direct spending by $427 billion over the FY2010-FY2019 period.[5] Of this total, Medicare (absent interaction affects)

[1] Those provisions are discussed in CRS Report R40892, *Public Health, Workforce, Quality, and Related Provisions in H.R. 3962*, coordinated by C. Stephen Redhead.

[2] Background information on the Medicare program can be found in the CRS Report R40425, *Medicare Primer*.

[3] The CBO score can be found at http://www.cbo.gov/ftpdocs/107xx/doc10710/hr3962Dingell_mgr_amendment_update.pdf. Provisions affecting Medicare were unchanged in the version of the bill passed on November 7, 2009.

[4] The Joint Committee on Taxation score may be found at http://www.jct.gov/publications.html?func=startdown&id=3633.

[5] The estimated overall effect of the proposed legislation is a net decrease in the federal budget deficit of $109 billion (continued...)

accounts for approximately $460.8 billion of the reduction; however, these spending reductions are offset by spending increases in Medicare, Medicaid, and other federal health care programs. Medicare reductions in direct spending over the 10-year period are estimated to be $501.7 billion, offset by Medicare payment increases of $40.9 billion.[6] CBO estimated that Medicare spending under the bill would increase more slowly over the next 20 years compared to the past 20 years—a 6% average annual rate compared to the prior 8%.

As noted by CBO, the provisions that would result in the largest savings are as follows:

- Permanent reductions in the annual updates to Medicare's fee-for-service payment rates (other than physicians' services) would account for an estimated budgetary savings of $228 billion over 10 years.[7]
- Using per-capita spending in fee-for-service Medicare to set rates for MA plans and changing the way MA payments are adjusted to account for health status would account for an estimated $170 billion in savings (before interactions) over 10 years.
- Changes in Medicare's prescription drug program (Medicare Part D) that would reduce the cost of drugs, expand coverage, and increase efficiencies would account for an estimated $50 billion in savings over the same period.

There are differing views about whether (and to what extent) Medicare savings should be considered as offsets to fund the expansion of health care coverage or, alternatively, should be used to secure the financial solvency of the Medicare program. The latter position is captured in a July 16 letter sent by 36 Republican Senators to the Senate Majority Leader discussing the need to use potential monies resulting from Medicare reform to ensure its future financial stability.[8] The alternative position that health insurance reform and the attendant changes to Medicare would bolster the program's solvency (and improve beneficiaries' access to care) is asserted in an eight-page report released by the Department of Health and Human Services (HHS) on August 27.[9]

(...continued)

over the FY2010-FY2019 period. The projected 10-year cost of increasing insurance coverage of $891 billion is offset by the net spending decrease of $427 billion and by revenue provisions that are estimated to raise $574 billion over the same period.

[6] H.R. 3962 does not include changes to the sustainable growth rate (SGR) formula used to set Medicare physician payment rates. A separate bill to address the SGR, H.R. 3961, the Medicare Physician Payment Reform Act of 2009, was introduced on October 20, 2009. See CRS Report R40907, *Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System*, by Jim Hahn.

[7] This estimate excludes interaction effects including the impact on these reductions to payments to Medicare Advantage plans and on the collection of Part B premiums.

[8] See http://corker.senate.gov/public/index.cfm?FuseAction=Files.View&FileStore_id=ad911e30-d2e2-43ae-9261-ae1ebf6626b3 accessed 10/30/2009 for a copy of the letter.

[9] See http://www.hhs.gov/news/press/2009pres/08/20090827a.html for the HHS press release and http://www.healthreform.gov/reports/seniors/index.html for the report.

Payment Rate Changes Affecting Medicare Fee-for-Service Providers

Medicare is a federal program that pays for covered health services for most persons 65 years of age and older and for most permanently disabled individuals under the age of 65. It consists of four parts, each responsible for paying for different benefits, subject to different eligibility criteria and financing mechanisms.[10] Under traditional Medicare, Part A and Part B services are typically paid on a fee-for-service basis (each service or group of services provided to a patient is reimbursed through a separate payment) using different prospective payment systems (PPS) or fee schedules.[11] Certain other services are paid on the basis of reasonable costs or reasonable charges. In general, each year, regulatory decisions (some of which are mandated by Congress) are implemented by the Centers for Medicare and Medicaid Services (CMS), which affect Medicare's payments to specific providers, physicians, practitioners, and suppliers. For instance, the program provides for annual updates of the program payments to reflect inflation and other factors. In some cases, these updates are linked to the consumer price index for all urban consumers (CPI-U) or to a provider-specific market basket (MB) index, which measures the change in the price of goods and services purchased by the provider to produce a unit of output.

In March of each year, the Medicare Payment Advisory Commission (MedPAC) makes payment update recommendations concerning Medicare's different fee-for-service payment systems to Congress. To do so, MedPAC staff first examines the adequacy of the Medicare payments for efficient providers in the current year and then assesses how provider costs are likely to change in the upcoming year, including scheduled policy changes that will affect Medicare's payment rates.[12] As stated by MedPAC, Medicare's payment systems should encourage efficiency and that providers can achieve efficiency gains similar to the economy at large. This policy target links Medicare's expectations for efficiency improvements to the productivity gains achieved by firms and workers who pay taxes that fund Medicare.[13] The amount, if any, of MedPAC's update recommendations will depend on its overall assessment of the circumstances of a given set of providers in any year.

In June of each year, MedPAC issues another report to Congress examining more systemic issues affecting the Medicare program and making recommendations to increase Medicare's value, to

[10] Part A, the Hospital Insurance program, covers hospital services, up to 100 days of post-hospital skilled nursing facility services, post-institutional home health visits, and hospice services. Part B, the Supplementary Medical Insurance program, covers a broad range of medical services including physician services, laboratory services, durable medical equipment, and outpatient hospital services. Part B also covers some home health visits. Part C provides private plan options, such as managed care, for beneficiaries who are enrolled in both Parts A and B. Part D provides optional outpatient prescription drug coverage.

[11] Medicare has specific rules for fee for service payments under Parts A and B as well as capitation (or per person) payments under Part C. Outpatient prescription drugs covered under Part D are not subject to Medicare payment rules. Prices are determined through negotiation between prescription drug plans (PDPs), or Medicare Advantage Prescription Drug (MA-PD) plans, and drug manufacturers. The Secretary of Health and Human Services is statutorily prohibited from intervening in Part D drug price negotiations.

[12] See pp. 35-41 of Medicare Payment Advisory Commission (MedPAC) *Report to Congress: Medicare Payment Policy*, March 2009 (subsequently referred to as MedPAC's *March 2009 Report)* for a discussion of their update framework.

[13] As noted by MedPAC, the Bureau of Labor Statistics' estimate of the 10-year moving average rate of past growth in total factor productivity for the economy as a whole is currently 1.3%.

promote its efficiency or payment accuracy, or to realign Medicare's payment incentives.[14] Most recently, for example, MedPAC has stated that Medicare's payment systems do not provide incentives to produce appropriate, high-quality care at an efficient price. Rather, Medicare's incentives, particularly in its fee-for-service program, reward excessive care and do not encourage service coordination or quality care.[15] Often considered as part of regulatory and legislative changes to the program, MedPAC's recommendations concerning Medicare are not binding and are not automatically implemented. To differing extents, their analyses and recommendations have shaped provisions in H.R. 3962; where possible, that influence will be noted, particularly in the appendix to this report.

Hospitals and Other Part A Providers

Part A provides coverage for inpatient hospital services, post-hospital skilled nursing facility (SNF) services, post-hospital home health services, and hospice care, subject to certain conditions and limitations. Approximately 20% of beneficiaries enrolled in Part A use these services during any year. CBO estimates that about $223 billion was spent on Part A benefits in 2008, an amount that is projected to increase to $435.2 billion in 2019. In part because of its sheer size, provisions reducing Part A spending comprise a significant proportion of the savings attributed to this legislation either through constraining payment updates or by other payment changes.

Acute Care Hospitals

Generally, the provisions of H.R. 3962 affecting Medicare's payments to acute care hospitals would constrain payment increases to these hospitals, restructure payments to address treatment inefficiencies, and then reshape Medicare's disproportionate share hospital (DSH) hospital subsidies. Also, the exception that permits physicians with ownership interests in a hospital to refer Medicare and Medicaid patients to that hospital would be eliminated for new physician-owned hospitals or those that did not meet certain criteria.

Specifically, H.R. 3962 would adjust Medicare's annual payment updates to Part A providers to account for economy-wide productivity increases for cost savings estimated to be $102 billion (of the $228 billion total savings attributed to limits on all Medicare's fee-for-service payment updates mentioned earlier) over 10 years. Under current law, the market basket component of the physician update or the Medicare economic index (MEI) is adjusted to exclude productivity gains. This provision uses the same measure of productivity improvement, the 10-year moving average of all-factory productivity, that is included in the MEI. Savings from extending this policy to acute care hospitals was not separately identified.

Under Medicare's current inpatient prospective payment system (IPPS), acute care hospitals receive a full payment for patient admissions even if the readmission is preventable and related to the initial admission, the result of inadequate discharge planning at the treating hospital, or results from inadequate post-discharge care coordination. MedPAC estimated that readmissions resulted in $15 billion in additional Medicare expenditures in FY2007; however, this estimate includes

[14] Appendix A of MedPAC's June report typically contains its review of CMS's preliminary update for the physician fee schedule as well.

[15] MedPAC's *Report to Congress: Improving Incentives in the Medicare Program*, June 2009 also included a Congressionally mandated report on the Medicare Advantage (MA) program.

readmissions that may not have been related to the initial diagnosis, those that may not have been preventable, where patients experienced complications or those caused by factors beyond the hospitals' control. As explained in the **Appendix**, this provision would reduce payments for acute care hospitals, which would reduce payments for acute care hospitals with excessive readmission rates relative to their expected readmission rate for selected conditions. CBO has estimated this provision as saving $9.3 billion over a 10-year period.[16]

Since 1986, an increasing number of hospitals have received additional Medicare payments because they serve a disproportionate share of low-income patients. The justification for this subsidy has changed over time. Originally, the DSH adjustment was intended to compensate hospitals for their higher Medicare costs associated with the provision of services to a large proportion of low-income patients. Now, the adjustment is considered as a way to protect access to care for Medicare beneficiaries. H.R. 3962 would reduce hospitals' DSH payments starting in FY2017 contingent upon a reduction in the number of uninsured individuals of eight percentage points from 2012 to 2014. A hospital with higher levels of uncompensated care would receive additional payments. CBO has estimated that this policy would save $10.3 billion from FY2017 to FY2019.

Skilled Nursing Facilities (SNFs)

Medicare covers nursing home services for beneficiaries who require skilled nursing care and/or rehabilitation services following a hospitalization of at least three consecutive days. The Balanced Budget Act of 1997 (BBA 97, P.L. 105-33) required the Secretary to establish a PPS for SNF care to be phased in over three years, beginning in 1998. Under the PPS, SNFs receive a daily payment that covers all the services provided that day, including room and board, nursing, therapy, and drugs, as well as an estimate of capital-related costs. Any profits are retained by the SNF, and any losses must be absorbed by the SNF. The daily base payment is based on 1995 costs that have been increased for inflation and vary by urban or rural location. A portion of these daily payments is further adjusted for variations in area wages, using the hospital wage index, to account for geographic variation in wages. SNF per diem PPS payments are also adjusted to include a temporary 128% increase for any SNF residents who are HIV-positive or have Acquired Immune Deficiency Syndrome. Section 1888(e) of the Social Security Act requires that the base payments be adjusted each year by the SNF MB update—that is, the measure of inflation of goods and services used by SNFs.

In the final rule FY2010 rule, CMS describes its proposal to recalibrate the case mix indexes to better account for the resources used in the care of the medically complex and to improve upon its payment refinements made in 2006. According to CMS, the total impact of these changes for FY2010, accounting for a MB increase of 2.2 percentage points, would be a decrease in Medicare payments for FY2010 to SNFs of 1.1% (or $360 million) below FY2009 payments. Some individual providers could experience larger decreases in payments than others due to case-mix utilization. The proposed PPS and Consolidated Billing SNF payment regulation for FY2010 describes how the Secretary would recalibrate the case-mix indexes (CMIs) for 2010 to more accurately match the service needs of beneficiaries.

[16] See Option 31, Reduce Medicare Payments to Hospitals with High Readmission Rates, in CBO's *Budget Options, Volume I, Health Care*, December, 2008, pp. 64-65 for additional information.

Although MedPAC finds that Medicare payments to SNFs overall are adequate, it has raised concerns about the efficiency of the payment categories pertaining to nontherapy ancillary (NTA) services (e.g., prescription drugs, medical equipment and supplies, IV therapy) and therapy services. To better account for SNF stays with exceptionally high ancillary care needs, MedPAC recommends, in a June 2009 letter to the Secretary[17] and its *March 2009 Report*,[18] that the Secretary revise the PPS by separating payments for NTA from the bundled PPS rate and by establishing an outlier policy for stays with exceptionally high NTA costs. In addition, MedPAC explains that the current reimbursement system for therapy costs encourages the under provision of therapy services to patients. To improve payments for therapy, MedPAC recommends that the Secretary recalibrate the payment category for therapy costs so as to better match such payments to the actual amount of therapy services needed by patients. MedPAC also recommends that the market basket update for 2010 be eliminated.

The provisions contained in H.R. 3962 are consistent with MedPAC's recommendations. Specifically, the bill would eliminate the SNF MB update for 2010 and make all subsequent MB annual updates subject to a productivity adjustment. Under the bill, the rate of growth in payments to SNFs would likely slow but it would never fall below zero.

H.R. 3962 would also require that budget neutral changes be made to the SNF payment categories pertaining to NTA and therapy services. The bill would also require that an addition or adjustment to the SNF payment be made to account for outliers in SNF costs. H.R. 3962 also contains provisions that would pay reduced Medicare payments to SNFs on claims associated with certain persons who are readmitted to a hospital from a SNF within 30 days of an initial hospital discharge. Finally, certain Medicare-certified SNFs would also be part of detailed plan for a Post-Acute Care Demonstration expansion to be developed by the Secretary. Such a demonstration would test the use of bundled payments for hospitals and post-acute care providers for improving the coordination, quality, and efficiency of post-acute care services and for reducing the need for readmission to hospitals from providers, among other outcomes.

Home Health Agencies (HHAs)

Home health agencies (HHAs) are paid under a prospective payment system (PPS), which covers skilled nursing, therapy, medical social services, aide visits, medical supplies, and others. Durable medical equipment is not included in the home health PPS. The base payment amount, or national standardized 60-day episode rate, is increased annually by an update factor that is determined, in part, by the projected increase in the home health market basket (MB) index. This index measures the changes in the costs of goods and services purchased by HHAs. HHAs are required to submit to the Secretary health care quality data. A HHA that does not submit the required quality data will receive an update of the MB minus two percentage points for that fiscal year.

The proposed rule for calendar year (CY) 2010 reports that the HH MB will increase by 2.2% for that year. In addition, in an effort to address potential fraud and abuse in the use of HH outlier payments, CMS proposes to cap outlier payments at 10% of total HH PPS payments and to target outlier payments to be no greater than 2.5% of total HH PPS payments, among other things.

[17] Letter from Glenn M. Hackbarth, J.D., Chairman, Medicare Payment Advisory Commission, to Charlene Frizerra, Acting Administrator, Centers for Medicare and Medicaid Services, June 29, 2009.

[18] MedPAC's *March 2009 Report*, Section 2D, pp. 157-182.

In CY2008, CMS made refinements to the home health (HH) PPS to try to improve payment efficiencies. Specifically, this regulation established changes to the home health agency (HHA) case-mix index to account for the relative resource utilization of different patients. These changes modified the coding or classification of different units of service that do not reflect real changes in case-mix. As a result, the national prospective 60-day episode payment rate was adjusted downward by 2.75% for CY2008, by 2.75% for each year of CY2009 and CY2010, and by 2.71% for CY2011.

In its *March 2009 Report*, MedPAC explains that payments to HHAs have exceeded costs by a wide margin since the PPS was implemented in 2000. As a result, MedPAC recommends that the MB increase for 2010 be eliminated and that the payment coding changes scheduled by the Secretary be accelerated. Further, MedPAC recommends that HHA rates be rebased to better reflect the average costs of care.

H.R. 3962 would slow payment growth to HHAs, as is consistent with MedPAC's recommendations. Specifically, the bill would eliminate the MB update for 2010 and make all subsequent MB annual updates subject to a productivity adjustment. Under the bill, the rate of growth in payments to HHAs would likely slow but it would never fall below zero.

H.R. 3962 would also require that the case-mix adjustments planned by the Secretary for CY2010 and CY2011 be fully implemented in 2010, resulting in a total downward adjustment of payments by 5.46% in 2010. Under the provision, the Secretary would also adjust HHA payments by a uniform percentage, ensuring that payments would be equal to payments of the previous year and then updated by the HH MB for that year. If the Secretary is unable to make these changes for 2011, then the Secretary would be required to pay 95% of what the prospective payment amount would have been had the provision not applied, among other things.

H.R. 3962 would also require the Secretary to develop a detailed plan for a Post-Acute Care Demonstration expansion, which would include HHAs. Such a demonstration would test the use of bundled payments for hospitals and post-acute care providers for improving the coordination, quality, and efficiency of post-acute care services and for reducing the need for readmission to hospitals from providers, among other outcomes.

Physicians and Other Part B Providers

The bill would make a number of changes to how Medicare physician payments are calculated under the fee schedule and modify reporting and bonus programs for physicians. The Secretary (through CMS) would have additional flexibility to be able to review and adjust potentially misvalued codes under the physician fee schedule, make adjustments to Medicare payment localities in California to address imbalances created by uneven economic growth, extend the floor for the index representing geographic variation in physician work used in determining payments, create a new 5% bonus payment for physicians who practice in areas where total Medicare per capita spending falls in the lowest 5% of all counties or equivalent areas, extend the payment for the technical component of certain pathology services, and modify the payment for imaging services to more closely reflect the actual use of the equipment. The bill would also modify the physician quality reporting initiative program (PQRI) to include a feedback program, integrate PQRI, and extend the years of the bonus payments. In addition, the bill would modify the existing resource-based feedback program for physicians by specifying in more detail the types of information that would be reported under the program and how CMS could use the information.

Changes Affecting Medicare Advantage

H.R. 3962 would *reduce* the maximum amount Medicare would pay private health plans in some areas of the country,[19] in addition to other payment and administrative changes. Payments to private plans are determined by comparing a plan's cost of providing required Medicare benefits (*bid*) to the maximum amount Medicare will pay for those benefits in each area (*benchmark*). Historically, Congress has increased the benchmark amounts, in part, to encourage plan participation in all areas of the country. As a result, the benchmark amounts in some areas are higher than the average cost of original fee-for-service (FFS) Medicare. Benchmarks exceed average spending in original Medicare by an estimated 17% in 2009. As a result, Medicare is projected to pay private plans an average of 14% more per beneficiary in 2009 than it does for beneficiaries in the original Medicare program.[20] Starting in 2011, H.R. 3962 would phase in MA benchmarks equal to per capita FFS spending in each county. Starting in 2013, MA benchmarks would be equal to per capita FFS spending in each county. This may result in reductions in access to private plan options, or the supplemental benefits and reduced cost-sharing that some private plans provide.

Starting in 2011, H.R. 3962 would also *increase* benchmarks for MA plans that provide quality health care in qualifying areas. Currently, MA plans are required to have quality improvement programs before January 1, 2010; however, payments to MA plans are not contingent on the quality of care provided to plan enrollees. Taken together, the provision to reduce benchmarks to the level of per capita FFS spending in original Medicare and the provision to increase benchmarks for plans that provide quality care in qualifying areas are estimated to save $47.5 billion over the FY2010-2014 period and $154.3 billion over the FY2010-2019 period.

H.R. 3962 would extend the Secretary's authority to adjust payments to plans for differences in the way diagnosis coding of patients differs between MA plans and original Medicare. In general, MA plan payments are risk-adjusted to account for the variation in the cost of providing care. Risk adjustment is designed to compensate plans for the increased cost of treating older and sicker beneficiaries, and thus discourage plans from preferential enrollment of healthier individuals. The Medicare risk adjustment models take into account the variation in expected medical expenditures of the Medicare population associated with demographic characteristics (age, sex, current Medicaid eligibility, original Medicare eligibility due to a disability), as well as medical diagnoses. The Deficit Reduction Act of 2005 (P.L. 109-171, DRA) required the Secretary, when risk adjusting payments to MA plans during 2008, 2009, and 2010, to adjust for patterns of diagnosis coding differences between MA plans and providers under parts A and B of Medicare, to the extent that the Secretary identified such differences based on an analysis of data submitted for 2004 and subsequent years. It is estimated that this provision would save $2.9 billion over the 2010-2014 period and $15.5 billion over the 2010-2019 period.

H.R. 3962 makes additional changes to the Medicare Advantage program that would result in costs or savings of less than $0.5 billion over the 10-year period (2010-2019), as estimated by CBO. Each of these provisions is explained in detail in the **Appendix**.

[19] For a more detailed description of payments to private plans under Medicare, see CRS Report R40374, *Medicare Advantage*.

[20] MedPAC's *March 2009 Report*, p. 258, http://www.medpac.gov/chapters/Mar09_Ch03.pdf.

Changes Affecting Medicare's Prescription Drug Benefit

In January 2009, the Medicare prescription drug program began its fourth year of operation. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) created this voluntary outpatient prescription drug benefit under a new Medicare Part D, effective January 1, 2006. At that time, Medicare replaced Medicaid as the primary source of drug coverage for beneficiaries covered under both programs (called *dual eligibles*). Prescription drug coverage is provided through private prescription drug plans (PDPs), which offer only prescription drug coverage, or through Medicare Advantage prescription drug plans (MA-PDs), which offer prescription drug coverage that is integrated with the health care coverage they provide to Medicare beneficiaries under Part C. Medicare law sets out a defined standard benefit structure under the Part D benefit. In 2009, the standard benefit includes a $295 deductible and a 25% coinsurance until the enrollee reaches $2,700 in total covered drug spending. After this initial coverage limit is reached, there is a gap in coverage in which the enrollee is responsible for the full cost of the drugs (often called the *doughnut hole*) until total costs hit the catastrophic threshold, $6,153.75 in 2009.

A major focus of the drug benefit is the enhanced coverage provided to low-income individuals who enroll in Part D. Individuals with incomes below 150% of the federal poverty limit and with limited assets are eligible for the low-income subsidy (LIS). The LIS reduces beneficiaries' out-of-pocket spending by paying for all or some of the Part D monthly premium and annual deductible, and limits drug copayments to a nominal price.

