

April 19, 