H.R. 3962 would make several changes to the Medicare Part D program to expand coverage and reduce costs to the program. Specifically, the bill would gradually phase out the coverage gap and completely eliminate it by 2019. During the coverage gap, consistent with a voluntary agreement with the pharmaceutical industry, Part D enrollees would be provided discounts of 50% for brand-name drugs. However, the full drug price (the amount paid by the beneficiary plus the discount) would be used to calculate a beneficiary's out-of-pocket costs, thus enabling beneficiaries to reach the catastrophic level more quickly, at which time most of the drug costs would be paid for by Medicare. The bill would also establish a new prescription drug rebate program under which drug manufacturers would provide Medicare with rebates for the cost of drugs dispensed to certain low-income beneficiaries.[21] CBO estimates that the combined savings from the discounts and the rebates would more than offset the cost of reducing the coverage gap and reduce Medicare expenditures approximately $42.3 billion for the 10-year period FY2010-2019. Additionally, because enrollees pay for about 25% of the cost of coverage through their premiums and the value of the prescription drug benefit would increase as the doughnut hole is phased out, CBO estimated, in an analysis of similar provisions in H.R. 3200, that premiums would increase faster than they would under current law. However, CBO also estimates that, on average, the reduction in beneficiary cost sharing would outweigh the increase in premiums. H.R. 3962 would also require the Secretary to negotiate prices with manufacturers. While some believe that the government would have greater leverage in negotiations and would be better able to obtain lower

[21] H.R. 3200 limited the rebates to full-benefit dual-eligible beneficiaries. H.R. 3962 would initially require rebates for dual-eligibles, but in 2015 would expand the requirement to include all Part D subsidy eligible enrollees.

prices than the plan sponsors, CBO scored this requirement as having no effect on federal expenditures.

The bill also contains several provisions that would make it easier for beneficiaries to apply and qualify for the low-income subsidy and would help to improve access to LIS plans. For example, self-certification of income and assets would be allowed when applying for the subsidy, the asset test for the low-income subsidy would be raised, and cost sharing would be eliminated for individuals receiving care under a home and community-based waiver who would otherwise require care in a facility for the mentally retarded. Additionally, HHS would be given the authority to auto-enroll subsidy-eligible individuals into plans using an "intelligent assignment" process instead of the random process currently used. The new process would be designed to better insure that beneficiaries are enrolled in plans that are low cost and that cover the drugs the beneficiaries are currently taking. The bill would also change the methodology used to determine which plans are eligible to enroll low-income beneficiaries. This change may enable more plans to qualify as low-income plans and help reduce the number of low-income beneficiaries who need to change plans from year to year. CBO has scored the changes to the low-income subsidy program at a combined cost to the Medicare and Medicaid programs of $13.5 billion over 10 years.

H.R. 3962 also includes a number of provisions aimed at expanding consumer protections for Part D enrollees. For example, Part D plans would be generally prohibited from making changes to their formularies during the plan year that would reduce coverage of needed drugs or increase cost-sharing. Additionally, the bill would enhance oversight to better ensure that low-income beneficiaries receive retroactive reimbursement payments owed to them by their drug plans (for cost sharing expenditures made by the beneficiary after the date the beneficiary became eligible for the subsidy).

Efforts to Reform Medicare's Fee-for-Service Payment Methods

As noted by MedPAC, the Medicare program must overcome limitations with its existing fee-for-service payment systems, by addressing its strong incentives to increase service volume and broadening the scope of Medicare's payment to encompass services provided by different entities during a patient's episode of care.[22] The wide geographic variation in Medicare's spending per beneficiary that is not explained by measurable differences in health status adds layers of complexity to any contemplated payment or health delivery reform proposal.

Certain provisions included in H.R. 3962 to establish pilot program to bundle payments for physician and hospital as well as post-acute care services represent a starting point with these payment reforms. Other pilot programs will establish accountable care organizations and medical homes in an effort to provide incentives to better manage the quality and cost-efficiency of health care delivered to a population of chronically sick patients over an extended period of time. These pilot programs would build on existing demonstration programs; unlike the existing efforts, if

[22] See MedPAC's *Report to Congress: Reforming the Delivery System*, June 2008, pp 7-17 for framework to evaluate the payment and delivery system reform

assessed as successfully accomplishing care coordination while maintaining budget neutrality, the pilot programs could be implemented on a permanent basis without further congressional action.

Changes to Address Fraud, Waste, and Abuse

H.R. 3962 includes a variety of measures aimed at reducing fraud, waste, and abuse in Medicare, Medicaid, and federal health care programs generally. These provisions target the Centers for Medicare and Medicaid's program integrity activities, funding for anti-fraud activities, and penalties for fraud. As the agency responsible for administering Medicare and Medicaid, CMS conducts a variety of activities designed to prevent, detect, and investigate health care fraud. These activities are often referred to as program integrity activities. CMS shares responsibility for combating fraud with three federal agencies: the Department of Health and Human Services Office of the Inspector General (OIG), the Department of Justice (DOJ), and the Federal Bureau of Investigation (FBI). The OIG is an independent unit within HHS that has the primary responsibility for detecting health care fraud and abuse in federal health care programs. The FBI conducts complex fraud investigations related to both private and public health care programs, and the OIG, FBI, and CMS refer suspected cases of fraud to the DOJ for prosecution.

Medicare program integrity and anti-fraud activities are funded through the Health Care Fraud and Abuse Control (HCFAC) program. HCFAC was established by the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191), which sought to increase and stabilize federal funding for anti-fraud activities. Specifically, HCFAC funds are directed to the enforcement and prosecution of health care fraud, whereas MIP funding supports the program integrity activities undertaken by CMS contractors. HIPAA appropriated funds to HHS, the OIG, the DOJ, and the FBI for activities undertaken for fiscal years 1997 through 2003. In December 2006, Congress passed the Tax Relief and Health Care Act (TRHCA) which extended the mandatory annual appropriation for HCFAC to 2010. Total funding for health care fraud activities for FY2009 amounted to approximately $1.4 billion.

In the area of program integrity, the bill would require that the Secretary develop enhanced screening procedures for providers enrolling in Medicare, Medicaid, and to CHIP. The level and type of screening would be determined by the Secretary according to risk. Under this legislation, providers could be subject to background checks, unannounced site visits, enhanced claims reviews, and moratoriums on enrollment. Other program integrity measures include requiring providers and certain suppliers to implement compliance programs, establishing sanctions for hospices that do not meet federal health and safety standards, mandating that providers and suppliers submit claims for payment within 12 months, and requiring home health and durable medical equipment (DME) providers to have face-to-face encounters with beneficiaries prior to reimbursement. The bill would also prohibit payment to any Medicare provider or supplier that does not accept payment electronically.

In the area of enforcement, the legislation introduces Civil Monetary Penalties (CMPs) for certain types of infractions, including falsifying information on enrollment applications and delaying investigations and audits by the OIG. The legislation would also enhance the Secretary's authority to impose penalties on MA plans for violating the terms of their contract. Certain practices such as enrolling beneficiaries into MA plans without their consent or inappropriately transferring beneficiaries between plans would be subject to penalties. The bill would also mandate that the Secretary establish a Self-Referral Disclosure Protocol for providers and suppliers to disclose violations of the Stark law.

To support these additional program integrity and enforcement efforts, H.R. 3962 would increase funding for the Health Care Fraud and Abuse Control Program (HCFAC) by $100 million annually beginning in 2011.

Concluding Observations

Under H.R. 3962, Medicare serves as both a funding source for health insurance reform and a tool to shape future changes in the way that health services are paid for and delivered. Policy makers are debating whether Medicare savings should be used to offset broader reform efforts or whether these funds are more appropriately directed at strengthening the program's future financial standing. Industry representatives are debating the extent to which the Medicare program can be viewed as a funding source without compromising beneficiaries' access to quality care. Proponents of health insurance reform argue that the Medicare program and care provided to beneficiaries would be strengthened by payment reforms included in the bill and not harmed by the payment reductions. How (and whether) these different discussions will be resolved remains an open question.

Appendix. Selected Medicare Provisions in Division B of H.R. 3962

This appendix contains the majority of provisions in H.R. 3962, as passed by the House on November 7, 2009, that affect the Medicare program. For each provision, a brief current law, a simplified provision description and, where possible, the associated CBO score is provided. The section number and title of Medicare provisions that have been omitted from the appendix are included in footnotes to the immediately preceding provision.

Sec. 1101. Skilled Nursing Facility Payment Update. Skilled nursing facilities (SNFs) are paid through a prospective payment system (PPS) which is composed of a daily ("per-diem") urban or rural base payment amount that is then adjusted for case mix and area wages. Each year, the SNF payment rate is increased by an update factor that is determined, in part, by the projected increase in the SNF market basket (MB) index. Without changes to current law, the SNF MB update for FY2010 is 2.2%. The provision would eliminate the MB update for SNFs between January 1, 2010 and September 30, 2010. Subject to another provision regarding a productivity adjustment, the rate would be increased by the skilled nursing facility MB percentage change for the fiscal year involved for each subsequent fiscal year. *The CBO score (with interaction with Section 1103) is -$6.0 billion for FY2010-FY2014 and -$23.9 billion for FY2010-FY2019*

Sec. 1102. Inpatient Rehabilitation Facility Payment Update. Starting January 1, 2002, Medicare payments to inpatient rehabilitation facilities (IRFs) are made under a discharge-based prospective payment system where one payment covers capital and operating costs. Typically, the per discharge payment amount is increased each fiscal year by an update factor based on the increase in the applicable market basket index. However, in FY2008 and FY2009, the update factor has been set at zero percent, starting for discharges as of April 1, 2008. The provision would extend the zero percent update factor until September 30, 2010 (the end of FY2010) but would not apply to payment units occurring before January 1, 2010. *The CBO score (with interaction with Section 1103) is -$1.4 billion for FY2010-FY2014 and -$5.3 billion for FY2010-FY2019.*

Sec. 1103. **Incorporating Productivity Improvements into Market Basket Updates That Do Not Already Incorporate Such Improvements.** Currently, most providers in fee-for-service (or traditional) Medicare, including acute care hospitals, SNFs, long term care hospitals (LTCHs), IRFs, inpatient psychiatric facilities (IPFs), and hospice care receive predetermined payment amounts established under different, unique prospective payment systems. Each year, the base payment amounts in the different Medicare payment systems are increased by an update factor to reflect the increase in the unit costs associated with providing health care services. Generally, Medicare's annual updates are linked to projected changes in specific market basket (MB) indices which are designed to measure the change in the price of goods and services purchased by the provider. Annual updates to the Medicare physician fee schedule are determined by a separate method that includes the sustainable growth rate (SGR) formula, which already incorporates adjustments for gains in physician productivity.

The update factors for certain providers would include a productivity adjustment which would equal the percentage change in 10-year moving average of annual economy-wide private nonfarm business multi-factor productivity. The adjustment would be included for IPPS hospitals for fiscal years beginning FY2010 for discharges after January 1, 2010. The component of the IPPS update

that is reduced when the acute care hospital does not submit quality data would not be reduced below zero. Similarly, the component of the IPPS update that is reduced for the acute care hospital is not a meaningful electronic health record (EHR) user would not be reduced below zero. The update reduction for those IPPS hospitals that are not meaningful EHR users would apply only with respect to the fiscal year involved and would not include the productivity adjustment; the Secretary would not be able to take into account the reduction in computing the applicable MB increase in subsequent years.

Updates for SNFs and IRFs would include the productivity adjustment starting FY2011. Hospice care increases would include the adjustment in FY2010 for days of care starting January 1, 2010. To the extent that the base rate for LTCHs would be subject to an annual update, the update factor would be subject to a productivity adjustment for discharges on or after January 1, 2010, during the rate year ending in 2010. To the extent that the base rate for IPFs would be subject to an annual update, the update factor would be subject to a productivity adjustment starting for rate year 2011. T*he CBO score (with interaction with Sections 1101 and 1102) is -$24.2 billion for FY2010-FY2014 and -$102.0 billion for FY2010-FY2019.*

Sec. 1111. Payments to Skilled Nursing Facilities. SNFs are paid through a PPS which is composed of a daily ("per-diem") urban or rural base payment amount that is then adjusted for case mix and area wages. The base payment is adjusted for treatment type and care needs of the beneficiary based on 53 payment-adjusted resource utilization groups (RUGs). In January 2006, CMS implemented a refined SNF PPS (using FY2001 claims data), including a parity adjustment to ensure that estimated total payments under the 53-group RUG model would maintain parity to the formerly used 44-group RUG model in a budget neutral manner. CMS also applied an adjustment to account for the variability in the use of nontherapy ancillary (NTA) services (e.g., prescription drugs, medical equipment and supplies, IV therapy). After noting that actual utilization patterns differed from CMS projections, CMS used actual CY 2006 claims data to update its calibrations and its parity adjustment so as to re-establish budget neutrality and its NTA adjustment component.

In the final rule published on Friday, July 31, 2009, CMS describes its proposal to recalibrate the case mix indexes to better account for the resources uses in the care of the medically complex. According to CMS, the total impact of this recalibration for FY2010, accounting for a MB increase of 2.2 percentage points, would be a decrease in Medicare payments to SNFs of 1.1% (or $360 million) below FY2009 payments. Some individual providers could experience larger decreases in payments than others due to case-mix utilization. The proposed PPS and Consolidated Billing SNF payment regulation for FY2010, describes how the Secretary would recalibrate the case-mix indexes (CMIs) for 2010 to more accurately match the service needs of beneficiaries.

The provision would require the Secretary to adjust the case mix indexes for FY2010, using CY2006 claims data, by the appropriate recalibration factor, as described in the SNF final rule issued by the Secretary on August 11, 2009. It would also require the Secretary to increase payments for non-therapy ancillary services by 10% and decrease payments for the therapy case mix component of such rates by 5.5%. Such payment changes would be required to apply for days on or after April 1, 2010, and until the Secretary implements an alternative case mix classification system for the SNF PPS.

The Secretary would also be required to conduct an analysis so as to ensure the accuracy of payments for NTA services furnished during a fiscal year beginning with FY2011, within certain

specifications. The Secretary would be required to implement changes to payments for NTA such that they would be budget neutral for estimated expenditures under such future SNF services classification system for a FY beginning with 2011.

Beginning with October 1, 2010, The Secretary would be required to provide for an addition or adjustment to the outlier payment amounts with respect to NTA and therapy services. Such outlier adjustments or additional payments would be required to be based on aggregate costs during a SNF stay on not on the number of days in such stay. These changes to the outlier component of the payment would be required to reduce estimated payments that would otherwise be made under the PPS with respect to a FY by 2 percent. The total amount of additional payments or payment adjustments for these outliers with respect to a FY could not exceed 2% of total payments projected or estimated based on the SNF PPS. *The CBO Score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

Sec. 1112. Medicare DSH Report and Payment Adjustments in Response to Coverage Expansions. Since 1986, an increasing number of acute care hospitals have received additional Medicare payments because they serve a disproportionate share of low-income patients. The policy justification for Medicare's disproportionate share hospital (DSH) spending has changed over time. Originally, the DSH adjustment was intended to compensate hospitals for their higher Medicare costs associated with their providing services to a large proportion of low-income patients. Now, the adjustment is considered as a way to protect access to care.

The provision would require the Secretary to submit no later than July 1, 2016 a Medicare DSH report including recommendations on the appropriate targeting of DSH funds that would be consistent with its original intent and consider any reduction in the number of uninsured individuals as well as hospitals' remaining uncompensated care costs. If H.R. 3962 decreases the national rate of uninsurance among the under 65-population by 8 or more percentage points from 2012 to 2014, the Medicare DSH adjustment would be reduced starting in FY2017. Additional payments (not to exceed 50% of the aggregate DSH reduction) would be made based on the estimated amount of uncompensated care, excluding bad debt, provided by a hospital; hospitals with higher levels of uncompensated care would receive higher uncompensated care payments. *The CBO score is $0.0 for FY2010-FY2014 and -10.3 billion for FY2010-FY2019.*

Sec. 1113. Extension of Hospice Regulation Moratorium. The prospective payment system (PPS) for hospices attempts to adjust for geographic differences through a wage index adjustment. When the data source used to adjust hospice payments for differences in the cost of labor across geographic area was changed in 1997 from the 1983 Bureau of Labor Statistics data to the hospital wage data, a budget neutrality adjustment factor (BNAF) was instituted by the Secretary to prevent participating hospices from experiencing reductions in total payments as a result of the change. This BNAF increases payments to certain hospices that would otherwise experience a payment reduction by boosting hospice payments to these providers by amounts that would make overall payments budget neutral to the levels that they would have received had the Secretary used the 1983 Bureau of Labor Statistics wage adjustment.

According to the final rule, published by HHS in the Federal Register on August 8, 2008, the BNAF would be phased out over three years, beginning with a 25% reduction in FY2009, an additional 50% reduction (totaling 75%) in FY2010, and a final 100%, or elimination, in FY2011. The American Recovery and Reinvestment Act of 2009 (P.L. 111-5) included a provision that delayed the implementation of the phase-out of the budget neutrality adjustment factor during FY2009. Consequently, Medicare payments to hospice during FY2009 contain budget neutrality

adjustments similar to those in previous years. The revised final rule for FY2010 specifies that the hospice wage index BNAF would not be phased out over seven years, with a 10% reduction in FY2010, and a 15% reduction for each year from FY2011 through FY2016.

The provision would extend the delay on the implementation of the phase-out of the budget neutrality adjustment factor through October 1, 2010. *The CBO Score is $0.1 billion for FY2010-FY2014 and $0.1 billion for FY2010-FY2019.*

Sec. 1114. Permitting Physician Assistants to Order Post-Hospital Extended Care Services and to Provide for Recognition of Attending Physician Assistants as Attending Physicians to Serve Hospice Patients. In a skilled nursing facility (SNF), Medicare law allows physicians, as well as nurse practitioners and clinical nurse specialists who do not have a direct or indirect employment relationship with a SNF, but who are working in collaboration with a physician, to certify the need for post-hospital extended care services for purposes of Medicare payment. Post-hospital extended care services are generally defined as services initiated within 30 days after discharge from a 3-day medically necessary inpatient hospital stay. The provision would allow a physician assistant [who is legally authorized by the state in which the services are being furnished] who does not have a direct or indirect employment relationship with a SNF, but who is working in collaboration with a physician, to certify the need for post-hospital extended care services for Medicare payment purposes.

Under the Medicare program, hospice services may only be provided to terminally ill individuals under a written plan of care established and periodically reviewed by the individual's attending physician and the medical director (and by the interdisciplinary group of the hospice program). For an individual to be eligible for Medicare-covered hospice services, the individual's attending physician (not including a nurse practitioner) and the medical director (or physician member of the interdisciplinary group of the hospice program) must each certify in writing that the individual is terminally ill at the beginning of the first 90-day period of hospice. For purposes of a hospice written plan of care, the provision would include a physician assistant who is [legally authorized by the state in which the care is being delivered and acting under the supervision of a physician] in the definition of an attending physician. The provision would continue to exclude physician assistants from the authority to certify an individual as terminally ill. *The CBO score is between minus50 million and $50 million for both FY2010-FY2014 and FY2010-FY2019.*

Sec. 1121. Resource-Based Feedback Program For Physicians In Medicare. Both MedPAC and GAO have suggested that CMS provide information to physicians on their resource use with the expectation that physicians who are outliers would alter their practice patterns as a result. Providing this information to physicians would enable them to assess their practice styles, evaluate whether they tend to use more resources than their peers or what evidence-based research (if available) recommends, and to revise practice styles as appropriate.

Section 131(c) of MIPPA established such a physician feedback program, which CMS implemented by January 1, 2009. CMS initially called this effort the Physician Resource Use Feedback Program, but has renamed this initiative the "Physician Resource Use Measurement and Reporting Program." MIPPA also requires the GAO to conduct a study of the Physician Feedback Program as described above, including the implementation of the Program, and to submit a report to Congress by March 1, 2011 containing the results of the study, together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

The bill would modify the existing physician feedback program and establish a feedback implementation plan for providing information to providers about their practice patterns. The Secretary would develop and specify the nature of the reports, based on results and findings from the Medicare program as in existence before the date of the enactment of this act. These reports could be based on a per capita basis, an episode basis that combines separate but clinically related physicians' services and other items and services furnished or ordered by a physician into an episode of care, as appropriate, or both. The nature of the reports would be developed by January 1, 2012.

During 2011, the Secretary would establish methodologies as appropriate to (i) attribute items and services to physicians, (ii) identify appropriate physicians for purposes of comparison, and (iii) aggregate items and services attributed to a physician into a composite measure per individual. The Secretary would evaluate the methods with regard to their efficacy in changing practice patterns to improve quality and decrease costs.

The Secretary would develop a plan to disseminate these reports in a significant manner in the regions and cities of the country with the highest utilization of Medicare services. To the extent practicable, the reports would be disseminated to increasing numbers of physicians each year; during 2014 and in subsequent years, the reports would be disseminated at least to physicians with utilization rates among the highest 5% of the nation. The Secretary could disseminate the reports via: direct meetings between contracted physicians, though contracts with local, non-profit entities engaged in quality improvement efforts at the community level, in mailings or other methods of communication that facilitate large-scale dissemination., or by other methods specified by the Secretary. *The CBO Score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

Sec. 1122. Misvalued Codes Under the Physician Fee Schedule. The Medicare physician fee schedule is based on assigning relative weights to each of the approximately 7,500 physician service codes used to bill Medicare. The relative value for a service compares the relative work involved in performing one service with the work involved in providing other physicians' services. The scale used to compare the value of one service with another is known as a resource-based relative value scale (RBRVS).

CMS, which is responsible for maintaining and updating the fee schedule, continually modifies and refines the methodology for estimating relative value units (RVUs). CMS relies on advice and recommendations from the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) in its assessments. In general, as currently implemented, increases in RVUs for a service or number of services lowers the resultant fees for other physician services. One consequence has been that the payments for evaluation and management codes, whose RVUs typically are not increased over time, have fallen relative to other codes whose RVUs have increased and as a consequence of new technologies that have been introduced into coverage with relatively high RVUs. CMS is required to review the RVUs no less than every five years.

Under this proposal, the Secretary would periodically identify and make appropriate adjustments to the relative values for the services identified as being potentially misvalued. The Secretary would examine the following, as appropriate: (1) codes (and families of codes as appropriate) for which there has been the fastest growth; (2) codes (and families of codes as appropriate) that have experienced substantial changes in practice expenses; (3) codes for new technologies or services within an appropriate period (such as three years) after the relative values are initially established for such codes; (4) multiple codes that are frequently billed in conjunction with furnishing a

single service; (5) codes with low relative values, particularly those that are often billed multiple times for a single treatment; (6) codes that have not been subject to review since the implementation of the RBRVS (the so-called 'Harvard-valued codes'); and (7) such other codes determined to be appropriate by the Secretary. *According to CBO, this provision would increase outlays by approximately $100 million over the next five years (2010-2014) and $200 million over the next ten (2010-2019).*

Sec. 1123. Payments for Efficient Areas. In certain circumstances, physicians receive an additional payment in addition to the Medicare fee schedule amount to encourage targeted activities. These bonuses, typically a percentage increase above the Medicare fee schedule amounts, can be awarded for a number of activities including reporting on quality measures, participating in electronic prescribing, or practicing in underserved areas.

The bill would create a new incentive payment for physicians; providers delivering services in counties or equivalent areas in the United States that fall in the lowest 5% based on per capita spending for Medicare part A and part B services would receive an additional 5% payment for the Medicare Part B services. The Secretary would standardize per capita spending to eliminate the effect of geographic adjustments in payment rates. *CBO estimates that an additional $400 million in outlays would be required by this provision, with all the spending occurring from 2011 to 2013.*

Sec. 1124. Modifications to the Physician Quality Reporting Initiative (PQRI). The Tax Relief and Health Care Act of 2006 (TRHCA, P.L. 109-432) required the establishment of a physician quality reporting system (the Physician Quality Reporting Initiative, PQRI) that would include an incentive payment to eligible professionals who satisfactorily report data on quality measures. MIPPA made this program permanent and extended the bonuses through 2010; the incentive payment was increased from 1.5% of total allowable charges under the physician fee schedule in 2007 and 2008 to 2% in 2009 and 2010.

The bill would modify the PQRI to include a feedback program for physicians, integrate PQRI and electronic health record (EHR) reporting, and extend the years of bonus payments. Not later than January 1, 2011, the Secretary would develop and implement a mechanism to provide timely feedback to eligible professionals on the performance of the eligible professional with respect to satisfactorily submitting data on quality measures under the PQRI program.

The bill would integrate physician quality reporting under the PQRI and EHR reporting relating to the meaningful use of EHR. The integration would consist of the following (1) the development of measures that would both demonstrate meaningful use of an electronic health record for purposes of EHR reporting and provide information on the clinical quality of the care furnished to an individual; (2) the collection of health data to identify deficiencies in the quality and coordination of care for Medicare beneficiaries; and (3) other activities as specified by the Secretary. The Secretary would develop such a plan no later than January 1, 2012. Incentive payments under the PQRI program would be extended through 2012; for each of the years 2009 through 2012, the bonus would be 2% of Part B payments. *According to the CBO, this provision would require an additional $500 million in 2012 and $800 million in 2013.*

Sec. 1125. Adjustment to Medicare Payment Localities. The Medicare fee schedule pays providers differently according to the geographic location, known as a Medicare physician payment locality, in which the provider practices. By construction, the costs of providing physician services were relatively consistent within each payment locality at the time when they were defined; sub-regions of a state were designated as separate payment localities only if the

data showed a marked difference between the costs in that area compared with the rest of the state. Economic conditions have affected parts of the country differently in the years since the payment localities were created. If localities were to be created based on data from recent years using the original methodology, the resulting number and composition of the payment localities might not be the same as the ones that currently exist.

The bill would alter the payment localities in the state of California used as the basis for the geographic adjustment of Medicare physician payments. Under the proposal, payments to California physicians would transition from a system based on the current localities to one based on Metropolitan Statistical Areas (MSAs) for services furnished on or after January 1, 2011. The provision includes a hold harmless condition that would require that no geographic adjustments be reduced below the index in effect on Dec. 31, 2010 during the first five years of the transition from the former county-based payment localities to the MSA-based fee schedule areas. The new fee schedule areas would be subject to periodic review and adjustments. *CBO estimates that these changes would require an additional $200 million over the next five years (2010-2014) and $300 over the next ten (2010-2019).*

Sec. 1131. Incorporating Productivity Improvements into Market Basket Updates That Do Not Already Incorporate Such Improvements. Payments for certain durable medical equipment (DME) in specific areas may be established by competitive bidding, but generally, Medicare pays for certain medical services and supplies using different prospective payment systems or fee schedules. Each year, the Medicare program, often directed by Congress, addresses the issue of whether or how much to increase payments. Under this provision, starting in CY2010, Medicare's annual updates for hospital outpatient department services, ambulance services, ambulatory surgical center services, clinical laboratory services would be subject to the productivity adjustment established earlier in the legislation The productivity adjustment would apply to DME payments starting June 2013. *The CBO score is -$9.2 billion for FY2010-FY2014 and -$42.1 billion for FY2010-FY2019.*

Sec. 1141. Rental and Purchase of Power-driven Wheelchairs. Medicare pays for new or replacement power-driven wheelchairs in one of two ways: either Medicare will pay the supplier a monthly rental amount during the beneficiary's period of medical need (not to exceed 13 continuous months), or, payment is made on a lump-sum basis at the time the supplier furnishes the chair. Power wheelchairs are classified into 3 broad groups based on their reported performance in categories such as speed, range of travel and the height of the vertical obstruction they can climb. This provision would restrict the 'lump-sum' payment provision for new and replacement power-driven wheelchairs to those recognized by the Secretary as classified within group 3 or higher. The provision would be effective for chairs furnished on or after January 1, 2010, but would not apply to areas where the payments for Medicare DMEPOS are based on the competitive bids of suppliers where bids had been submitted before October 1, 2010. *The CBO score is -$0.6 billion for FY2010-FY2014 and -$0.8 billion for FY2010-FY2019.*

Sec. 1141A. Election to Take Ownership, or to Decline Ownership, of a Certain Item of Complex Durable Medical Equipment After the 13-Month Capped Rental Period Ends. Pressure reducing support surfaces are used for the care or prevention of pressure ulcers or bedsores and are a covered Medicare Part B DME benefit. For beneficiaries that fulfill coverage criteria for a pressure reducing support surface, Medicare will pay the supplier a monthly rental amount during the beneficiary's period of medical need (though payments are not to exceed 13 continuous months). On the first day after the 13th continuous month of rental payments, the supplier of the item is required to transfer title of the item to the beneficiary. After the supplier

transfers title to the beneficiary, Medicare pays for maintenance and servicing for parts and labor not otherwise covered under a manufacturer's warranty if the Secretary determines that payments are reasonable and necessary. Payment amounts for such maintenance and services are determined by the Secretary. Support surfaces come in different categories. A group 3 support surface is a complete bed system known as air-fluidized beds. It simulates the movement of fluid by circulating filtered air through silicone-coated ceramic beads.

This provision would eliminate the automatic transfer of title of group 3 support surfaces to beneficiaries after 13 months of continuous use. Effective upon enactment, this provision would require DME suppliers, during the 10th continuous month of rental, to offer the beneficiary the option to accept or reject the transfer of title to a group 3 support surface after the 13th month of rental. The beneficiary would be deemed to reject the title, unless it was accepted within one month of the offer. If the individual accepted the title, it would be transferred on the first day that begins after the 13th month of continuous rental. If on the effective date of this legislation, the individual's rental period has exceeded 10 continuous months, but has not reached the first day after the 13th month of continuous rental, the supplier would be required to offer the beneficiary the option to reject or accept title to the group three support surface. The supplier would be required to do so within 1 month of the effective date. The beneficiary has one month to accept or reject the title. The beneficiary is deemed to reject the title unless it is accepts the title. The provision would require the supplier to continue to supply the support surface for the reasonable useful lifetime of the surface without charge if the beneficiary rejects the transfer of title but continues to require the support surface. Reasonable and necessary maintenance and servicing not otherwise covered by a manufacturer's warranty would be covered by Medicare, as under current law. *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

Sec. 1142. Extension of Payment Rule for Brachytherapy. As required by MMA, Medicare's outpatient prospective payment system make separate payments for specified brachytherapy sources. As mandated by TRHCA, this separate payment will be made using hospitals' charges adjusted to their costs until January 1, 2008. MMSEA extended cost reimbursement for brachytherapy services until July 1, 2008. MMSEA also specified that therapeutic radiopharmaceuticals will be paid using this methodology for services provided on or after January 1, 2008, and before July 1, 2008. MIPPA extended cost reimbursement for brachytherapy and therapeutic radiopharmaceuticals until January 1, 2010. The provision would extend cost reimbursement for brachytherapy and therapeutic radiopharmaceuticals until January 1, 2012. *The CBO score is between -$50 million and $50 million for both FY2010-FY2014 and FY2010-FY2019.*

Sec. 1143. Home Infusion Therapy Report to Congress. Infusion therapy involves the administration of medication through a needle or a catheter. If a physician determines that it is medically appropriate for a particular patient, some infusion therapies may be provided in a patient's home. Infusion drugs administered in a patient's home are covered under the Medicare Part D drug benefit. Medicare Part D does not, however, cover supplies, equipment or professional services associated with home infusion therapy. The provision would require MedPAC to analyze the scope of infusion therapy services provided under specified programs, the benefits and costs of providing coverage under Medicare, and analysis of how payment for such services could be structured. MedPAC is to submit a report to Congress not later than July 1, 2011. *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

Sec. 1144. Require Ambulatory Surgical Centers (ASCs) to Submit Cost Data and Other Data. Ambulatory surgery centers (ASCs) must meet certain health, safety, and other specified

standards in order to participate in Medicare. ASCs have never been required to submit cost reports. In March 2009, MedPAC recommended that Congress require ASCs to submit cost data and quality data that would allow for an effective evaluation of the adequacy of Medicare's payment rates. The provision would require ASCs to submit information on their facility costs as a condition for agreeing to participate in Medicare beginning 18 months after the date the Secretary develops the cost reporting form. No later than three years from enactment, an ASC cost reporting form would be developed taking into account the hospital cost reporting requirements. The ASC cost reports would be periodically audited. The requirements would apply to agreements applicable to cost reporting periods. Starting 2012, ASCs would be required to report quality data, including data on health care associated infections. *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

Sec. 1145. Treatment of Certain Cancer Hospitals. Eleven cancer hospitals are exempt from the IPPS used to pay inpatient hospital services provided by acute care hospitals. Historically, they have been paid on a reasonable cost basis, subject to certain payment limitations and incentives. These hospitals are also held harmless under the outpatient prospective payment system (OPPS) and will not receive less from Medicare under this payment system than under the prior outpatient payment system. Under OPPS, Medicare pays for outpatient services using ambulatory payment classification (APC) groups. The Secretary would be required to determine if the costs incurred by cancer hospitals with respect to APCs exceed those costs incurred by other hospitals reimbursed under OPPS. If so, cancer hospitals would receive APC payments with an appropriate adjustment for outpatient services furnished starting January 1, 2011. *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

Sec. 1146. Payment for Imaging Services. Under the Medicare fee schedule, some services have separate payments for the technical component and the professional component. Medicare pays for each of these components separately when the technical component is furnished by one provider and the professional component by another. When both components are furnished by one provider, Medicare makes a single global payment that is equal to the sum of the payment for each of the components. Imaging procedures generally have two parts: the actual taking of the image (the technical component), and the interpretation of the image (the professional component).

CMS's method for calculating the Medicare fee schedule reimbursement rate for advanced imaging services assumes that imaging machines are operated 25 hours per week, or 50% of the time that practices are open for business. Setting the equipment use factor at a lower—rather than at a higher—rate has led to higher payment for these services. Citing evidence showing that the utilization rate is 90%, rather than the 50% previously assumed, MedPAC is urging CMS to use the higher utilization rate in the calculation of fee schedule payments for advanced imaging services.

The bill proposes to increase the utilization rate for calculating the payment for advanced diagnostic imaging equipment from 50% to 75%; this would result in a decrease in the payment. In addition, for single session imaging involving continuous body parts, the proposal would reduce the technical component fees for additional imaging services to 50% to reflect efficiency. These modifications would apply to services furnished on or after January 1, 2011. *The CBO score is -$1.3 billion for FY2010-FY2014 and -$3.4 billion for FY2010-FY2019.*

Sec. 1147. Durable Medical Equipment Program Improvements. This provision modified requirements for surety bonds, oxygen equipment and accreditation. *The CBO score for Section 1147 is between -$50 million and $50 million for both FY2010-FY2014 and FY2010-FY2019.*

***Surety Bond*:** The Secretary can not issue or renew a Medicare provider number for payment of Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) claims unless the supplier provides the Secretary with a surety bond of not less than $50,000. The final regulation exempts certain individuals from the requirement, including certain physicians and non-physician practitioners, physical and occupational therapists, state-licensed orthotic and prosthetic personnel, and government-owned suppliers. This provision would waive the surety bond requirement for a pharmacy or supplier that exclusively furnishes eyeglasses or contact lenses, or a pharmacy or supplier that (1) supplies durable medical equipment, prosthetics, orthotics, and supplies, (2) has been issued a provider number for at least five years, and (3) has not received an adverse action.

***Oxygen Equipment*:** Medicare makes rental payments for oxygen equipment. The monthly payments are made for the period of medical need, not to 36-months. The statute requires suppliers to continue furnishing the equipment during any period of medical need for the remainder of the reasonable useful lifetime of the equipment, which is defined by the Secretary as five years (or 60 months). This provision would modify the time period during which the supplier would be required to furnish medically necessary oxygen and oxygen equipment. As of the 27th month of the 36 month rental period, the supplier furnishing the equipment would be required to continue furnishing the equipment (either directly or through arrangements with other suppliers) during any subsequent period of medical need for the remainder of the reasonable useful lifetime of the equipment regardless of the location of the individual, unless another supplier accepted the responsibility to furnish equipment during the remainder of the period. This provision would apply to equipment furnished to individuals for whom the 27th month of a continuous period of use occurred on or after July 1, 2010. This provision would also allow a beneficiary to begin a new 36 month rental period if the supplier who had been furnishing oxygen and oxygen equipment to the beneficiary was declared bankrupt and its assets were liquidated and at the time of the declaration and liquidation more than 24 months of rental payments had been made.

Accreditation: MMA required the Secretary to establish and implement quality and accreditation requirements for Medicare suppliers of DMEPOS. MIPPA exempted a group of health care professionals from having to become accredited unless the Secretary determined the standards were designed specifically to be applied to those professionals. The Secretary was given authority to exempt other professionals from the accreditation. This provision would exempt pharmacies enrolled as Medicare DMEPOS suppliers from the accreditation requirement for the purposes of supplying diabetic testing supplies, canes, and crutches. Any supplier that had submitted an application for accreditation before August 1, 2009 would retain their Medicare provider or supplier number until an accreditation organization had determined compliance with the accreditation requirement.

Section 1148. MedPAC Study and Report on Bone Mass Measurement. The Medicare Payment Advisory Commission would conduct a study regarding bone mass measurement, including computed tomography, duel-energy x-ray absorptriometry, and vertebral fracture assessment. The study would focus on the following: (1) an assessment of the adequacy of Medicare payment rates for such services, taking into account costs of acquiring the necessary equipment, professional work time, and practice expense costs; (2) the impact of Medicare payment changes since 2006 on beneficiary access to bone mass measurement benefits in general

and in rural and minority communities specifically; (3) a review of the clinically appropriate and recommended use among Medicare beneficiaries and how usage rates among such beneficiaries compares to such recommendations; and (4) in conjunction with the findings under (3), recommendations, if necessary, regarding methods for reaching appropriate use of bone mass measurement studies among Medicare beneficiaries. Not later than 9 months after enactment, the Commission would submit a report to the Congress containing a description of the results of the aforementioned study and the conclusions and recommendations, if any, regarding each of the issues described above. *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

Sec. 1149. Timely Access to Post-Mastectomy Items. A breast prosthesis is covered by Medicare Part B for a patient who has *had* a mastectomy. An external breast prosthesis garment, with mastectomy form is covered for use in the postoperative period prior to a permanent breast prosthesis or as an alternative to a mastectomy bra and breast prosthesis. The breast prosthesis and garment are not covered by Medicare prior to the mastectomy or breast cancer surgery as there is no medical need for the items. By not later than January 1, 2011, the provision would specify that payment for post-mastectomy external breast prosthesis garments would be made regardless of whether the items are supplied to the beneficiary prior to or after the mastectomy procedure or other breast cancer surgical procedure. The Secretary would be required to develop policies to ensure appropriate beneficiary access and utilization safeguards. *The CBO score is between -$50 million and $50 million for both FY2010-FY2014 and FY2010-FY2019.*

Sec. 1149A. Payment for Biosimilar Biological Products. A biologic is a preparation, such as a therapeutic product or a vaccine, that is made from living organisms. Medicare Part B pays for a limited number of drugs and therapeutic products, including biologics, administered to patients in physician offices and hospital outpatient departments, or those administered through durable medical equipment (DME) and billed by pharmacy suppliers. CMS assigns a Healthcare Common Procedure Coding System (HCPCS) code to each drug, and Medicare payments for Part B drugs are based on the average sales price (ASP) for each HCPCS code. CMS uses the same HCPCS code for all drug products listed as therapeutically equivalent in FDA's *Orange Book*. Therefore, a brand-name drug and any generic versions of the same drug would have the same HCPCS code and the prices would be averaged together for ASP determinations.

Under this provision interchangeable biological products and their reference biological product would be included in the same billing and payment code and reimbursed at ASP, determined using the methodology for multiple source Part B drugs, plus 6% of this ASP. A biosimilar product would be reimbursed at ASP, using the methodology applied to single source drugs, plus 6% of this ASP or 6% of the ASP for the reference biological product. If a biological product is the reference product for both an interchangeable biological product and a biosimilar product, its reimbursement would be based on the ASP methodology (plus 6%) used for multiple source drugs. An interchangeable biological product would mean a biologicial product licensed as an interchangeable biological product under the Public Health Service Act (PHSA), and a biosimilar biological product would be defined as a biological product licensed as a biosimilar biological product under the PHSA. The term "reference biological product" would mean the licensed biological product that is referred to in the application for the biosimilar or interchangeable biological product. This provision assumes enactment of Section 2575 of the Act which would expand the regulatory activities of FDA by opening a licensure pathway for the approval of

biosimilars.[23] *The CBO score (combined with Section 2575) is -$0.1 billion for FY2010-FY2014 and -$6.2 billion for FY2010-FY2019.*

Sec. 1149B. Study and Report on DME Competitive Bidding Process. Medicare Part B covers a wide variety of durable medical equipment, prosthetics, orthotics, and other medical supplies (DMEPOS) if they are medically necessary and are prescribed by a physician. Medicare pays for most DME on the basis of a fee schedule. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA, 108-173) required the Secretary to establish a competitive acquisition program for specified durable medical equipment; the competitive acquisition program is to use payments based on *suppliers*' bids to replace the Medicare fee schedule payments. The program is to be phased-in, starting in nine of the largest metropolitan statistical areas (MSAs) in 2009 (round 1); expanding to an additional 70 of the largest MSAs in 2011 (round two) and remaining areas after 2011. This provision would require the Comptroller General of the United States to conduct a study to evaluate the potential establishment of a program under Medicare to acquire DMEPOS through a competitive bidding process among *manufacturers* of medical equipment and supplies. The study would be required to address (1) identification of appropriate types of DME for the program, (2) recommendations of the structure of an acquisition program to promote fiscal responsibility and beneficiary access, (3) recommendations on how to phase-in a program and on what geographic level, (4) recommendations on criteria (in addition to price) that could be factored into the bidding, (5) recommendations on how suppliers could be compensated for furnishing and servicing equipment and supplies acquired in the program, (6) comparison of such program to the current Medicare DMEPOS competitive acquisition program, as well as other federal acquisition programs, and (7) other relevant considerations. *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

Sec. 1151. Reducing Potentially Preventable Hospital Readmissions. Medicare pays for most acute care hospital stays using a prospectively determined payment for each discharge. Payment also depends on the relative resource use associated with a patient classification group, referred to as the Medicare Severity diagnosis related groups (MS-DRGs), to which the patient is assigned. Medicare's IPPS includes adjustments that reflect certain characteristics of the hospital, such as the wage index of the area where the hospital is located or where it has been reassigned, its teaching hospital status and DSH status. Hospitals in Maryland are not paid using IPPS; rather they receive Medicare payments based on a state-specific Medicare reimbursement system. Critical Access Hospitals (CAHs) are limited-service facilities that are located more than 35 miles from another hospital (15 miles in certain circumstances) or designated by the state as a necessary provider of health care; offer 24-hour emergency care; have no more than 25 acute care inpatient beds; and have a 96-hour average length of stay. Medicare pays CAHs on the basis of 101% of the reasonable costs of the facility for inpatient and outpatient services. Certain aspects of the CAH payment system are not subject to administrative or judicial review.

According to MedPAC's analysis of 2005 Medicare data, 6.2% of hospitalizations of Medicare beneficiaries resulted in readmission within 7 days and 17.6% of hospitalizations resulted in readmission within 30 days. The 17.6% of hospital readmission accounts for $15 billion in Medicare spending. These readmission rates reflect the total number of readmissions, including those that may not have been related to the initial diagnosis and may not have been preventable.

[23] See CRS Report R40892, *Public Health, Workforce, Quality, and Related Provisions in H.R. 3962*, coordinated by C. Stephen Redhead.

MedPAC, CMS, and others have expressed concern that providers do not have financial incentives to reduce potentially preventable readmissions. In addition, MedPAC, in its June 2008 report, recommended that Medicare's payments to hospitals with relatively high readmission rates for select conditions be reduced.

Penalties for Hospitals IPPS hospitals and acute care hospitals in Maryland would receive reduced payments for potentially preventable hospital readmissions occurring on or after October 1, 2011. Reduced hospital payments for readmissions would be calculated by multiplying the base operating DRG payment amount by an adjustment amount. The base operating DRG payment amount is the base amount that would have been paid under IPPS reduced by payments associated with indirect medical education and DSH payments. In the case of hospitals in Maryland, the base amount would be the payment amount under their state system.

The adjustment factor for a hospital in a fiscal year would be the greater of (1) a floor adjustment factor equal to a reduced percentage of the discharge payment or (2) the excess readmissions ratio for the applicable fiscal year. The floor adjustment factor would be 0.99 of the discharge payments in FY2012, 0.98 of the discharge in FY2013, 0.97 in FY2014; or 0.95 in subsequent fiscal years. The excess readmissions ratio would equal 1 minus the ratio of the aggregate payments for excess readmissions for the hospital divided by the aggregate payments for all discharges. (Each component of this formula is specified in the provision.) Beginning with discharges for FY2014, the Secretary would be able to provide additional incentives for hospitals to reduce their potentially preventable readmission rates (by ranking hospitals by readmission ratios from lower to higher readmissions and establishing a benchmark that is lower than the 50^{th} percentile).

An applicable condition would be defined as a condition or procedure that represents high volume (above a minimum threshold) or high expenditures for Medicare or meets other specified criteria that also satisfies certain measures of readmissions (that have been endorsed by a consensus-based entity). Readmissions would be defined as an admission to the hospital of an individual who had been discharged from either the same or another applicable hospital within a specified time period from the date of discharge.

Starting in FY2012, the Secretary would select 3 applicable conditions that have been endorsed by the consensus based entity as of the date of enactment. Beginning with FY2013, the Secretary would be required to expand the list of applicable conditions to include 4 conditions identified by the MedPAC in its June 2007 *Report to Congress*. The Secretary would also be able to extend it to other conditions including an appropriate all-condition measure of readmissions. In expanding the list of conditions, the Secretary would be required to seek the endorsement by a consensus-based entity, but would be able to apply such conditions without such endorsement.

Hospital activities would be monitored to determine if the hospitals took the steps to avoid patients at risk for readmissions. Such activities could be sanctioned, after appropriate notice and opportunity for the hospital to redress these actions.

Starting in FY2011, targeted hospitals that had at least a 30% disproportionate share patient percentage using the latest available data could receive increased payments for activities designed to address patient noncompliance issues including transitional care activities. Transitional care services would be defined as activities furnished by a qualified provider, who meets relevant experience and training requirements, that support a beneficiary beginning at admission and ending no later than 90 days from discharge. Services would include assessments and

development of an evidence based transitional care plan with such other activities as: care coordination services; hiring translators and interpreters; increasing discharge planning services among other actions. The payment increase would be subject to aggregate and hospital-specific caps. In the aggregate, payment increases would not exceed 5% of the estimated savings attributed to the hospital readmission policy in a fiscal year. A specific hospital would not receive more than the estimated difference attributed to the excess readmissions policy. The Secretary would make these additional payments on a lump sum basis, a periodic basis, a claim by claim basis or in any other form deemed appropriate. Not later than three years after funds are first made available, GAO would be required to submit a report on the use of such funds.

No administrative or judicial review could be conducted of the determination of the base operating DRG amounts; the methodology for determining the excess readmission adjustment factor and its various components (excess readmissions ratio, aggregate payments for excess readmissions and aggregate payments for all discharges, applicable conditions, and applicable periods); measures of readmissions; the determination of a targeted hospital for additional payments, the increase in payments, the aggregate cap, the hospital-specific limit, and the form of the additional payment.

Application to Critical Access Hospitals (CAHs). Starting for cost reporting periods beginning in FY2012, CAHs would receive reduced payments for preventable hospital readmissions. The adjustment factor for acute care hospitals would be applied. The methodology for determining the adjustment factor, including the determination of aggregate payments for actual and expected readmissions, applicable periods, applicable conditions and measures of readmission would not be subject to administrative or judicial review.

Application to Post-Acute Care Providers. The proposal would also reduce Medicare payments on claims from post-acute care providers (SNFs, IRFs, HHA, and LTCHs) for patients readmitted to an applicable hospital or a CAH within 30 days of an initial discharge from a hospital or a CAH. The day of admission or first day of post-acute care would not be included. Payments to post-acute providers would be reduced by 0.996 for the fiscal year or rate year 2012; 0.993 for the fiscal or rate year 2013; and 0.99 for fiscal or rate year 2014. This policy would apply to the discharges or services starting the first day of the fiscal or rate year starting October 1, 2011, depending upon the providers' Medicare rate setting schedule.

The Secretary would be required to develop appropriate measures of readmissions rates for post-acute care providers and to submit such measures for endorsement through a consensus-based entity. The Secretary would be required to adopt, expand and apply such measures, in the same manner as for applicable hospitals established earlier in the legislation. To the extent such measures would be adopted, the Secretary would adopt similar payment policies for post-acute providers on or after October 1, 2013 that have been established for applicable hospitals and CAHs earlier in this proposed legislation. Post-acute providers would also be subject to the monitoring and penalties established for applicable hospitals and CAHs earlier in this proposed legislation.

Physicians. The Secretary would be required to conduct a study to determine how this readmissions policy could be applied to physicians and issue a public report no later than one year after enactment. Such approaches would be required to be considered: (1) creating a code (or codes) and budget neutral payment amount(s) under the fee schedule for services furnished by an appropriate physicians who sees an individual within the first week after discharge from a hospital or CAH.; (2) developing measures of readmissions rates for individuals treated by

physicians; (3) applying a payment reduction for physicians who treat the patient during the initial admissions that results in a readmission; and (4) methods for attributing payments or payment reductions to the appropriate physician or physicians.

Funding. In addition to funds otherwise available, $25 million for each fiscal year beginning with 2010 would be appropriated to the CMS Program Management Account; the amounts appropriated for a fiscal year would be available until expended. *The CBO score is -$2.0 billion for FY2010-FY2014 and -$9.3 billion for FY2010-FY2019.*

Sec. 1152. Post-Acute Care Services Payment Reform Plan and Bundling Pilot Program. Medicare pays for most post-acute care (PAC) services, including skilled nursing facilities (SNF), long-term care hospitals (LTCH), inpatient rehabilitation facilities (IRF), and home health, under prospective payment systems (PPS) established for each type of provider. Payments across PAC settings may differ considerably even though the clinical characteristics of the patient and the services delivered may be very similar. The Deficit Reduction Act of 2005 (P.L. 109-171) required the Centers for Medicare and Medicaid Services (CMS) to develop a Post Acute Care Payment Reform Demonstration (PAC demonstration) to standardize patient assessment information from PAC settings and to use these data to guide payment policy in the Medicare program. This demonstration began in 2008 and a report is expected to be submitted to Congress by the Secretary in 2011. CMS has also established a three-year Acute Care Episode (ACE) Demonstration to test the effects of using a bundled payment for hospital and physician services for a set of 9 orthopedic and 28 cardiovascular conditions. There are five participants in the ACE demonstration which began early in 2009.

The provision would require the Secretary to develop a detailed plan for bundling payments for Medicare's PAC services (SNFs, IRFs, LTCHs, hospital based outpatient rehabilitation facilities, and home health agencies services) provided after discharge from a hospital and as determined appropriate by the Secretary. The goals of this payment reform would be to improve the coordination, quality and efficiency of PAC services and improve outcomes for individuals such as reducing the need for readmission to hospitals from providers. In addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there would be appropriated to the Secretary, $15 million for each of FYs 2010 through 2012. Such amounts would be required to be available until expended. In addition to issuing interim public reports, The Secretary would be required to issue a final public report on this plan no later than three years after this Act's enactment.

This provision would also require the Secretary, by no later than January 1, 2011 to convert the acute care episode demonstration into a pilot program and expand it to include post-acute services and such other services the Secretary determines to be appropriate. Under this pilot program, the Secretary could apply bundled payments to: (i) hospitals and physicians; (ii) hospitals and post-acute-care providers; (iii) hospitals, physicians, and post-acute care providers; or (iv) combinations of post-acute providers. Bundled payments would be applied in manner as to include collaborative care networks and continuing care hospitals, as defined by the legislation. The Secretary could expand the demonstration program if it increases quality of care and reduces program expenditures. Secretary would also be required to provide a study of and development of a plan, that could be implemented by the Secretary in a demonstration, to test additional ways to increase bundling of payments for physicians in connection with an episode of care. *The CBO score is between -$50 million and $50 million for both FY2010-FY2014 and FY2010-FY2019.*

Sec. 1153. Home Health Payment Update for 2010. HHAs are paid under a PPS in which payments are based on 60-day episodes of care for beneficiaries, subject to several adjustments, with unlimited episodes of care in a year. The payment covers skilled nursing, therapy, medical social services, aide visits, medical supplies, and others. Durable medical equipment is not included in the home health PPS. The base payment amount, or national standardized 60-day episode rate, is increased annually by an update factor that is determined, in part, by the projected increase in the home health market basket (MB) index. This index measures changes in the costs of goods and services purchased by HHAs. For CY 2010, the HH MB is expected to be 2.2%. Starting in 2007, HHAs were required to submit to the Secretary health care quality data. A HHA that does not submit the required quality data now receives an update of the MB minus two percentage points. This reduction only applies to the fiscal year in question.

The provision would eliminate the MB update for home health payments for 2010. Home health agencies would still be subject to the requirement to submit required quality data in subsequent years. Subject to another provision regarding a productivity adjustment, payments for HHAs would be increased by the HH MB percentage change for the fiscal year involved for each subsequent fiscal year. *For home health provisions 1153 through 1155, the CBO score is -$16.7 billion for FY2010-FY2014 and -$56.7 billion for FY2010-FY2019.*

Sec. 1154. Payment Adjustments for Home Health Care. HHAs are paid under a PPS. Payment is based on 60-day episodes of care for beneficiaries, subject to several adjustments, with unlimited episodes of care in a year. In calendar year (CY) 2008, CMS made refinements to the PPS that resulted in payment reductions established in 42 CFR §484.220 as described in the *Federal Register* issued on August 29, 2007 (72 FR 49879). This regulation established changes to the HHA case-mix index to account for the relative resource utilization of different patients. These changes modified the coding or classification of different units of service that do not reflect real changes in case-mix. As a result, the national prospective 60-day episode payment rate was adjusted downward by 2.75% for CY2008; by 2.75% for each calendar year 2009 and 2010, and by 2.71% for CY2011. The proposed rule for CY 2010 would continue with the previously promulgated 2.75% reduction to the HH PPS rates in CY 2010. It would also cap outlier payments at 10% of total HH PPS payments, update the fixed dollar loss ratio to 0.67, and target outlier payments to be no more than 2.5% of total HH PPS payments.

The provision would accelerate the case-mix adjustments by implementing both the planned CY2011 adjustment of 2.71% and the planned CY2010 of 2.75% at the same time in CY2010, for a total CY2010 downward adjustment of 5.46%. These adjustment amounts would not be limited if more recent data were to indicate that a greater adjustment would be appropriate. Starting in 2011, PPS amounts would be adjusted by a uniform percentage determined appropriate by the Secretary and based on analysis of certain factors. After 2011, such amounts would be required to be equal to the amount paid for the previous year updated by the HH MB. If the Secretary is not able to compute the changed prospective payment amounts for 2011 on a timely basis, then the Secretary would be required to pay 95% of what the prospective payment amount would have been had this provision not applied and to compare, before July 1, 2011, amounts paid to amounts that would have been paid had the Secretary been able to compute the adjustment on a timely basis. For 2012, the Secretary would be required to decrease or increase the prospective payment amount (or at the Secretary's discretion, over a period of several years beginning with 2012), by the amount (if any) by which the amount applied is greater or less, respectively, than the amount that should have been applied. *For home health provisions 1153 through 1155, the CBO score is -$16.7 billion for FY2010-FY2014 and -$56.7 billion for FY2010-FY2019.*

Sec. 1155. Incorporating Productivity Improvements Into Market Basket Update For Home Health Services. Home health agencies (HHAs) are paid under a prospective payment system (PPS). The base payment amount, or national standardized 60-day episode rate, is increased annually by an update factor that is determined, in part, by the projected increase in the home health MB index. This index measures changes in the costs of goods and services purchased by HHAs. HHAs are required to submit to the Secretary health care quality data. A HHA that does not submit the required quality data will receive an update of the MB minus two percentage points. The provision would make annual updates by the HH MB, beginning with 2011, subject to a productivity adjustment as long as the annual update would not be less than zero. The productivity adjustment would equal the 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity. *For home health provisions 1153 through 1155, the CBO score is -$16.0 billion for FY2010-FY2014 and -$54.7 billion for FY2010-FY2019.*

Sec. 1155A. MedPAC Study on Variation in Home Health Margins. In its March 2009 report, MedPAC reported that home health agencies experienced margins of 16.6% in 2007, about equal to the average of 16.5% for 2002–2007. In its view, HHA margins (generally the difference between the cost of providing the services and Medicare payments received for those services) provide an indication of whether payment rates have been established and updated at an appropriate level for efficient providers to provide necessary services. Sustained substantial positive margins might indicate that the rates are excessive in the aggregate or for particular subgroups of providers. As a result, MedPAC concluded that home health payments should be significantly reduced in 2010 and payments rebased and revised in 2011 to ensure that Medicare does not continue to overpay home health providers. The provision would require MedPAC to conduct a study regarding variation in performance of HHAs to explain variation in Medicare margins across agencies. No later than June 1, 2011, the Commission would be required to submit a report to Congress on the results of the study, among other things. *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

Sec. 1155B. Permitting Home Health Agencies to Assign the Most Appropriate Skilled Service to Make the Initial Assessment Visit under A Medicare Home Health Plan of Care for Rehabilitation Cases. With some exceptions, Medicare regulations require a registered nurse to conduct an initial assessment visit of a HHA beneficiary to determine the immediate care and support needs of the patient, and, for Medicare patients, to determine eligibility for Medicare home health benefits, including whether the individual meets Medicare's requirement that he or she is homebound. One exception to this rule is applied when rehabilitation therapy services (speech, language pathology, physical therapy, or occupation therapy) is the only service ordered by the physician, and if the need for that service establishes program eligibility. In this case, the initial assessment visit may be made by the appropriate rehabilitation professional. The provision would allow HHAs to determine the most appropriate skilled therapist to make the initial assessment visit for an individual who is referred (and may be eligible) for home health services, but who does not require skilled nursing care as long as the skilled service (for which the therapist is qualified to provide) is included as part of the home health care plan. *The CBO score is between -$50 million and $50 million for both FY2010-FY2014 and FY2010-FY2019.*

Sec. 1156. Limitation on Medicare Exception to the Prohibition on Certain Physician Referrals for Hospitals. Physicians are generally prohibited from referring Medicare patients for certain services to facilities in which they (or their immediate family members) have financial interests. However, among other exceptions, physicians are not prohibited from referring patients to whole hospitals in which they have ownership or investment interests. Providers that furnish

substantially all of its designated health services to individuals residing in rural areas are exempt as well.

Entities receiving Medicare payment for covered items and services are required to provide the information on the entities' ownership, investment, and compensation arrangements. This information includes the covered items and services provided by the entity, and the names and unique physician identification numbers of all physicians (or those whose immediate relatives) who have an ownership or investment interest, or certain compensation arrangements.

Under this provision, only hospitals that met certain requirements would be exempt from the prohibition on self-referral. Hospitals (including rural providers) that have physician ownership and a provider agreement in operation on January 1, 2009 and that met other specified reporting and public disclosure requirements would be exempt from this self-referral ban. The percentage of the total ownership or investment held in the hospital (or in an entity whose assets include the hospital) by physician owners or investors in the aggregate would not be able to exceed such percentage as of the date of enactment. With certain exceptions, the number of operating rooms, procedure rooms, or beds of the hospital would not be able to increase after the enactment date. The hospital could not have converted from an ambulatory surgical center to a hospital after enactment.

Information provided by hospitals would be published and periodically updated on the Internet website of the Centers for Medicare and Medicaid Services (CMS). Any person who fails to meet required reporting and disclosure requirements would be subject to a civil monetary penalty of not more than $10,000 for each day for which reporting is required to have been made or for each case in which disclosure is required to have been made.

Exempt hospitals would ensure bona fide ownership and investment by meeting certain requirements. Generally, any ownership or investment interest offered to a physician could not be offered on more favorable terms than those offered to a person who is not in a position to refer patients or otherwise generate hospital business. Other restrictions would apply. To ensure patient safety, those exempt hospitals that do not offer emergency services would have to have the capacity to provide assessment and initial treatment for medical emergencies as well as the ability refer and transfer the patient with the medical emergency to an appropriate hospitals. Hospitals that do not have any physician available on the premises 24 hours per day, 7 days a week must disclose such a fact to the patient before admitting the patient and receive a signed acknowledgement from the patient. The Secretary would retain the ability to terminate a hospital's provider agreement if the hospital is not in compliance with Medicare's conditions of participation.

With certain exceptions, exempt hospitals would not be permitted to increase the number of operating rooms, procedure rooms or beds after the date of enactment. A process would be established to allow certain hospitals meeting specific requirements to expand. Fewer requirements would apply to those hospitals that had the highest percentage of Medicaid admissions in comparison to any other hospital in the county. Any capacity increase would be limited to facilities on the main campus of the hospital and could not exceed 200% of the number of operating rooms, procedure rooms and beds at the time of enactment. The Secretary would be required to promulgate regulations establishing the appeal process no later than the first day of the month beginning 18 months after the date of enactment, The appeal process would be implemented one month after the date of regulations are promulgated. The final decision regarding an expansion request will be posted on the CMS website of no later than 120 days after

a complete application is received. There shall be no administrative or judicial review of this process.

The Secretary would be required to establish policies and procedures to ensure compliance with these requirements. The enforcement efforts would be able to include unannounced site reviews of hospitals. Starting in FY2010, $5 million would be appropriated in each fiscal year to carry out this section. Appropriated funds would be available until expended. *The CBO score is -$0.3 billion for FY2010-FY2014 and -$1.0 billion for FY2010-FY2019.*

Sec. 1157. Institute of Medicine Study of Geographic Adjustment Factors Under Medicare. Generally, Medicare's payment systems include adjustment factors to account for the geographic differences in the costs of providing health care services. For example, Medicare's physician fee schedule (which with modifications is used to reimburse other health care practitioners) uses the geographic practice cost index (GPCI) for this purpose; Medicare's IPPS uses a hospital wage index to adjust payments for acute care hospitals. With modifications, the IPPS wage index is used to calculate payments for inpatient rehabilitation hospitals, inpatient psychiatric hospitals, long term care hospitals, skilled nursing facilities, and home health agencies.

Under this provision, the Secretary would enter into a contract with the Institutes of Medicine of the National Academy of Sciences (IOM) to conduct an empirical study with appropriate recommendations on the accuracy of the geographic adjustment factors established for Medicare's physician fee schedule and for Medicare's IPPS The study would also examine the effect of the adjustment factors on the level and distribution of the health workforce within the United States as well as the effect of the adjustment factors on population health, quality of care, and the ability of providers to furnish efficient, high value care. The IOM report would be submitted to the Secretary and to Congress no later than one year from enactment. Necessary funds would be authorized to be appropriated to carry out this study. *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019*.

Sec. 1158. Revision of Medicare Payment Systems to Address Geographic Inequities. Generally, Medicare's payment systems include adjustment factors to account for the geographic differences in the costs of providing health care services. In the previous section, IOM was required to conduct a study of the GPC used to adjust Medicare's physician fee schedule and the hospital wage index used in Medicare's IPPS. With modifications, Medicare's physician fee schedule and the hospital wage index are used to reimburse other practitioners and providers.

Generally, the CMS promulgates changes to Medicare's physician fee schedule and IPPS through an annual rulemaking process where proposed changes and a notice of a public comment period are published in Federal Register with the final rule establishing the payment polices and responding to the public comments issued subsequently in the Federal Register. Medicare's IPPS and physician payments are on different payment years and therefore rulemaking schedules. Generally the new IPPS payment rates are effective October 1st of each year and new physician fee schedule is effective as of January 1st of each year.

Under this provision, the Secretary would be required to take into account the IOM recommendations and include appropriate proposals to revise the respective geographic adjustments in the physician fee schedule and IPPS proposed rules. The proposals would be included in the next applicable rulemaking cycle after submission of the IOM report to the Secretary. The Secretary would be able to change the geographic adjustments accordingly. For payment years before 2014, the geographic adjustment would not be below that which applied in

the payment system in the prior year. For payment years starting in 2014, the geographic adjustment would not be implemented in a way that would otherwise increase Medicare expenditures. Amounts in the Medicare Improvement Fund (MIF) would be available to fund these changes in the geographic factors for services before January 1, 2014; no more than half of the available funds would be spent in any one payment year. MIF would have $8 billion authorized for FY2011 to FY2019. Starting in FY2014, monies not used for the geographic adjustment would be returned to the MIF. *The CBO score is $8.7 billion for FY2010-FY2014 and $14.3 billion for FY2010-FY2019.*

Sec. 1159. Institute of Medicine Study of Geographic Variation in Health Care Spending and Promoting High-Value Health Care. This provision would require the Secretary to enter into an agreement with the Institute of Medicine (IOM) of the National Academies to conduct a study on geographic variation and growth in volume and intensity of services in per capita health care spending among the Medicare, Medicaid, privately insured and uninsured populations. The IOM would then make recommendations for improving payments under fee-for-service Medicare, private insurance, and other programs by promoting "high value care," defined as the efficient delivery of high quality, evidence-based, patient-centered care.

The IOM study would include evaluations or assessments of many variables pertinent to geographic variation, including (1) the extent of the geographic variation, (2) how much the geographic variation can be attributed to differences in input prices, health status, practice patterns, access to and supply of medical services, or to other factors, (3) the correlation between variations in spending and patient access to care, insurance status, distribution of health care resources, health care outcomes, and consensus-based measures of health care quality, (4) how much the variation can be attributed to physician and practitioner discretion in making treatment decisions, (5) the extent to which variation can be attributed to patient preferences and patient compliance with treatment protocols, (6) the degree to which variation cannot be explained by empirical evidence, (7) the extent to which variations in spending for Medicare beneficiaries are correlated with various indicators of insurance status, and (8) other factors as the IOM would deem to be appropriate.

The IOM would take into account the study findings as well as the changes to the payment systems made by this Act and recommend changes to fee-for-service Medicare payments to address variation in Medicare per capita spending (not including add-ons for graduate medical education, disproportionate share payments, and health information technology). These recommendations would promote high value care with particular attention to high-volume, high-cost conditions.

In making the recommendations, the IOM would specifically address whether Medicare payment systems for physicians and hospitals should be further modified to incentivize high-value care. In so doing, the IOM would consider the adoption of a value index based on a composite of appropriate measures of quality and cost that would adjust provider payments on a regional or provider-level basis. If the Institute were to find that application of such a value index would significantly incentivize providers to furnish high-value care, it would make specific recommendations on how such an index would be designed and implemented. In so doing, it would identify specific measures of quality and cost appropriate for use in such an index, and include a thorough analysis (including on a geographic basis) of how Medicare payments and spending would be affected by such an index. The IOM would submit a report containing findings and recommendations of the study to the Secretary and to each House of Congress not later than April 15, 2011.

Following submission of the above report, the IOM would use the data collected and analyzed to issue a subsequent report, or series of reports, on how best to address geographic variation or efforts to promote high-value care for items and services reimbursed by private insurance or other programs. These reports would include a comparison to the IOM's findings and recommendations regarding the Medicare program. These reports, and any recommendations, would not be subject to the procedures outlined in section 1160. To carry out this section, $10 million would be authorized to be appropriated from the general fund of the Treasury. This amount would remain available until expended. *The CBO score is minimal (less than $50 million) over the first five years and $0 over the second five years of the budget window.*

Sec. 1160 Implementation, and Congressional Review, of Proposal to Revise Medicare Payments to Promote High-Value Health Care. Section 1160 requires the Secretary of Health and Human Services to submit to each House of Congress a "Final Implementation Plan," proposing changes in payments for services under Medicare Parts A and B which are designed to promote "high value healthcare." The Secretary is further directed to promulgate regulations implementing these changes in the first rulemaking cycle beginning after a "congressional action deadline," unless a joint resolution of disapproval is enacted halting the process. The measure defines "congressional action deadline," as May 31, 2012, or, if later, the date that is 145 days after the date of receipt of the final implementation plan by each chamber of Congress.

This section also establishes "fast track" parliamentary procedures governing House and Senate consideration of such a joint resolution of disapproval. These procedures are different from the parliamentary mechanisms the House and Senate normally use to consider most legislation, and are designed to ensure that Congress can act promptly to stop the regulations should it choose to do so. Section 1160 also includes provisions which are intended to facilitate the exchange of legislation between the House and Senate. If, before voting upon its own joint resolution of disapproval, one chamber receives a disapproval resolution passed by the other chamber, that engrossed legislation will automatically become the one which the receiving chamber acts on in lieu of its own. *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

Sec. 1161. Phase-in of Payment Based on Fee-for-Service Costs; Quality Bonus Payments. This provision modifies the calculation of Medicare Advantage benchmarks by reducing them to the level of per capita spending in original Medicare and increasing them for qualifying MA plans based on plan quality. *The CBO score for Section 1161 is -$47.5 billion for FY2010-FY2014 and -$154.3 billion for FY2010-FY2019.*

Phase-in payment based on fee-for-service costs: Medicare Advantage (MA) is an alternative way for Medicare beneficiaries to receive covered benefits. Under MA, private health plans are paid a per-person amount to provide all Medicare-covered benefits (except hospice) to beneficiaries who enroll in their plan. Payments to MA plans are determined by comparing plan *bids* to a *benchmark*. Each bid represents the plan's estimated revenue requirement for providing required Medicare services to an average Medicare beneficiary. The benchmark is the maximum amount Medicare will pay a plan. If the plan bid is below the benchmark, the plan payment is the bid plus 75% of the difference between the bid and the benchmark. If the bid is above the benchmark, the plan payment is equal to the benchmark and each plan enrollee must pay a premium equal to the difference between the bid and the benchmark. MA benchmarks are based, in part, on historical Medicare private plan payment rates. BBA 97 increased payments to private plans above rates of per capita FFS costs in some areas. Subsequent legislation also increased payment rates to private plans. The historical payment rates were used as the basis for the

benchmark amounts. As a result, current MA benchmarks exceed per capita FFS costs in some areas. This provision would phase-in MA benchmarks equal to per capita FFS spending in each county starting in 2011. Starting 2013, MA benchmarks would be equal to per capita FFS spending in each county. Benchmarks could not be less than per capita FFS spending. The provision would not apply to Programs of All-Inclusive Care for the Elderly (PACE).

Quality bonus payment: Though all MA organizations are required to have a quality improvement program by January 1, 2010, under current law, payments to MA plans are not contingent on the quality of care provided to plan enrollees. Under this provision, starting in 2011, MA plans could receive an increase in their benchmark if they were a qualifying plan in a qualifying county. The benchmark increases would equal 1.5% in 2011, 3.0% in 2012 and 5.0% in subsequent years. A qualifying plan would have had a quality ranking (based on a quality ranking system to be established by the Secretary) of 4 stars or higher during a specified previous year. A qualifying county would be one, for a year, (a) that was within the lowest third of counties with respect to per capita spending in original Medicare, and (b) within which, 20% of individuals were enrolled in MA. A plan could lose its quality bonus payment for non-compliance with MA rules.

Sec. 1162. Extension of Secretarial Coding Intensity Adjustment Authority. Medicare payments to MA plans are risk-adjusted to account for the variation in the cost of providing care. DRA required the Secretary to adjust for patterns of diagnosis coding differences between MA plans and providers under parts A and B of Medicare for plan payments in 2008, 2009, and 2010, to the extent that the Secretary identified such differences. The Secretary did not make adjustments in 2008 and 2009, due to ongoing analyses, but is to adjust rates in 2010. The provision would extend the requirement that MA plan payments be adjusted for differences in coding patterns beyond 2010. The provision would require the Secretary to conduct analyses of coding differences periodically and incorporate the findings on a timely basis. *The CBO score is -$2.9 billion for FY2010-FY2014 and -$15.5 billion for FY2010-FY2019.*

Sec. 1163. Simplification of Annual Beneficiary Election Periods. Medicare beneficiaries may enroll in or change their enrollment in MA from November 15 to December 31 each year (the annual, coordinated election period). Changes go into effect January 1st of the next year. During the first three months of the year, beneficiaries can enroll in an MA plan, and individuals enrolled in an MA plan can either switch to a different MA plan or return to original Medicare. This period is known as the continuous open enrollment and disenrollment period. The provision would move the annual, coordinated election period to 15 days earlier in the year—November 1st to December 15th, rather than from November 15th to December 30th. The provision would eliminate the continuous open enrollment and disenrollment period (during the first three months of the year.) *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

Sec. 1164. Extension of Reasonable Cost Contracts. Reasonable cost plans are MA plans that are reimbursed by Medicare for the actual cost of providing services to enrollees. Cost plans were created in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA, P.L. 97-248). BBA 97 included a provision to phase-out the reasonable cost contracts, however, the phase-out has been delayed over the years through congressional action. These plans are allowed to operate indefinitely, unless two other plans of the same type (i.e., either 2 local or 2 regional plans) offered by different organizations operate for the entire year in the cost contract's service area. After January 1, 2010, the Secretary may not extend or renew a reasonable cost contract for a service area if (1) during the entire previous year there were either two or more MA regional plans *or* two or more MA local plans in the service area offered by different MA organizations;

and (2) these regional or local plans meet minimum enrollment requirements. This provision would extend for two years—from January 1, 2010, to January 1, 2012—the length of time reasonable cost plans could continue operating regardless of any other MA plans serving the area. The provision would modify the minimum enrollment requirement used as one of the criteria the Secretary considers when determining whether to renew or extend a reasonable cost plan. The enrollment criteria would apply to the portion of the MA regional or local plan's service area for the year that it was within the service area of the reasonable cost contract (and not the total service area of the MA regional or local plan). *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

Sec. 1165. Limitation of Waiver Authority for Employer Group Plans. The Secretary has the authority to waive or modify requirements that hinder the design of, the offering of, or the enrollment in employer or union sponsored MA plans. Such plans can be offered either under contracts between the union or employer group and a MA organization, or directly by the employer or union group. For all employer or union group MA plans, the Secretary would only have authority to waive or modify MA requirements for the plan if 90% of eligible individuals enrolled in the plan live in a county in which the MA organization offers an MA local plan. This provision would apply to plan years on or after January 1, 2011, and would not apply to plans in effect as of December 31, 2010. *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

Sec. 1166. Improving Risk Adjustment for MA Payments. In general, Medicare payments to MA plans are risk adjusted to account for the variation in the cost of providing care. Risk adjustment is designed to compensate plans for the increased cost of treating older and sicker beneficiaries, and thus discourage plans from preferential enrollment of healthier individuals. The Medicare risk adjustment models take into account the variation in expected medical expenditures associated with demographic characteristics (age, sex, current Medicaid eligibility, original Medicare eligibility due to a disability), as well as medical diagnoses, and differences in coding practices between MA and providers under Medicare Part A and B. The provision would require the Secretary to evaluate and report on the adequacy of MA risk adjustments at predicting costs for beneficiaries with chronic or co-morbid conditions, beneficiaries dually-eligible for Medicare and Medicaid, and non-Medicaid eligible low-income beneficiaries. The report would also address the need and feasibility of including further gradations of diseases or conditions and multiple years of beneficiary data. Taking this report into account, not later than January 1, 2012, the Secretary would be required to implement necessary improvements to the MA risk adjustment system. *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

Sec. 1167. Elimination of the MA Regional Plan Stabilization Fund. MMA created the MA Regional Program and established the MA Regional Plan Stabilization Fund to encourage plans to enter into and/or remain in the MA Regional Program. The fund was originally set at $10 billion with additional money added to the fund from savings in the bidding process. Funds were to be available from 2007 through the end of 2013. Subsequent legislation decreased the amount of funds available and delayed their availability. Most recently, MIPPA reduced the initial funding of the program to one dollar. Money from the regional plan bidding process continues to flow into the Fund, but availability is delayed until 2014. The provision would eliminate the Fund and transfer amounts in the Fund to the Part B Trust Fund. *The CBO score is -$0.2 billion for FY2010-FY2014 and -$0.2 billion for FY2010-FY2019.*

Sec. 1168. Study Regarding the Effects of Calculating Medicare Advantage Payment Rates on a Regional Average of Medicare Fee for Service Rates. The provision would require CMS

to conduct a study to determine the potential effects of calculating MA rates on a more aggregated geographic basis, rather than using county boundaries. The study would consider whether the alternatives would effect (a) plan quality, (b) plan networks including implications for provider contracting, and (c) the predictability of benchmark amounts. CMS would be required to consult with certain experts and stakeholders. CMS would be required to submit a report to Congress, including recommendations, no later than one year after the date of enactment. *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

Sec. 1171. Limitation on Cost-Sharing for Individual Health Services. Each MA plan must provide all required Part A and B Medicare benefits (other than hospice) to individuals entitled to Medicare Part A and enrolled in Part B. Beginning January 2011, MA plans would be prohibited from offering benefits with cost sharing requirements that are greater than the cost sharing requirements imposed under the traditional Medicare program. This provision would also prohibit plans from imposing cost-sharing for dual-eligible individuals or qualified Medicare beneficiaries that exceeds the cost-sharing amounts permitted under the Medicare and Medicaid statutes. *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

Sec. 1172. Continuous Open Enrollment for Enrollees in Plans with Enrollment Suspension. Special Election Periods (SEPs) allow beneficiaries the option to discontinue or change their enrollment in a MA plan outside of the annual coordinated election period. The circumstances in which an enrollee can exercise this option include (1) an MA plan terminates its participation in the MA program or in a specific area, (2) an individual's place of residence changes, (3) the MA plan violates a provision of its contract or misrepresents the plan's provisions in marketing the plan, or (4) other exceptional conditions as provided by the Secretary. This provision would expand the categories of beneficiaries eligible to participate in a SEP to include beneficiaries enrolled in private plans that have been suspended for not meeting the terms of their contract. *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

Sec. 1173. Information for Beneficiaries on MA Plan Administrative Costs. This provision would require the publication of administrative cost information, including the medical loss ratio (MLR), for MA plans. The Secretary would be required to develop and implement standardized elements and definitions for reporting the data necessary to calculate a MLR. Plans that fail to meet a minimum MLR would be subject to sanctions. Beginning in 2014, if the Secretary determines that a MA plan failed to have a MLR of at least 0.85, the Secretary would be required to mandate that the MA plan provide enrollees with a rebate of their Part C premiums (or Part B or D, if applicable) by the amount necessary to meet the 0.85 requirement. The Secretary would also be required to restrict enrollment in the MA plan for 3 consecutive years and terminate the plan's contract if the plan failed to meet the MLR requirements for 5 consecutive years. *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

Sec. 1174. Strengthening Audit Authority. The Secretary is required to provide for the annual auditing of the financial records of at least 1/3 of MA plans. Beginning January 2011, each contract with a MA plan would be required to include a provision that the Secretary have the authority to take necessary action, including the pursuit of financial recoveries, to address deficiencies identified during an annual audit. The provision would apply to Part D Prescription Drug Plans (PDPs) in the same manner as certain other MA contract provisions apply to PDP plans. *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

Sec. 1175. Authority to Deny Plan Bids. By the first Monday in June, each local MA plan must submit to the Secretary an aggregate monthly bid amount (which includes separate bids for

required services, any offered supplemental benefits, and any offered drug benefits) for each MA plan it intends to offer in the upcoming calendar year. The Secretary has the authority to evaluate and negotiate the plan's bid amounts and its proposed benefit packages. Beginning January 2011, the Secretary would not be required to accept any or every bid submitted by a MA or PDP plan. *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

Sec. 1175A. State Authority to Enforce Standardized Marketing Requirements. Federal standards preempt state laws except in the areas of licensing and solvency. Under this provision, States would have the authority to conduct market examinations or impose CMPs against MA and PDP plans or their agents for violating federal marketing requirements. States would also have the authority to recommend sanctions to the Secretary, and the Secretary would be required to respond to the State within 30 days on the status of their recommendation. MA and PDP plans could not be subject to enforcement actions taken by both the Secretary and the States. The Secretary would retain its authority to impose sanctions other than CMPs and States would retain their authority to regulate MA or PDP plan brokers.

Sec. 1176. Limitation on Enrollment Outside Open Enrollment Period of Individuals into Chronic Care Specialized MA Plans for Special Need Individuals. MMA established a new type of Medicare Advantage (MA) coordinated care plan focused on individuals with special needs. Special needs plans (SNPs) are allowed to target enrollment to one or more types of special needs individuals including (1) institutionalized; (2) dually eligible; and/or (3) individuals with severe or disabling chronic conditions. Subsequent legislation has extended the effective date of SNPs (which was set to expire December 31, 2008). MMSEA authorized the SNP program through December 31, 2009, but also established a limited moratorium on the creation of SNPs after January 1, 2008 (existing plans could continue to enroll qualified individuals). More recently, MIPPA, among other changes, authorized the SNP program and extended the moratorium on designation of new SNPs until January 1, 2011.

The number of SNPs has increased dramatically since 2004, the first year of operation. In 2004, CMS approved 11 SNPs, but by January 2008, CMS had approved 787 SNPs, including 442 dual-eligible SNPs, 256 chronic care SNPs, and 89 institutional SNPs. In September 2008, there were 1.2 million beneficiaries in SNPs. Medicare beneficiaries may enroll in or change their enrollment in Medicare Advantage from November 15th to December 31st each year. Changes would go into effect January 1st of the next year. H.R. 3962 would require that beginning on January 1, 2011, SNPs serving beneficiaries with severe or disabling conditions could only enroll eligible individuals during an annual, coordinated open enrollment period or at the time of diagnosis of the disease or condition that would qualify an individual for a chronic care SNP. *The CBO score for Sections 1176—1178 is +$0.2 billion for FY2010-FY2014 and $0.1 billion for FY2010-FY2019.*

Sec. 1177. Extension of Authority of Special Needs Plans to Restrict Enrollment. Prior to January 1, 2011, SNPs may restrict enrollment to those who are in one or more classes of special needs individuals. Starting January 1, 2010, new SNP enrollment must be limited exclusively to individuals that meet the criteria for which the SNP is designated: dual eligible, chronic care, and institutional care. Further, MIPPA required that dual eligible SNPs contract with state Medicaid agencies to provide medical assistance services (Medicaid), which may include long-term care services. If SNPs do not have contracts with Medicaid agencies by January 1, 2010, then they can continue to operate, but are prohibited from expanding their service areas. However, state Medicaid agencies are not required to enter into contracts with SNPs.

This provision would extend the time period, from January 1, 2011 to January 1, 2013, during which SNPs may restrict current enrollment to individuals who meet the definition of the respective SNP. In addition, selected SNPs that had contracts with states that had a state program to operate an integrated Medicaid-Medicare program that was approved by CMS as of January 1, 2004, would be allowed to restrict enrollment to beneficiaries who meet the definition of special needs individuals through January 1, 2016.

The Secretary would be required to provide an analysis of the SNPs that were approved by CMS as of January 1, 2004. The analysis of these grandfathered SNPs would include the impact of such plans on cost, quality of care, patient satisfaction, and other subjects as specified by the Secretary. By December 31, 2011, the Secretary would be required to submit a report to Congress including recommendations on how the appropriate treatment of these plans. *The CBO score for Sections 1176—1178 is +$0.2 billion for FY2010-FY2014 and $0.1 billion for FY2010-FY2019.*

Sec. 1178. Extension of Medicare Senior Housing. In general, Medicare Advantage plans are required to serve an area no smaller than a county, which prevents plans from targeting smaller areas of healthier, low-cost enrollees. However, it is possible for an MA plan to receive a waiver of this requirement to be able to restrict enrollment to residents of a retirement community.

Prior to December 31, 2012, H.R. 3962 would create a new type of Medicare Advantage plan called a Medicare Advantage Senior Housing Facility Plan, which would be allowed to limit its service area to a senior housing facility within a geographic area. An MA Senior Housing Facility Plan would be an MA plan that serves beneficiaries who reside in a continuing care retirement community, has a sufficient number of on-site primary care providers as determined by the Secretary, supplies transportation benefits to other providers, and was in existence under a demonstration for at least one year prior to January 1, 2010. *The CBO score for Sections 1176—1178 is +$0.2 billion for FY2010-FY2014 and $0.1 billion for FY2010-FY2019.*

Sec. 1181. Elimination of Coverage Gap. Medicare law sets out a defined standard benefit structure under the Part D prescription drug benefit that includes a gap in coverage (the *doughnut hole*) during which enrollees, who are not eligible for the low-income subsidy, are responsible for paying 100% of the cost of their drugs. Federal assistance is provided to certain low-income persons to help them meet Medicare Part D premium and cost-sharing charges. In general, beneficiaries may qualify for a subsidy if they have an annual income below 150% of the FPL and if their resources do not exceed a certain limit (in 2009, $12,510 for individuals or $25,010 if married). Prior to the implementation of the Medicare Part D outpatient prescription drug benefit in 2006, Medicaid was the primary payer for drugs for beneficiaries eligible for both Medicare and Medicaid (dual-eligible) beneficiaries. Drug manufacturers who wish to have their drugs available for Medicaid enrollees must provide state Medicaid programs with rebates on drugs paid on behalf of Medicaid beneficiaries.

This provision would gradually phase out the coverage gap until it is completely eliminated in 2019. Drug manufacturers would be required to provide the Secretary rebates for drugs dispensed to "rebate eligible" Part D plan enrollees, and the funds would be used to pay for all or part of the elimination of the coverage gap. Rebate eligible enrollees would initially include only full-benefit dual eligibles; beginning in 2015, the definition would be expanded to include all Part D subsidy eligible enrollees. *The CBO score (with interaction with Section 1182) is –$21.1 billion for FY2010-FY2014 and -$42.3 billion for FY2010-FY2019. In a separate analysis of a similar*

provision under H.R. 3200,[24] CBO estimated that beneficiary premiums would increase faster than they would under current law; however, on average, the reduction in beneficiary cost sharing would outweigh the increase in premiums.

Sec. 1182. Discounts for Certain Part D Drugs in Original Coverage Gap. This provision incorporates a voluntary PhRMA agreement to provide discounts of 50% for brand-name drugs used by Part D enrollees in the Part D coverage gap. Manufacturers of prescription drugs would enter into agreements with Medicare Part D drug plan sponsors to provide discounts on drugs provided to plan enrollees in the coverage gap period. The amount of the discount, in addition to the amount actually paid by the enrollee, would count toward costs incurred by the plan enrollee. Plan enrollees receiving the low income subsidy would not be eligible for the discount. This provision would be applicable to drugs dispensed after December 31, 2010. *The CBO score (with interaction with Section 1181) is –$21.1 billion for FY2010-FY2014 and -$42.3 billion for FY2010-FY2019.*

Sec. 1183. Repeal of Provision Relating To Submission Of Claims By Pharmacies Located In Or Contracting With Long-Term Care Facilities. Section 172 of MIPPA provided for a new set of requirements for contracts between Part D drug plan sponsors and pharmacies located in or contracting with long-term care facilities for plan years beginning on or after January 1, 2010. Each contract entered into with a PDP sponsor or MA-PD plan is required to provide that a pharmacy located in or having a contract with a long-term care facility would have between 30 and 90 days to submit claims for reimbursement. H.R. 3962 would repeal Section 172 of MIPPA and eliminate these deadlines for long-term care pharmacists to file Part D claims to allow more time for coordination with state Medicaid programs. *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

Sec. 1184. Including Costs Incurred By AIDS Drug Assistance Programs And Indian Health Service In Providing Prescription Drugs Toward The Annual Out Of Pocket Threshold Under Part D. Under a standard Medicare Part D plan design, beneficiaries must incur a certain level of out-of-pocket costs ($4,350 in 2009) before catastrophic protection begins. These include costs that are incurred for the deductible, cost-sharing, or benefits not paid because they fall in the coverage gap. Costs are counted as incurred, and thus treated as true out-of-pocket (TrOOP) costs only if they are paid by the individual (or by another family member on behalf of the individual), paid on behalf of a low-income individual under the subsidy provisions, or paid under a State Pharmaceutical Assistance Program. Additional payments that do not count toward TrOOP include Part D premiums and coverage by other insurance, including group health plans, workers' compensation, Part D plans' supplemental or enhanced benefits, or other third parties. This provision would allow costs paid by the Indian Health Service or under an AIDS Drug Assistance Program to count toward the out-of-pocket threshold for costs incurred on or after January 1, 2011. *The CBO score is +$0.3 billion for FY2010-FY2014 and+$0.8 billion for FY2010-FY2019.*

Sec. 1185. No Mid-Year Formulary Changes Permitted. Part D plans are permitted to operate formularies—lists of drugs that a plan chooses to cover and the terms under which they are covered. By law, Part D plans may not change the therapeutic categories and classes in a

[24] Letter to the Honorable Dave Camp, Ranking Member, Committee on Ways and Means, from Douglas W. Elmendorf, Director, Congressional Budget Office, August 28, 2009, http://www.cbo.gov/ftpdocs/105xx/doc10543/08-28-MedicarePartD.pdf.

formulary other than at the beginning of each plan year except as the Secretary may permit to take into account new therapeutic uses and newly approved covered part D drugs. Drug plans are also allowed to apply various utilization management restrictions to drugs on their formularies. These restrictions may include assignment of drugs to tiers that correspond to different levels of cost sharing; prior authorization, in which the beneficiary must obtain a plan's approval before it will cover a particular drug; and step therapy, in which a beneficiary must first try a generic or less expensive drug; and quantity limits. If a plan removes a covered part D drug from a formulary or makes any change in the preferred or tiered cost-sharing status of a drug, appropriate notice must be provided to the Secretary, affected enrollees, physicians, pharmacies, and pharmacists.

Under this provision, beginning in 2011, Part D sponsors would not be allowed to remove a covered drug from a plan formulary, or make any other material change to the formulary that would have the effect of reducing coverage or of increasing cost-sharing for the drug, after the start of marketing activities for the plan year. The provision would allow for exceptions if the change is in regard to a brand name drug for which a generic drug was approved during the plan year, or if a recall or a withdrawal of a drug was issued by the Food and Drug Administration (FDA). *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

Sec. 1186. Negotiation of Lower Covered Part D Drug Prices on Behalf of Medicare Beneficiaries. Part D plan sponsors (or the pharmacy benefit managers they have contracted with) negotiate prices with drug manufacturers, wholesalers, and pharmacies and are required to provide enrollees with access to these negotiated prices for covered Part D drugs. The law specifically states that the Secretary may not interfere with the negotiations between drug manufacturers and pharmacies and PDP sponsors. Further, the Secretary may not require a particular formulary or institute a price structure for the reimbursement of covered Part D drugs. This is known as the "non-interference provision" (SSA § 1860D-11(i)). Section 1186 would strike SSA § 1860D-11(i), and in its place, add language that would require the Secretary to negotiate prescription drug prices (including discounts, rebates and other price concessions) that may be charged to PDP sponsors and MA organizations, but would still allow prescription drug plans to obtain discounts or price reductions below those negotiated by the Secretary. The provision would also maintain the prohibition against the establishment of a formulary by the Secretary; however, there would no longer be an explicit prohibition of the institution of a price structure. The provision would take effect on the date of enactment and would first apply to negotiations and prices for plan years beginning on January 1, 2011. *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

Sec. 1187. Accurate Dispensing in Long-Term Care Facilities. Part D plans are required to offer a contract to any pharmacy wiling to participate in its long-term care (LTC) pharmacy network so long as the pharmacy is capable of meeting certain minimum performance and service criteria and any other standard terms and conditions established by the plan for its network pharmacies. Each LTC facility selects at least one eligible LTC pharmacy to provide Medicare drug benefits to its residents. Plan formularies must be structured so that they meet the needs of long-term care residents and provide coverage for all medically necessary medications at all levels of care. Both physician prescribing patterns and pharmacy benefit manager (PBM) payment practices result in prescriptions commonly being dispensed in 30- or 90-day quantities. In situations when the full amount dispensed is not utilized by the patient, for example, due to discharge, death, adverse reactions, the remaining medication may become waste. This provision would require Part D sponsors, starting January 1, 2012, to employ utilization management techniques as determined by the Secretary, such as weekly, daily, or automated dose dispensing,

to reduce the quantity dispensed per fill when dispensing medications to beneficiaries who reside in long-term care facilities in order to reduce waste associated with 30-day fills. *The CBO score is -$1.0 billion for FY2010-FY2014 and -$5.7 billion for FY2010-FY2019.*

Section 1188. Free Generic Refill. Section 1128A(a) of the Social Security Act authorizes the imposition of civil monetary penalties and assessments on a person, including an organization, agency, or other entity, who engages in various types of improper conduct with respect to federal health care programs.[25] One form of prohibited conduct, described in section 1128A(a)(5), occurs when a person offers or transfers remuneration to a Medicare or Medicaid beneficiary when such person knows or should know the remuneration is likely to influence the beneficiary's ordering or receiving items or services (payable by Medicare or Medicaid) from a particular provider, practitioner, or supplier. This conduct may be subject to penalties of up to $10,000 for each item received. Section 1128A(i)(6) of the Act defines "remuneration" to include waivers of copayments and deductible amounts (or any part thereof) and transfers of items or services for free or for other than fair market value, subject to certain exceptions.

This section would amend section 1128A(i)(6) of the Social Security Act to exclude from the definition of remuneration a reduction in or waiver of the copayment amount (under a prescription drug plan offered by a PDP sponsor or an MA-PD plan offered by an MA organization) that is given to an individual to induce the individual to switch to a generic, bioequivalent drug, or biosimilar. This provision would apply to remuneration offered, paid, solicited, or received on or after January 1, 2011. *The CBO score is -$1.1 billion for FY2010-FY2014 and -$3.0 billion for FY2010-FY2019.*

Sec. 1189 State Certification Prior to Waiver of Licensure Requirements Under Medicare Prescription Drug Program. Medicare Part D participants must obtain coverage through a Part D sponsor—a private insurer or other entity that has contracted with Medicare to provide prescription drug benefits. According to Section 1860D-12 of the SSA, a sponsor of a prescription drug plan is required to be organized and licensed under state law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each state it offers a prescription drug plan. Under certain circumstances, a sponsor may apply to CMS for a waiver of this requirement. The National Association of Insurance Commissioners (NAIC) has noted instances in which PDP sponsors have been granted waivers from state licensure requirements but did not have fully completed applications for licensure pending at the time the waiver had been granted.

The provision would amend Section 1860D-12 of the SSA to require that CMS may only grant a waiver of licensure for a particular state if it has received a certification from the State Insurance Commissioner that the prescription drug plan has a substantially complete application pending in that state. Additionally, the waiver could be revoked if the State Insurance Commissioner submits a certification to CMS that the sponsor committed fraud with respect to the waiver, did not make a good faith effort to satisfy state licensing requirements, or was determined by the state to be ineligible for licensure. The requirements would be effective for plan years beginning January 1, 2010. *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

Sec. 1191. Telehealth Expansion and Enhancements. Medicare covers certain services including professional consultations, office and other outpatient visits, individual psychotherapy, pharmacological management, psychiatric diagnostic interview examinations, neurobehavioral

[25] 42 U.S.C. § 1320a-7a.

status exams, and end stage renal disease related services delivered via an eligible telecommunications system. An interactive telecommunications system is required as a condition of payment. The originating site (the location of the beneficiary receiving the telehealth service) can be a physician or practitioner's office, a critical access hospital, a rural health clinic, a federally qualified health center, a hospital-based renal dialysis center, a skilled nursing facility, a community mental health center or a hospital. The originating site must be in a rural health professional shortage area or in a county that is not in a metropolitan statistical area or at an entity that participates in a specified federal telemedicine demonstration project.

Under this provision, a renal dialysis facility would be included as a covered originating site for telehealth services effective for services starting January 1, 2011. The Secretary would appoint a Telehealth Advisory Committee to make policy recommendations regarding telehealth services including the appropriate addition or deletion of covered services and procedure codes for authorized payments. In making determinations with respect to covered services, the Secretary would be required to take into account the recommendations of the Committee. If the Secretary does not implement a recommendation, the Secretary would publish a statement providing the reason for such decision in the *Federal Register*. The Secretary would issue hospital guidance to simplify practitioner credentialing for medical staff privileging decisions with respect to telehealth services no later than 60 days from enactment. As such a hospital would be able, but not required, to accept a credentialing package compiled by another Medicare participating hospital. A hospital that did accept such a package would not be required to exercise oversight over the other hospital's process for compiling and verifying credentials. This provision would apply only to credentialing and does not apply to applicable privileging requirements. *The CBO score is between -$50 million and $50 million for both FY2010-FY2014 and FY2010-FY2019.*

Sec. 1192. Extension of Outpatient Hold Harmless Provision. Small rural hospitals (with no more than 100 beds) that are not sole community hospitals (SCHs) can receive additional Medicare payments if their outpatient payments under the prospective payment system are less than under the prior reimbursement system. For calendar year (CY) 2006, these hospitals received 95% of the difference between payments under the prospective payment system and those that would have been made under the prior reimbursement system. The hospitals received 90% of the difference in CY2007 and 85% of the difference in CY2008. The payment is set at 85% for CY2009. Sole community hospitals with not more than 100 beds receive 85% of the payment difference for covered HOPD services furnished on or after January 1, 2009, and before January 1, 2010. Under this provision, small rural hospitals and sole community hospitals with not more than 100 beds would receive 85% of the payment difference for covered HOPD services furnished until January 1, 2012. *The CBO score is $0.2 billion for FY2010-FY2014 and $0.2 billion for FY2010-FY2019.*

Sec. 1193. Extension of Section 508 Hospital Reclassifications. Section 508 of MMA provided $900 million for a one-time, three-year geographic reclassification of certain hospitals that were otherwise unable to qualify for administrative reclassification to areas with higher wage index values. These reclassifications were extended from March 31, 2006 to September 30, 2007 by the Tax Relief and Health Care Act of 2006 (P.L. 109-432). MMSEA extended the reclassifications to September 30, 2008. MIPPA extended the reclassifications until September 30, 2009. These extensions are exempt from any budget neutrality requirements. Under this provision, Section 508 reclassifications would be extended until September 30, 2011. These payments would be based on the FY2010 wage index. *The CBO score is $0.5 billion for FY2010-FY2014 and $0.5 billion for FY2010-FY2019.*

Sec. 1194. Extension of Geographic Floor for Work. The Medicare fee schedule is adjusted geographically for three factors to reflect differences in the cost of resources needed to produce physician services: physician work, practice expense, and medical malpractice insurance. The geographic adjustments are indices that reflect how each area compares to the national average in a "market basket" of goods. A geographic practice cost index (GPCI) with a value of 1.00 represents an average across all areas. A series of bills set a temporary floor value of 1.00 on the physician work index beginning January 2004; most recently, Section 134 of the MIPPA extended the application of this floor when calculating Medicare physician reimbursement through December, 2009. The other geographic indices (for practice expense and medical malpractice) were not modified by these Acts. The proposal would extend the 1.00 floor for the geographic index for physician work for an additional three years through December 2012. *CBO estimates that this provision would increase outlays by $1.1 billion with all the outlays occurring in the next three years (2010-2012).*

Sec. 1195. Extension of Payment for Technical Component of Certain Physician Pathology Services. Legislation enacted in 1997 specified that independent labs that had agreements with hospitals on July 22, 1999 to bill directly for the technical component of pathology services could continue to do so in 2001 and 2002. The provision has been periodically extended, most recently through December 31, 2009 by MIPPA. This provision would extend this payment through 2011. *CBO estimates that this would increase outlays by roughly $100 million in each of the next two years (2010 and 2011).*

Sec. 1196. Extension of Ambulance Add-Ons. Ground ambulance services are paid on the basis of a phased in national fee schedule. In 2010 and subsequently, the payments in all areas will be based on the national fee schedule amount. The fee schedule payment for an ambulance service equals a base rate for the level of service plus payment for mileage. Geographic adjustments are made to a portion of the base rate. For the period July 2004 to December 2009, mileage payments are increased for ground ambulance services originating in rural low population density areas. For the period July 1, 2004 until December 31, 2008, there is a 25% bonus on the mileage rate for trips of 51 miles and more. Payments for ground transports originating in rural areas or rural census tracts are increased by 3% for the period of October 1, 2008 through December 31, 2009. MIPPA specifies that any area designated as rural for the purposes of making payments for air ambulance services on December 31, 2006, will be treated as rural for the purpose of making air ambulance payments during the period July 1, 2008 until December 31, 2009.

The provision would maintain the 3% higher payments for ground transports originating in rural areas or rural census tracts until December 31, 2012. The MIPPA provision maintaining the designation of certain areas as rural for the purposes of Medicare's payments for air ambulance services would be maintained until December 31, 2011. *The CBO score is $0.2 billion for FY2010-FY2014 and $0.2 billion for FY2010-FY2019.*

Sec. 1201. Improving Assets Tests for Medicare Savings Program and Low-income Subsidy Program. Federal assistance is provided to certain low-income persons to help them meet Medicare Part D premium and cost-sharing charges. To qualify for the Part D low-income subsidy, Medicare beneficiaries must have resources no greater than the income and resource limits established by MMA. In general, beneficiaries may qualify for a subsidy if they have an annual income below 150% of the FPL and if their resources do not exceed a certain limit (in 2009, $12,510 for individuals or $25,010 if married). Under this provision, the asset test used to determine eligibility for the low income subsidy and Medicare Savings programs would be increased. In 2012, the level would be $17,000 for an individual and $34,000 for a couple and

would be indexed annually by the CPI. *The CBO score (the combined score for Sections 1201-1207) for the effects on Medicare spending is +$3.2 billion for FY2010-2014 and +$11.8 billion for FY2010-2019. The CBO score (the combined score for Sections 1201-1207) for the effects on Medicaid spending is +$0.4 billion for FY2010-2014 and +$1.7 billion for FY2010-2019.*

Sec. 1202. Elimination of Part D Cost-sharing for Certain Non-institutionalized Full-benefit Dual Eligible Individuals. Cost-sharing subsides for LIS enrollees are linked to the standard Part D prescription drug coverage. Full-subsidy eligibles have no deductible, minimal cost sharing during the initial coverage period and coverage gap, and no cost-sharing over the catastrophic threshold. Full-benefit dual eligibles who are residents of medical institutions or nursing facilities have no cost-sharing. This provision would eliminate cost sharing for people receiving care under a home and community based waiver who would otherwise require institutional care in a facility for the mentally retarded for drugs dispensed on or after January 1, 2011. *The CBO score (the combined score for Sections 1201-1207) for the effects on Medicare spending is +$3.2 billion for FY2010-2014 and +$11.8 billion for FY2010-2019. The CBO score (the combined score for Sections 1201-1207) for the effects on Medicaid spending is +$0.4 billion for FY2010-2014 and +$1.7 billion for FY2010-2019.*

Sec. 1203. Eliminating Barriers to Enrollment. Under the Medicare Part D low-income subsidy program, dual eligibles, those receiving assistance through Medicare Savings Programs, and recipients of SSI are deemed subsidy-eligible individuals for up to one year; other persons, or their personal representatives, have to apply for assistance either at state Medicaid offices or Social Security offices. Applicants are required to provide information from financial institutions as requested to support information in the application, and to certify as to the accuracy of the information provided. Under this provision, individuals applying for the low-income subsidy under the prescription drug program would be permitted to qualify on the basis of self-certification of income and resources beginning January 1, 2010. *The CBO score (the combined score for Sections 1201-1207) for the effects on Medicare spending is +$3.2 billion for FY2010-2014 and +$11.8 billion for FY2010-2019. The CBO score (the combined score for Sections 1201-1207) for the effects on Medicaid spending is +$0.4 billion for FY2010-2014 and +$1.7 billion for FY2010-2019.*

Sec. 1204. Enhanced Oversight Relating to Reimbursements for Retroactive Low Income Subsidy Enrollment. Individuals who qualify for Medicaid, a Medicare Savings Program, or SSI are automatically deemed eligible for the low-income subsidy, while other individuals with limited income and resources may apply for the low-income subsidy and have their eligibility determined by either the SSA or their state Medicaid agency. As eligibility is effective the month the application was submitted, LIS status is often applied retroactively. If a beneficiary is already enrolled in a Part D plan, the Part D sponsor must take steps to ensure that the beneficiary has been reimbursed for any premiums or cost-sharing the member had paid that should have been covered by the subsidy. This provision would enhance oversight to make sure that low-income beneficiaries who are owed retroactive reimbursement payments from their drug plans receive them. The reimbursement would be made automatically by the Part D sponsor upon appropriate notice that the beneficiary is eligible for assistance and no further information would need to be submitted to the plan by the beneficiary. *The CBO score (the combined score for Sections 1201-1207) for the effects on Medicare spending is +$3.2 billion for FY2010-2014 and +$11.8 billion for FY2010-2019. The CBO score (the combined score for Sections 1201-1207) for the effects on Medicaid spending is +$0.4 billion for FY2010-2014 and +$1.7 billion for FY2010-2019.*

Sec. 1205. Intelligent Assignment in Enrollment. Generally, there is a two-step process for low-income persons to gain Part D coverage. First, a determination must be made that they qualify for the assistance; second, they must enroll, or be enrolled, in a specific Part D plan. Full-benefit dual-eligible individuals who have not elected a Part D plan are auto-enrolled into one by CMS using a random assignment process. Because of the random nature of the process, some dual eligibles may be enrolled in plans that may not best meet their needs; for example, necessary drugs may not be covered by the new plan. Under this provision, for contract years beginning with 2012, the Secretary would be given the option to use an "intelligent assignment" process as an alternative to the random assignment process which would take into account the quality, cost, and formularies of plans *The CBO score (the combined score for Sections 1201-1207) for the effects on Medicare spending is +$3.2 billion for FY2010-2014 and +$11.8 billion for FY2010-2019. The CBO score (the combined score for Sections 1201-1207) for the effects on Medicaid spending is +$0.4 billion for FY2010-2014 and +$1.7 billion for FY2010-2019.*

Sec. 1206. Special Enrollment Period and Automatic Enrollment Process for Certain Subsidy Eligible Individuals. In general, a Medicare beneficiary who does not enroll in Part D during his or her initial enrollment period may enroll only during the annual open enrollment period, which occurs from November 15 to December 31 each year. Beneficiaries already enrolled in a Part D plan may change their plans during the annual open enrollment period. There are a few additional, limited occasions when an individual may enroll in or disenroll from a Part D plan or switch from one Part D plan to another, called special enrollment periods. The provision would establish a new special enrollment period for persons deemed to be low-income subsidy eligible individuals for subsidy determination made for months beginning with January 2011. HHS would be given the authority to enroll subsidy-eligible beneficiaries into plans using a process that accounts for the quality, cost and/or formulary of plans, while also giving beneficiaries the option of choosing another plan. *The CBO score (the combined score for Sections 1201-1207) for the effects on Medicare spending is +$3.2 billion for FY2010-2014 and +$11.8 billion for FY2010-2019. The CBO score (the combined score for Sections 1201-1207) for the effects on Medicaid spending is +$0.4 billion for FY2010-2014 and +$1.7 billion for FY2010-2019.*

Sec. 1207. Application of MA Premiums Prior to Rebate and Quality Bonus Payments in Calculation of Low Income Subsidy Benchmark. The federal government pays up to 100% of the Part D premiums for LIS beneficiaries who are enrolled in "benchmark" plans. A Part D plan qualifies as a benchmark plan if it offers basic Part D coverage with premiums equal to or lower than the regional low-income premium subsidy amount. MA plans offering prescription drug coverage submit a separate bid for the Part D portion. Payment for the portion of the premium attributable to basic prescription drug benefits is calculated in the same way as that for stand-alone PDPs, however the MA plan may choose to apply some of its Part C rebate payments to lower the Part D premium. MedPAC has noted that the number of plans that qualify as low-income benchmark plans has been decreasing in recent years, resulting in fewer options for LIS enrollees. For the 2009 plan year, approximately 2.3 million LIS enrollees were affected by the decrease in the number of qualifying plans and needed to enroll, or be enrolled, in new plans. This provision would exclude the Medicare Advantage rebate amounts and MA quality bonus payments, as defined in Section 1161 of this Act, from the MA-PDP premium bids when calculating the low-income regional benchmark for subsidy determinations made for months beginning with January 2011. *The CBO score (the combined score for Sections 1201-1207) for the effects on Medicare spending is +$3.2 billion for FY2010-2014 and +$11.8 billion for*

FY2010-2019. The CBO score (the combined score for Sections 1201-1207) for the effects on Medicaid spending is +$0.4 billion for FY2010-2014 and +$1.7 billion for FY2010-2019. [26]

Sec. 1231. Extension Of Therapy Caps Exceptions Process. Current law places two annual per beneficiary payment limits for all outpatient therapy services provided by non-hospital providers. For 2009, the annual limit on the allowed amount for outpatient physical therapy and speech-language pathology combined is $1,840, and there is a separate limit for occupational therapy of $1,840. The Secretary was required to implement an exceptions process for 2006, 2007, and the first half of 2008 for cases in which the provision of additional therapy services was determined to be medically necessary. Section 141 of MIPPA extended the exceptions process for therapy caps through December 31, 2009. The provision would extend the exceptions process for therapy caps for two years, through December 31, 2011. *CBO estimates that this provision would increase outlays by $0.9 billion for 2010-2012.*

Sec. 1232. Extended Months of Coverage of Immunosuppressive Drugs for Kidney Transplant Patients and Other Renal Dialysis Provisions. Medicare coverage for beneficiaries with end-stage renal disease (ESRD) generally begins in the fourth month of dialysis treatments or the month of a kidney transplant. After receiving a kidney transplant, individuals are prescribed immunosuppressive drugs to reduce the risk of their immune system rejecting the new organ. If a beneficiary already had Medicare because of age or disability before the onset of end-stage renal disease, or if an individual became eligible for Medicare because of age or disability after receiving a transplant paid for by Medicare, Medicare will continue to pay for immunosuppressive drugs with no time limit. However, if a beneficiary qualifies for Medicare only because of kidney failure, Medicare, together with coverage of the immunosuppressive drugs, ends 36 months after the month of the successful transplant. This provision would eliminate the current 36-month limitation on Medicare coverage of immunosuppressive drugs for kidney transplant patients who would otherwise lose this coverage on or after January 1, 2012. It would also make technical changes to the Medicare ESRD bundled payment system. *The CBO score is between +$50 million and -$50 million for FY2010-2014 and -$0.1 billion for FY2010-2019.*

Sec. 1233. Voluntary Advance Care Planning Consultation. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) added "end-of-life planning" to the initial preventive physical exam that Medicare beneficiaries receive upon enrollment. MIPPA also defines "end-of-life planning" to mean verbal or written information regarding: an individual's ability to prepare an advance directive in the case that an injury or illness causes the individual to be unable to make health care decisions; and whether or not the physician is willing to follow the individual's wishes as expressed in an advance directive.

The provision would amend Medicare law to add a voluntary advance care planning consultation as a new covered service for eligible Medicare beneficiaries under Part B and would provide payment to physicians for such consultations. A voluntary advance care planning consultation would mean an optional consultation between the individual and a practitioner regarding advance care planning if the individual involved has not had such consultation within the last five years. Such consultation could be conducted more frequently if there is a significant change in an individual's health. A consultation may include an explanation by the practitioner of advance care

[26] Sections 1221, 1222, 1223, and 1224 in Subtitle B: Reducing Health Disparities are discussed in CRS Report R40892, *Public Health, Workforce, Quality, and Related Provisions in H.R. 3962*, coordinated by C. Stephen Redhead.

planning; advance directives and their uses; role and responsibilities of a health care proxy; the continuum of end-of-life care services and supports available, including palliative and hospice, and related services covered by Medicare; and orders regarding life sustaining treatment or similar orders as specified. Nothing in this section would require the individual to complete an advance directive, an order for life sustaining treatment, or other advance care planning document; require an individual to consent to restrictions on the amount, duration, or scope of medical benefits an individual is entitled to receive under Medicare; or encourage the promotion of suicide or assisted suicide. *The CBO score is $0.7 billion for FY2010-FY2014 and $2.0 billion for FY2010-FY2019.*

Sec. 1234. Part B Special Enrollment Period and Waiver of Limited Enrollment Penalty for TRICARE Beneficiaries. Starting in 2001, military retirees and their eligible dependents become eligible for Tricare for Life at the same time they become eligible for Medicare. Tricare for Life essentially functions as a Medicare supplement and provides coverage for authorized services not covered by Medicare. Enrollment in Medicare Part B is required for access to Tricare for Life. Prior to the legislation creating Tricare for Life, many retirees had not enrolled in Part B, believing that they would always have access to military medical facilities. With the establishment of Tricare for Life and the concomitant need to enroll in Medicare Part B, there was concern over the potential imposition of significant penalties for late enrollment in Part B. Subsequent legislation–Section 625 of MMA–waived the Part B enrollment penalty for eligible retirees who enrolled in Part B prior to December 31, 2004. This provision would create a special 12-month enrollment period in which military retirees (or their eligible dependents) who have not yet enrolled in Medicare Part B can enroll in Part B, thus becoming eligible for Tricare for Life, without incurring a late enrollment penalty. This provision would also require the Secretary of HHS to establish a method for providing rebates for late enrollment penalties that were charged to certain disabled and end-stage renal disease (ESRD) beneficiaries who enrolled during or after January 2005 and before the month of enactment of this Act. *The CBO score is between -$50 million and $50 million for both FY2010-FY2014 and FY2010-FY2019.*

Sec. 1235. Exception for Use of More Recent Tax Year in Case of Gains From Sale of Primary Residence in Computing Part B Income-Related Premium. Medicare beneficiaries have out-of-pocket cost-sharing requirements that differ according to the services they receive. Physician and outpatient services provided under Part B are financed through a combination of beneficiary premiums, deductibles, and federal general revenues. In general, Part B beneficiary premiums equal 25% of estimated program costs for the aged, with federal general revenues accounting for the remaining 75%. Beginning in 2007, higher-income enrollees pay a higher percentage of Part B costs. The provision would exclude income from the gains attributable to the sale of a primary residence from the beneficiary's modified adjusted gross income in determining the Part B income-related premium. This modification would apply to premiums and payments for years beginning with 2011. *The CBO score is between -$50 million and $50 million for both FY2010-FY2014 and FY2010-FY2019.*

Sec. 1236. Demonstration Program on Use of Patient Decisions Aids. Current law does not explicitly address patient decision aids, which are information tools to help patients understand health care options, and make informed choices that take into account their lifestyle, preferences, and beliefs. This provision would require the Secretary to conduct a Medicare demonstration program to determine if using patient decision aids would improve beneficiaries' understanding of their medical treatment options. The program would enroll not more than 30 eligible providers, with preference given to providers that have documented experience, and the necessary information technology infrastructure and training, in using patient decision aids. Eligible

providers would be required to provide follow-up counseling visits after beneficiaries have viewed decision aids, to address questions about subsequent medical care and the beneficiary's preferences. The Secretary would have to provide for the development of a code(s) and reimbursement for the follow-up counseling. Eligible providers would be responsible for the costs of selecting, purchasing, and delivering patient decision aids, and reporting data on quality and outcome measures. The program would be funded through the Supplementary Medical Insurance Trust Fund. *The CBO score is between -$50 million and $50 million for both FY2010-FY2014 and FY2010-FY2019.*

Sec. 1301. Accountable Care Organization Pilot Program. No current provision. In April 2005, CMS initiated the Physician Group Practice demonstration, which offers 10 large practices the opportunity to earn performance payments for improving the quality and cost-efficiency of health care delivered to Medicare fee-for-service beneficiaries.

This provision would add a new section 1866D to the Social Security Act (SSA) to establish the accountable care organization pilot program to test different payment incentive models. Specific payment incentive models to be tested include the performance target model, the partial capitation model, and other payment models. A qualifying accountable care organization (qualifying ACO) would be a group of physicians or other physician organizational models which is organized, at least in part, for the purpose of providing physician services and meet other specified standards. A qualifying ACO could include a hospital or any other provider or supplier (furnishing Medicare covered services) that is affiliated with the ACO under an arrangement structured so that the provider or supplier participates in the pilot program and shares in any incentive payments. The pilot program would begin no later than January 1, 2012. An agreement with a qualifying ACO under this pilot would cover a multi-year period of between three and five years.

Certain requirements with respect to the computation of performance targets, adjustment factors and incentive payments would be established. The Secretary would also be required to establish annual quality targets that qualifying ACOs must meet in order to receive incentive payments, operate at financial risk, or participate in the alternative financing models. The Secretary would evaluate the payment incentive model for each qualifying ACO to assess the pilot's impact on beneficiaries, providers of services, suppliers and the program. The evaluation would be publicly available within 60 days of the date of completion of such report. The OIG would be responsible for monitoring of the operation of ACOs under the pilot program with regard to violations of the Stark self referral prohibition (Section 1877 of the SSA). No later than two years after the date the first pilot agreement is established, and every two years thereafter for six years, the Secretary would report to Congress on the use of authorities under the pilot program and its impact on expenditures, access, and quality. The Secretary would be able issue regulations to implement on a permanent basis 1 or more models of the pilot program that are beneficial to Medicare. However, to do so, the Chief Actuary of CMS would be required to certify that the expansion of the program's components would result in estimated spending that would be less than what spending would otherwise be estimated to be in the absence of such expansion.

The program management account of CMS would be appropriated $25 million for FY2010 through FY2014 and $20 million in FY2015 for the purposes of administering and carrying out the pilot program, but not for payments for Medicare covered items and services or for incentive payments. *The CBO score is -$0.2 billion for FY2010-FY2014 and -$2.6 billion for FY2010-FY2019.*

Sec. 1302. Medical Home Pilot Program. TRHCA, as modified by MIPPA, requires the Secretary to establish a three-year demonstration in up to 8 states with urban, rural and underserved areas, to redesign the health care delivery system to provide targeted, accessible, continuous, and coordinated family-centered care to high need Medicare populations with chronic or prolonged illnesses requiring regular medical monitoring, advising or treatment.

This provision would add a new section 1866F to the SSA to establish the medical home pilot program for the purpose of evaluating the Medicare payments to qualified patient-centered medical homes for furnishing medical home services to high need beneficiaries in urban, rural, and underserved areas. New subsection 1866F(a) would require the Secretary to establish pilot programs to evaluate two medical home models: (1) the independent patient-centered medical home model; and (2) the community-based medical home model. Nothing in this provision would prevent a nurse practitioner or physician assistant from leading a patient centered medical home so long as all of the pilot program requirements are met and the nurse practitioner or physician assistant is acting consistently with State law.

The independent patient-centered medical home pilot program would begin within 6 months of enactment. The Secretary would be required to pay independent patient-centered medical homes a monthly fee, paid prospectively, for each targeted high need beneficiary who consents to receive services. This pilot program would have to be designed to include the participation of physicians in practices with fewer than 10 full-time equivalent physicians, as well as physicians in larger practices, particularly in underserved and rural areas, as well as federally qualified community health centers, and rural health centers.

The Secretary would be required to make payments for medical home services provided by a community based medical home (CBMH) to a high need beneficiary. A CBMH would employ community health workers, including nurses or other non-physician practitioners, lay health workers, or other appropriate persons who assist the primary or principal care physician or nurse practitioner in chronic care management activities.

The Secretary would be required to start the CBMH pilot program within 12 months of enactment. Demonstration sites under the pilot program would operate for five years. The Secretary would be required to establish a methodology for payment for medical home services furnished under the CBMH model, to include two separate prospective monthly payments for each high need beneficiary: one to a community-based or State-based organization, and one to the primary or principal care practice.

The Secretary would be required, within 60 days of completion of the pilot program, to submit a report to Congress on the evaluation. Subject to the evaluation, the Secretary would be authorized to issue regulations to implement one or more models on a permanent basis, to the extent that such models are beneficial to Medicare, but only if the Chief Actuary of CMS were to first certify that the expansion would not result in higher estimated Medicare spending.

Six million dollars for each of fiscal years 2010 through 2014 would be transferred from the Federal Supplementary Medical Insurance Trust Fund (Part B Trust Fund) to the CMS Program Management Account to carry out this section. $200 million for each of fiscal years 2010 through 2014 for payments for independent patient-centered medical home services, and $125 million for each of fiscal years 2012 through 2016 for CBMH services would be available for CMS from the Part B Trust Fund. In addition to funds otherwise available, $2.5 million for each of fiscal years 2010 through 2012 would be available to CMS from the Part B Trust Fund for initial

implementation costs. Any amounts made available under this subsection for a fiscal year would be available until expended. The authority for the Medicare Medical Home Demonstration project would be repealed. The $100 million established by the TRHCA for the existing Medicare Medical Home Demonstration would be made available to the independent patient-centered medical home pilot program. *The CBO score is $1.5 billion for FY2010-FY2014 and $1.8 billion for FY2010-FY2019.*

Sec. 1303. Payment Incentive for Selected Primary Care Services. Section 1833(m) of the Social Security Act provides bonus payments (10% of what would otherwise be paid under the fee schedule) for physicians who furnish medical care services in geographic areas that are designated by the Health Resources and Services Administration (HRSA) as primary medical care health professional shortage areas (HPSAs) under section 332 (a)(1)(A) of the Public Health Service (PHS) Act. In addition, for claims with dates of service on or after July 1, 2004, psychiatrists furnishing services in mental health HPSAs are also eligible to receive bonus payments.

The provision would establish payment incentives for primary care services furnished on or after January 1, 2011 by a primary care practitioner. The amount of the payment incentive would be 5% (or 10% if the practitioner provides the services predominately in an area that is designated as a primary care health professional shortage area) and would be paid from the Part B Trust Fund. Primary care services would be defined as evaluation and management services and preventive services, regardless of the specialty of the physician providing the service. The primary care services incentive payments would not be taken into account in determining the additional payments for physicians in health professions shortage areas or in physician scarcity areas. *The CBO score is $1.8 billion for FY2010-FY2014 and $4.7 billion for FY2010-FY2019.*

Sec. 1304. Increased Reimbursement Rate for Certified Nurse-Midwives. In general, Medicare pays 80% of the reasonable charges (the lesser of the actual charge for the services or the amount determined by the fee schedule) for provider services covered under Medicare Part B. However, Medicare payments for services performed by certified nurse–midwives to Medicare beneficiaries are currently limited to no more than 65% of the fee schedule amount for the same service performed by a physician. The proposal would remove the 65% restriction for Medicare payments to certified nurse-midwives. The modification would apply to services furnished on or after January 1, 2011. *The CBO score is between -$50 million and $50 million for both FY2010-FY2014 and FY2010-FY2019.*[27]

Sec. 1307. Excluding Clinical Social Worker Services From Coverage Under the Medicare Skilled Nursing Facility Prospective Payment System and Consolidated Payment. The majority of services provided to beneficiaries in a Medicare covered SNF stay are included in the bundled prospective payment made to the SNF. Certain services have been specifically excluded from SNF consolidated billing. In these instances, Medicare will pay the entity providing the service directly. Currently, the items and services provided by a clinical social worker are included in the SNF consolidated billing. The provision would exclude items and services provided by clinical social workers to Medicare beneficiaries in a SNF from SNF consolidated

[27] Sections 1305 and 1306 concerning coverage and waiver of cost sharing for certain preventive services are discussed in CRS Report R40892, *Public Health, Workforce, Quality, and Related Provisions in H.R. 3962*, coordinated by C. Stephen Redhead.

billing and would establish a separate Medicare payment on or after October 1, 2010. *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

Sec. 1308. Coverage of Marriage and Family Therapist Services and Mental Health Counselor Services. Section 1861(s)(2) of the SSA defines "medical and other health services" as including medical supplies, hospital services, diagnostic services, outpatient physical therapy services, rural health clinic services, home dialysis services and supplies, antigens and physician assistant and nurse practitioner services. Marriage and family therapists and mental health counselors are not included under current law.

The provision would add two subcategories of medical and health services: marriage and family therapists, and mental health counselors. Required qualifications for a marriage and family therapist, and mental health counselor would be established. Medicare would pay 80% of the lesser of the actual charge for services or 75% of the amount that would be paid for a psychologist's services. The Secretary would be required to consider confidentiality issues while developing criteria to allow direct payment of the therapist and medical information sharing with the patient's primary care physician or nurse practitioner. Services provided by marriage and family therapists and mental health counselors would be excluded from consolidated billing by SNFs; marriage and family therapists and mental health counselors would be providers in rural health clinics and federally qualified health centers. Marriage and family therapists and mental health counselors would be one of the practitioner categories who can file claims for services provided. *The CBO score is $0.1 billion for FY2010-FY2014 and $0.4 billion for FY2010-FY2019.*

Sec. 1309. Extension of Physician Fee Schedule Mental Health Add-on. By law, every five years CMS examines Medicare billing codes under the physician fee schedule to determine whether they are overvalued or undervalued. Subsequent to the most recent evaluation, Medicare increased the rates for the codes used by physicians to bill for "evaluation and management" (E/M) services (face-to-face visits with patients), effective January 1, 2007. To maintain budget neutrality, rates for certain other codes, including some used to bill for psychotherapy services, were reduced. MIPPA increased Medicare payments under the fee-schedule for psychotherapy services by 5% beginning on July 1, 2008 and ending on December 31, 2009. The provision would extend the increase payments for psychotherapy services for an additional two years (ending December 31, 2011). *The CBO score is $0.1 billion for FY2010-FY2014 and $0.1 billion for FY2010-FY2019.*

Sec. 1310. Expanding Access to Vaccines Under Medicare. This section would provide Medicare Part B coverage for all federally recommended vaccines, defined as any approved vaccine that is recommended by the CDC upon advice from the Advisory Committee on Immunization Practices. *The CBO score is $0.2 billion for FY2010-FY2014 and $1.5 billion for FY2010-FY2019.*

Sec. 1312. Independence at Home Demonstration Program. The Secretary would be required to conduct a Medicare demonstration program, beginning no later than January 1, 2012, to test a payment incentive and service delivery model that uses physician and nurse practitioner directed home-based primary care teams designed to reduce expenditures and improve health outcomes in the provision of items and services to certain chronically ill Medicare beneficiaries. The Secretary would enter into agreements with qualifying independence at home medical practices, legal entities comprised of an individual physician or nurse practitioner or group of physicians and nurse practitioners that provide care as part of a team that includes physicians, nurses, physician

assistants, pharmacists, and other health and social services staff, as appropriate. These practice staff would have experience providing home-based primary care services to applicable beneficiaries. Practice staff would, among other requirements, make in-home visits to applicable beneficiaries and be available 24 hours per day, 7 days per week to implement care plans tailored to the individual beneficiary's chronic conditions and designed to reduce expenditures and improve health outcomes. Applicable beneficiaries, limited to 10,000 in the demonstration, would be determined by a practice to have at least 2 or more chronic illnesses, a nonelective hospital admission in the past 12 months, and 2 or more functional dependencies requiring assistance, among others.

The Secretary would be required to establish a methodology for sharing savings with independence at home medical practices for annual expenditures less than a target spending level for items and services covered under parts A and B. Target spending levels, which would account for normal variation in expenditures for items and services covered under parts A and B, could be set for either all qualifying practices or for groups of practices or a single practice. Practices with annual aggregate expenditures for applicable beneficiaries less than the target spending level would be eligible for an incentive payment. The Secretary would determine how savings beyond the first 5% (relative to set target spending levels) are to be apportioned among practices, taking into account the number of beneficiaries served by each practice, the characteristics of the individuals enrolled in each practice, the practices' performance on quality performance measures, and other factors as the Secretary determines appropriate. The Secretary must limit payments for shared savings to each practice so that aggregate expenditures for applicable beneficiaries would not exceed the amount that the Secretary estimates, less 5 percent, would be expended for such services for such beneficiaries enrolled in an independence at home medical practice if the demonstration program had not been implemented.

Agreements with practices under the program could cover no more than a three-year period. The Secretary would be required to submit to Congress a final report on the demonstration's best practices and the impact of the demonstration program on coordination of care, expenditures under this title, beneficiary access to services, and the quality of health care services provided to applicable beneficiaries. The Secretary is required to ensure that an entity entering into an agreement under the demonstration project guarantees it will not deny, limit, or condition the coverage or provision of benefits that a participating beneficiary would have otherwise been entitled to on the basis of health status if not included in this program. The provision would appropriate to the CMS Program Management Account $5 million for each of fiscal years 2010 through 2015 to administer the demonstration program. *The CBO score is between -$50 million and $50 million for both FY2010-FY2014 and FY2010-FY2019.*

Sec. 1313. Certified Diabetes Educators as Certified Medicare Providers. This section would amend SSA Sec. 1861 to designate certain certified diabetes educators as Medicare-certified providers of covered diabetes self-management training (DSMT) services. A "certified diabetes educator" would be defined as an individual who meets specified criteria, including certification by a "recognized certifying body," which also would be defined. *The CBO score is between -$50 million and $50 million for both FY2010-FY2014 and FY2010-FY2019.*[28]

[28] Most of the sections concerning quality in Title IV and all of the sections in Title V concerning graduate medical education are discussed in CRS Report R40892, *Public Health, Workforce, Quality, and Related Provisions in H.R. 3962*, coordinated by C. Stephen Redhead.

Sec. 1601. Increased Funding and Flexibility to Fight Fraud and Abuse. The Health Care Fraud and Abuse Control (HCFAC) account funds activities to fight health care fraud. The HCFAC program along with the Medicare Integrity Program (MIP) were both established by the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191) which sought to increase and stabilize federal funding for health care anti-fraud activities. Specifically, HCFAC funds are directed to the enforcement and prosecution of health care fraud whereas MIP funding supports the program integrity activities undertaken by CMS contractors. This provision would increase funding for HCFAC and MIP by $100 million annually beginning with FY2011. Total mandatory and discretionary funding for health care fraud activities in FY2009 amounted to $1.4 billion.[29] *The CBO score is $0.4 billion for FY2010-FY2014 and $0.9 billion for FY2010-FY2019.*

Sec. 1611. Enhanced Penalties for False Statements on Provider or Supplier Enrollment Applications. In Medicare, providers and suppliers are required to submit an application to enroll in the program in order to receive payment. Beginning January 2010, this provision would provide that a provider, supplier, or health care entity who knowingly makes or causes to be made any false statement, omission, or misrepresentation on an application, agreement, bid, or contract to participate in a federal health program be subject to a civil monetary penalty (CMP) of $50,000. In addition to providers and suppliers participating in Medicare, entities such as Medicaid managed care organizations, Medicare Advantage (MA) organizations, and Part D Prescription Drug Plans (PDPs) would be subject to this provision. *The aggregate CBO score for Sections 1611-1621 is -$0.1 billion for FY2010-FY2014 and -$0.2 billion for FY2010-FY2019.*

Sec. 1612. Enhanced Penalties for Submission of False Statements Material to a False Claim. The CMP authority in the SSA requires the imposition of CMPs on any person, including an organization, agency, or other entity, who engages in various types of improper conduct with respect to federal health care programs, including presenting false or fraudulent claims to a federal agency. Beginning January 2010, persons who knowingly make, use, or cause to be made a false record or statement material to a false claim would be subject to a CMP of $50,000 for each false record or statement. *The aggregate CBO score for Sections 1611-1621 is -$0.1 billion for FY2010-FY2014 and -$0.2 billion for FY2010-FY2019.*

Sec. 1613. Enhanced Penalties for Delaying Investigations. Beginning January 2010, this provision would provide that persons who fail to grant timely access, upon reasonable request, to the Office of the Inspector General (OIG) for the purpose of audits, investigations, and evaluations be subject to CMPs of $15,000 per day. The provision would also modify the contractual requirements for MA plans to allow the Secretary to conduct timely audits and inspections of MA plans. *The aggregate CBO score for Sections 1611-1621 is -$0.1 billion for FY2010-FY2014 and -$0.2 billion for FY2010-FY2019.*

Sec. 1614. Enhanced Hospice Program Safeguards. Medicare statute mandates the establishment of health and safety standards that providers must meet in order to participate in the Medicare and Medicaid programs (i.e. hospitals, hospices, nursing homes, and home health agencies). These standards are often referred to as Conditions of Participation (CoPs). Generally, state agencies, under contract with CMS, survey providers to determine compliance with CoPs. This provision would require the Secretary, by July 1, 2012, to develop and implement intermediate sanctions and appeals procedures for hospices that fail to meet federal health and

[29] For additional information on HCFAC and MIP programs see CRS Report RL34217, *Medicare Program Integrity: Activities to Protect Medicare from Payment Errors, Fraud, and Abuse*, by Holly Stockdale.

safety standards. The sanctions may include CMPs of up to $10,000 for each day of non-compliance or $25,000 per violation, denial of payment, the appointment of temporary managers to oversee the hospice, correction plans, and staff training. The provision would apply to hospice's participating in Medicare, Medicaid, and CHIP. *The aggregate CBO score for Sections 1611-1621 is -$0.1 billion for FY2010-FY2014 and -$0.2 billion for FY2010-FY2019.*

Sec. 1615. Enhanced Penalties for Individuals Excluded from Program Participation. The Secretary (and through delegation, the OIG) has the authority to exclude individuals and entities from participation in federal health care programs under a variety of circumstances. Payment is prohibited by any Federal health care program for any items or services furnished, ordered, or prescribed by an excluded individual or entity. Beginning January 2010, this provision would provide that any excluded person who knowingly orders or prescribes an item or service, including home health care, lab tests, prescription drugs, durable medical equipment (DME), ambulance services, or physical and occupational therapy, be subject to a CMP of $50,000 for each order or prescription.[30] *The aggregate CBO score for Sections 1611-1621 is -$0.1 billion for FY2010-FY2014 and -$0.2 billion for FY2010-FY2019.*

Sec. 1616. Enhanced Penalties for Provision of False Information by Medicare Advantage and Part D Plans. The Secretary has the authority to impose intermediate sanctions and CMPs ranging from $25,000 to $100,000 on MA plans that violate the terms of their contract. Among the types of violations are failing to provide medically necessary care, imposing excess beneficiary premiums, expelling or refusing to re-enroll beneficiaries, or misrepresenting or falsifying information. Beginning January 2010, this provision would add an additional penalty for MA and Part D plans to include an assessment of up to three times the amount claimed by the plan based on the misrepresentation or falsified information. *The aggregate CBO score for Sections 1611-1621 is -$0.1 billion for FY2010-FY2014 and -$0.2 billion for FY2010-FY2019.*

Sec. 1617. Enhanced Penalties for Medicare Advantage and Part D Marketing Violations. The Secretary has the authority to impose intermediate sanctions and CMPs ranging from $25,000 to $100,000 on MA plans that violate the terms of their contract. This provision would increase the number of violations that would be subject to the imposition of sanctions and CMPs by the Secretary. Beginning January 2010, employees, agents, or participating providers of MA plans that 1) enroll beneficiaries in a MA or Part D plan without their consent, 2) transfer an individual from one plan to another for the purpose of earning a commission, 3) or fail to comply with CMS marketing requirements could be subject to sanctions imposed by the Secretary. *The aggregate CBO score for Sections 1611-1621 is -$0.1 billion for FY2010-FY2014 and -$0.2 billion for FY2010-FY2019.*

Sec. 1618. Enhanced Penalties for Obstruction of Program Audits. The OIG has permissive authority (i.e. discretion) to exclude an entity or individual from a federal health program for a conviction related to the obstruction of a health care fraud investigation. Beginning January 2010, this provision would expand the OIG's permissive exclusion authority to include a conviction related to the obstruction of an audit related to the use of federal funds. *The aggregate CBO score for Sections 1611-1621 is -$0.1 billion for FY2010-FY2014 and -$0.2 billion for FY2010-FY2019.*

[30] The OIG has the authority to exclude individuals from participation in federal health care programs for a variety of offenses. Under exclusion, no payment may be made by a federal health care program for any items or services ordered or prescribed by an excluded individual.

Sec. 1619. Exclusion of Certain Individuals and Entities from Participation in Medicare and State Health Care Programs. The Secretary (and through delegation, the OIG) has the authority to exclude individuals and entities from participation in federal health care programs under a variety of circumstances. Payment is prohibited by any Federal health care program for any items or services furnished, ordered, or prescribed by an excluded individual or entity. This provision would clarify the effect of an exclusion on payment made under a federal health care program. Subject to certain exceptions, payment could not be made from any federal health care program with respect to an item or service furnished (1) by an excluded individual or entity, or (2) at the medical direction, or on the prescription of an authorized individual (e.g., a physician) when the person submitting a claim for the item or service knew or had reason to know of an individual's exclusion. *The aggregate CBO score for Sections 1611-1621 is -$0.1 billion for FY2010-FY2014 and -$0.2 billion for FY2010-FY2019.*

Sec. 1620. OIG Authority to Exclude from Federal Health Care Programs Officers and Owners of Entities Convicted of Fraud. The Secretary (and through delegation, the OIG) has the authority to exclude individuals and entities from participation in federal health care programs under a variety of circumstances. Payment is prohibited by any Federal health care program for any items or services furnished, ordered, or prescribed by an excluded individual or entity. For instance, the Secretary may exclude persons with a direct or indirect ownership or control interest in an entity that has been sanctioned, provided the individual knows or should know of the basis for the sanction, as well as officers and managing employees. This provision would clarify that this authority would apply only to those officers, managing employees, or persons that had a direct or indirect ownership or control interest in the entity at the time the entity had been sanctioned. *The aggregate CBO score for Sections 1611-1621 is -$0.1 billion for FY2010-FY2014 and -$0.2 billion for FY2010-FY2019.*

Sec. 1621. Self-Referral Disclosure Protocol. Section 1877 of the Social Security Act, commonly referred to as the Stark law, provides that if a physician or a physician's immediate family member has a "financial relationship" with an entity, the physician may not make a referral to the entity for certain health services, and the entity may not present (or cause to be presented) a claim to the federal health care program for these services. Violators of the physician self-referral law may be subject to sanctions including a denial of payment, civil monetary penalties, and exclusion from participation in the Medicare and Medicaid programs. In 1998, the OIG issued a Self-Disclosure Protocol (SDP) that includes a process under which a health care provider can voluntarily self-disclose evidence of potential fraud to avoid the costs or disruptions that may be associated with an investigation or litigation. OIG has also indicated that health care providers who utilize the self-disclosure protocol may be subject to penalties "on the lower end of the continuum."[31] On March 24, 2009, OIG issued an "Open Letter to Health Care Providers" that makes refinements to the SDP. In the Open Letter, OIG announced that it would no longer accept disclosure of a matter that involves only liability under the physician self-referral law in "the absence of a colorable anti-kickback statute violation."[32] This change has led to some confusion

[31] Office of Inspector General, Department of Health and Human Services, An Open Letter to Health Care Providers (Apr. 24, 2006), available at http://oig.hhs.gov/fraud/docs/openletters/Open%20Letter%20to%20Providers%202006.pdf.

[32] Under section 1128B of the Social Security Act, commonly referred to as the anti-kickback statute, it is a felony for a person to knowingly and willfully offer, pay, solicit, or receive anything of value (i.e., "remuneration"), directly or indirectly, overtly or covertly, in cash or in kind, in return for a referral or to induce generation of business reimbursable under a federal health care program. 42 U.S.C. 1320a-7b(b). Under the anti-kickback statute, persons found guilty of violating the anti-kickback statute may be subject to a fine of up to $25,000, imprisonment of up to five (continued...)

for health care providers seeking to disclose potential Stark law violations.[33] This section would require the Secretary, in cooperation with the OIG, to establish a protocol for allowing health care providers and suppliers to disclose actual and potential violations of the Stark law. The protocol must include information regarding the person, official, or office to whom such disclosures may be made, as well as the implication of the protocol on corporate integrity agreements and corporate compliance agreements. The Secretary would be required to post information on the CMS website regarding how to disclose these violations. In addition, the Secretary would also have the authority to reduce the amount that would be paid for a violation of the Stark law. This section provides factors that the Secretary may consider in reducing this amount. *The aggregate CBO score for Sections 1611-1621 is -$0.1 billion for FY2010-FY2014 and -$0.2 billion for FY2010-FY2019.*

Sec. 1631. Enhanced CMS Program Protection Authority. Beginning January 2011, this provision would authorize the Secretary to subject Medicare, Medicaid, and CHIP providers and suppliers to enhanced screening, oversight, or a moratorium on enrollment in instances where there is a significant risk of fraud. The provisions would apply to both new enrollees as well as providers and suppliers renewing their enrollment. Determinations of what constitutes a significant risk of fraud would be made by the Secretary with respect to a category of providers or suppliers, including a category within a specific geographic area. The Secretary would be required to establish procedures for screening and enhanced oversight which could include licensing checks, screening against the list of excluded providers, background checks, and unannounced site visits. In instances of serious ongoing fraud, the Secretary would have the authority to impose a moratorium on enrolling providers within a certain category of providers or specific geographic area. *The aggregate CBO score for Sections 1631-1647 is -$0.8 billion for FY2010-FY2014 and -$2.3 billion for FY2010-FY2019.*

Sec. 1632. Enhanced Medicare, Medicaid, and CHIP Program Disclosure Requirements Relating to Previous Affiliations. In order to receive payment from Medicare, providers must enroll in the Medicare program. CMS regulations mandate that Medicare enrollment applications contain information to uniquely identify the provider (i.e. proof of business name, social security number, or Tax ID number) and include documentation necessary to verify licensure. State Medicaid agencies determine whether a provider or supplier is eligible to participate in the Medicaid program by providing for written agreements with providers and suppliers. Beginning January 2011, this provision would require that providers or suppliers enrolling or re-enrolling in Medicare, Medicaid, or CHIP be required to disclose information on any current or previous affiliation (within the last 10 years) with a provider or supplier that has uncollected debt, that has been suspended or excluded, or has had their billing privileges revoked. The Secretary would have the authority to apply enhanced safeguards as well as deny enrollment in instances when an affiliation poses a risk of fraud. *The aggregate CBO score for Sections 1631-1647 is -$0.8 billion for FY2010-FY2014 and -$2.3 billion for FY2010-FY2019.*

Sec. 1633. Required Inclusion of Payment Modifier for Certain Evaluation and Management Services. Evaluation and management services include certain primary care services, hospital inpatient medical services, preventive medicine visits, and others. This

(...continued)

years, and exclusion from participation in federal health care programs for up to one year.

[33] Rebecca C. Fayed, The Narrowing of the OIG's Self-Disclosure Protocol: Where Do We Go Now?, 11 Journal of Health Care Compliance 4 (2009).

provision would require the Secretary to establish a payment modifier for evaluation and management services that result in the ordering of additional services (i.e. lab tests, prescription drugs, DME, or other services) determined by the Secretary to be at high risk of fraud *The aggregate CBO score for Sections 1631-1647 is -$0.8 billion for FY2010-FY2014 and -$2.3 billion for FY2010-FY2019.*

Sec. 1634. Evaluations and Reports Required Under Medicare Integrity Program. The MIP program requires the Secretary to enter into contracts with private entities to conduct a variety of program integrity activities for the Medicare program including auditing providers, reviewing claims for medical necessity, and identifying and investigating alleged fraud. Beginning in 2011, this provision would require MIP contractors to assure the Secretary that they will conduct periodic evaluations of the effectiveness of their activities and submit annual reports to the Secretary. *The aggregate CBO score for Sections 1631-1647 is -$0.8 billion for FY2010-FY2014 and -$2.3 billion for FY2010-FY2019.*

Sec. 1635. Require Providers and Suppliers to Adopt Programs to Reduce Waste, Fraud, and Abuse. There are no statutory requirements for Medicare participating providers to develop compliance programs to protect themselves from fraud, waste, and abuse. This provision would prohibit the Secretary from enrolling or re-enrolling providers and suppliers in Medicare that have not established such programs. The Secretary, in consultation with the OIG, would be required to establish the core components for these programs and create a timeline for their implementation. Prior to implementation, the Secretary would be authorized to conduct a pilot for certain high-risk providers. Physicians and skilled nursing facilities would be exempt from this provision. *The aggregate CBO score for Sections 1631-1647 is -$0.8 billion for FY2010-FY2014 and -$2.3 billion for FY2010-FY2019.*

Sec. 1636. Maximum Period for Submission of Medicare Claims Reduced to Not More Than 12 Months. Medicare statute requires that payments be made only to Medicare eligible providers and only if a written request for payment is filed within three calendar years after the year in which the services were provided. The Secretary is authorized to reduce this period to no less than one year if necessary. Beginning January 2011, this provision would reduce the time period for filing a claim from three calendar years to one calendar year. The provision would also require contracts with MA and PDP plans to require providers to submit claims for payment within one year. *The aggregate CBO score for Sections 1631-1647 is -$0.8 billion for FY2010-FY2014 and -$2.3 billion for FY2010-FY2019.*

Sec. 1637. Physicians Who Order DME or Home Health Services Required to be Medicare Enrolled Physicians or Eligible Professionals. In order to receive payment from Medicare, physicians are required to certify that specified services (i.e. inpatient psychiatric services, post-hospital extended care services, and home health services) meet certain conditions. For example, physicians must certify that home health care services are necessary because the patient is confined to his/her home and needs skilled nursing care. In the case of DME, payment may only be made if the physician has communicated to the supplier a written order for the item. Beginning January 2010, this provision would require that physicians who order DME or home health services be a Medicare eligible professional or enrolled in the Medicare program. *The aggregate CBO score for Sections 1631-1647 is -$0.8 billion for FY2010-FY2014 and -$2.3 billion for FY2010-FY2019.*

Sec. 1638. Requirement for Physicians to Provide Documentation on Referrals to Programs at High Risk of Waste and Abuse. Beginning January 2010, the Secretary would have the

authority to disenroll, for no more than one year, a Medicare enrolled physician or supplier that fails to maintain and provide access to written orders or requests for payment for DME, home health services, or referrals for other items and services to the Secretary. The provision would also extend the OIG's permissive exclusion authority to include individuals or entities that order, refer, or certify the need for health care services that fail to provide adequate documentation to the Secretary. *The aggregate CBO score for Sections 1631-1647 is -$0.8 billion for FY2010-FY2014 and -$2.3 billion for FY2010-FY2019.*

Sec. 1639. Face to Face Encounter with Patient Required Before Physicians May Certify Eligibility for Home Health Services or DME. In order to receive payment from Medicare, physicians are required to certify that specified services (i.e. inpatient psychiatric services, post-hospital extended care services, and home health services) meet certain conditions. For example, physicians must certify that home health care services are necessary because the patient is confined to his/her home and needs skilled nursing care. In the case of DME, payment may only be made if the physician has communicated to the supplier a written order for the item. Beginning in January 2010, this provision would require that physicians have a face-to-face encounter (including through telehealth) with the patient sometime in the previous six months prior to issuing a certification or re-certification. The Secretary would have the authority to apply this face-to-face requirement to other Medicare services as well.The provision would apply to physicians participating in Medicare, Medicaid, and CHIP. *The aggregate CBO score for Sections 1631-1647 is -$0.8 billion for FY2010-FY2014 and -$2.3 billion for FY2010-FY2019.*

Sec. 1640. Extension of Testimonial Subpoena Authority to Program Exclusion Investigations. The Secretary has the authority to exclude individuals and entities from participation in federal health care programs under a variety of circumstances. Beginning January 2010, this provision would apply the Secretary's testimonial subpoena authority to program exclusion investigations. Thus, the Secretary would be able to issue subpoenas and require the attendance and testimony of witnesses and the production of any other evidence relating to matters under investigation or in question by the Secretary. *The aggregate CBO score for Sections 1631-1647 is -$0.8 billion for FY2010-FY2014 and -$2.3 billion for FY2010-FY2019.*

Sec. 1641. Required Repayments of Medicare and Medicaid Overpayments. This provision would require Medicare and Medicaid providers and suppliers, including Medicaid managed care plans, MA plans, and Part D plans, that know of an overpayment to report and return the overpayment within 60 days. *The aggregate CBO score for Sections 1631-1647 is -$0.8 billion for FY2010-FY2014 and -$2.3 billion for FY2010-FY2019.*

Sec. 1642. Expanded Application of Hardship Waivers for OIG Exclusions to Beneficiaries of any Federal Health Care Program. The Secretary has the authority to exclude individuals and entities from participation in federal health care programs under a variety of circumstances. However, if a federal health care program administrator determines that the exclusion would impose a hardship, the Secretary may, after consultation with the OIG, waive the exclusion under certain circumstances. This provision would clarify that the "hardship waiver" for exclusions applies to beneficiaries enrolled in that federal health care program. *The aggregate CBO score for Sections 1631-1647 is -$0.8 billion for FY2010-FY2014 and -$2.3 billion for FY2010-FY2019.*

Sec. 1643. Access to Certain Information on Renal Dialysis Facilities. This provision would require End State Renal Disease Facilities to provide the Secretary with access to information relating to any ownership or compensation arrangement between the facility and the medical director of such facility or between the facility and any physician for the purposes of an audit or

evaluation. *The aggregate CBO score for Sections 1631-1647 is -$0.8 billion for FY2010-FY2014 and -$2.3 billion for FY2010-FY2019.*

Sec. 1644. Billing Agents, Clearinghouses, or Other Alternate Payees Required to Register Under Medicare. CMS has implemented regulations requiring Medicare providers and suppliers to submit an application to enroll in the Medicare program in order to receive billing privileges. The enrollment application requires that providers and suppliers include the names, addresses, and tax ID numbers for billing agencies on their applications. Beginning January 2012, this provision would require billing agencies, clearinghouses, or other payees that submit claims on behalf of a health care provider to register with the Secretary. *The aggregate CBO score for Sections 1631-1647 is -$0.8 billion for FY2010-FY2014 and -$2.3 billion for FY2010-FY2019.*

Sec. 1645. Conforming CMPs to False Claims Act (FCA) Amendments. The federal False Claims Act (FCA), codified at 31 U.S.C. §§ 3729-3733, provides for the imposition of CMPs and damages for the knowing submission of false claims to the United States government. The recently enacted Fraud Enforcement and Recovery Act of 2009 (FERA, P.L. 111-21), made several amendments to the FCA, which essentially expanded the types of conduct that could lead to FCA liability. The CMP authority in the SSA requires the imposition of CMPs on any person, including an organization, agency, or other entity, who engages in various types of improper conduct with respect to federal health care programs. Similar to the FERA amendments to the FCA, this provision would amend the CMP statute by expanding the types of conduct that could lead to CMPs. For example, the provision would remove the requirement that a claim be presented to a government officer, employee, agent, or agency in order to be liable for CMPs. In addition, the bill would create a new section 1128A(a)(12), which would impose CMPs on a person who conspires to commit a violation of the CMP statute. *The aggregate CBO score for Sections 1631-1647 is -$0.8 billion for FY2010-FY2014 and -$2.3 billion for FY2010-FY2019.*

Sec. 1646. Requiring provider and supplier payments under Medicare to be made through direct deposit or electronic funds transfer (EFT) at insured depository institutions. There is no statutory requirement for EFT under Medicare, however CMS manual instructions require that all new providers and suppliers entering the Medicare program enroll in EFT. Beginning July 2012, this provision would prohibit payment to any provider or supplier billing Medicare unless the payment is made through EFT or direct deposit. *The aggregate CBO score for Sections 1631-1647 is -$0.8 billion for FY2010-FY2014 and -$2.3 billion for FY2010-FY2019.*

Sec. 1651. Access to Information Necessary to Identify Waste and Abuse. Medicare statute requires that Part C and D plans furnish information necessary for determining payments to the Secretary. This information may be accessed by officers, employees, and HHS contractors and only for the purposes of determining payment. This provision would expand access to this information, as well as other financial information, to the OIG, the CMS administrator, and the Attorney General for anti-fraud purposes. This provision would also ensure that the GAO have access to any information disclosed to or obtained by the Secretary under Medicare Parts C and D. *The aggregate CBO score for Sections 1631-1647 is $0.0 billion for FY2010-FY2014 and -$0.0 billion for FY2010-FY2019.*

Sec. 1652. Elimination of Duplication Between the Healthcare Integrity and Protection Databank and the National Practitioner Databank. Medicare statute requires the Secretary to develop and maintain a national health care fraud and abuse data collection program, the Health Care Integrity and Protection Data Bank (HIPDB), for the reporting of adverse actions taken against health care providers or suppliers. The Health Care Quality Improvement Act of 1986

established the National Practitioner Data Bank (NPDB). The NPDB collects and releases data on the professional competence of physicians, dentists, and certain healthcare practitioners. This provision would require the Secretary to establish a process to phase out the HIPDB. The transition would be funded from the fees collected to access the database and from the annual HCFAC appropriation. *The aggregate CBO score for Sections 1631-1647 is $0.0 billion for FY2010-FY2014 and -$0.0 billion for FY2010-FY2019.*

Sec. 1653. Compliance with HIPAA Privacy and Security Standards. The Privacy Act of 1974 generally prohibits disclosures of records contained in a system of records maintained by a federal agency without the written request or consent of the individual to whom the record pertains. HIPAA Privacy and Security Rules establish national standards for the privacy and security of protected health information. This provision would clarify that the privacy and security regulations promulgated under the HIPAA and the Privacy Act of 1974 apply to all fraud, waste, and abuse provisions in this bill. *The aggregate CBO score for Sections 1631-1647 is $0.0 billion for FY2010-FY2014 and -$0.0 billion for FY2010-FY2019.*

Sec. 1654. Disclosure of Medicare Fraud and Abuse Hotline Number on Explanation of Benefits. The Secretary is required to provide Medicare beneficiaries with a clear and simple explanation of benefits on an annual basis. In addition to information on Medicare benefits and cost-sharing, the notice is required to include a statement indicating that beneficiaries should review their explanation of benefits for accuracy and report questionable charges by calling the OIG's fraud hotline. Beginning July 1, 2011, this provision would transfer the toll-free fraud hotline from the OIG to the Secretary and require that the explanation of benefits include the new hotline number. *This provision was not scored by CBO.*

Sec. 1801. Disclosures to Facilitate Identification of Individuals Likely to Be Ineligible for the Low-Income Assistance Under the Medicare Prescription Drug Program to Assist Social Security Administration's Outreach to Eligible Individuals. Under Medicare Part D, beneficiaries with incomes and assets below certain levels may be eligible for low-income subsidy benefits. Section 1144 of the SSA requires the Commissioner of Social Security to conduct outreach efforts to inform potential LIS beneficiaries about the additional premium and cost-sharing subsidies. The Social Security Administration, from its own records, and other available non-tax records is able to determine a potential pool of LIS beneficiaries, but such pool may be over-inclusive and include persons ineligible for the LIS benefits. It is believed that the IRS possesses additional income information, and, through imputation, some asset information, that could narrow the pool of potentially eligible LIS beneficiaries thereby reducing outreach costs. Under this provision IRS would be authorized to disclose to the Social Security Administration certain taxpayer return information to assist in identifying individuals likely to be eligible for the low-income subsidy and help focus outreach efforts. *The Joint Committee on Taxation scored this provision as having no revenue effect.*[34]

Sec. 1901. Repeal of the Trigger Provision. The Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds are overseen by a board of trustees that reports annually to Congress on Medicare expenditures and revenues. As part of their analysis, as required MMA, the trustees must determine whether or not general revenue financing will exceed 45% of total Medicare outlays within the next seven years. MMA requires that if an excess general revenue

[34] Title VII with provisions amending the Medicaid and CHIP programs will be discussed in a forthcoming CRS report. Section 1802 in Title VIII Revenue Related Provisions will not be not included in that report.

funding determination is made for two successive years, the President must submit a legislative proposal to respond to the warning and Congress is required to consider the proposals on an expedited basis. On January 6, 2009, the House approved a rules package (H.Res. 5) that nullifies the trigger provision in the House for the 111th Congress. This provision would repeal the 45% trigger. *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

Sec. 1902. Repeal of Comparative Cost Adjustment Program. The requirement for a six-year program that will begin in 2010 to examine comparative cost adjustment (CCA) in designated CCA areas would be repealed. Specifically this program requires that payments to local MA plans in CCA areas would, in part, be based on competitive bids (similar to payments for regional MA plans), and Part B premiums for individuals enrolled in traditional Medicare may be adjusted, either up of down. This program would be phased-in and there is also a 5% annual limit on the adjustment, so that the amount of the adjustment to the beneficiary's premium for a year can not exceed 5% of the amount of the monthly Part B premium, in non-CCA areas. *The CBO score is -$0.1 billion for FY2010-FY2014 and -$0.1 billion for FY2010-FY2019.*

Sec. 1903. Extension of Gainsharing Demonstration. Section 5007 of DRA authorizes a gainsharing demonstration to evaluate arrangements between hospitals and physicians designed to improve the quality and the efficiency of care provided to beneficiaries. In the absence of this DRA authority, gainsharing arrangements are restricted by the Civil Monetary Penalty law. CMS is operating two projects, each consisting of one hospital in New York and West Virginia. Although authorized to begin on January 1, 2007, the project began on October 1, 2008 and will end as mandated on December 31, 2009. The Secretary was required to submit a report on quality improvement and achieved savings as a result of the demonstration no later than December 1, 2008. The final report on these issues was due on May 1, 2010. The project was appropriated $6 million in FY2006 to be available for expenditure through FY2010. The provision would extend the gainsharing demonstration until September 30, 2011. The due date of the quality improvement and achieved savings report would be extended from December 1, 2008, to March 31, 2011. The final report would be due March 31, 2013, instead of May 1, 2010. An additional $1.6 million would be appropriated in FY2010. All appropriations would be available for expenditure through FY2014. *The CBO score is between -$50 million and $50 million for both FY2010-FY2014 and FY2010-FY2019.*[35]

Sec. 1906. Assessment Of Medicare Cost-Intensive Diseases And Conditions. The Secretary would conduct an assessment of the diseases and conditions that are the most cost-intensive for the Medicare program or that could become so in the future. In conducting the assessment, the Secretary would include the input of relevant research agencies, including the National Institutes of Health, the Agency for Healthcare Research and Quality, the Food and Drug Administration, and the Centers for Medicare and Medicaid Services.

The Secretary would issue a report that would (1) include the assessment of current and future trends of cost-intensive diseases and conditions, (2) address whether current research priorities are appropriately addressing current and future cost-intensive conditions; and (3) include recommendations concerning research in the Department of Health and Human Services that should be funded to improve the prevention, treatment, or cure of such cost-intensive diseases and

[35] Sections 1904 and 1905 pertaining to home visitation programs and coordination of care for dual eligible beneficiaries will be discussed in a forthcoming CRS report.

conditions. The Secretary would transmit this report to the Committees on Energy and Commerce, Ways and Means, and Appropriations of the House of Representatives and the Committees on Health, Education, Labor and Pensions, Finance, and Appropriations of Senate by January 1, 2011. Not later than January 1, 2013, and biennially thereafter, the Secretary would review and update the assessment and recommendations and submit a report to the Committees on the updated assessment and recommendations. *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

Sec. 1907. Establishment of Center for Medicare and Medicaid Innovation Within CMS. This section would create a new SSA Sec.1115A requiring the establishment of the Center for Medicare and Medicaid Innovation (the CMI) within CMS. The purpose of the CMI would be to test innovative payment and service delivery models to improve the coordination, quality, and efficiency of health care services provided to Medicare and Medicaid beneficiaries and to expand such models that are successful. This section sets forth requirements for both the testing of these models (PHASE I) and the expansion of these models (PHASE II). Specifically, the CMI would test models to determine their effect on program expenditures and on the quality of care. In selecting models for testing, the Secretary would be required to give preference to models that address a defined population for which there are deficits in care leading to poor clinical outcomes. All models would be terminated unless the Secretary determines that the model is expected to (1) improve the quality of patient care without increasing spending; (2) reduce spending without reducing the quality of care; or (3) improve quality and reduce spending. This section would allow the Secretary to expand the duration and the scope of a model that is being tested under this section, to the extent determined appropriate by the Secretary, if the Secretary determines that such expansion would be expected to meet the spending and/or quality criteria above. This section would also require the Secretary to submit to Congress reports on activities under this section, as specified.

This section would require to be available, equally divided between the Part A and Part B Trust Funds, $350 million for FY2010, $440 million for FY2011, $550 million for FY2012, and, according to a specified formula, for a subsequent fiscal year. These monies would be authorized to be used for payments for additional benefits for items and services under tested models not otherwise covered and for researching, designing, implementing and evaluating such models. This section would appropriate from the Treasury $25 million for each fiscal year beginning with FY2010, to the Secretary for the Centers for Medicare and Medicaid Services Program Management Account, for administrative costs associated with administering this section with respect to the Medicaid program. *The net CBO score for funding the center and the effect on Medicare spending is $0.8 billion for FY2010-FY2014 and -$1.7 billion for FY2010-FY2019.*[36]

[36] Section 1908 regarding emergency services is discussed in CRS Report R40892, *Public Health, Workforce, Quality, and Related Provisions in H.R. 3962*, coordinated by C. Stephen Redhead. Section 1909 will not be addressed.

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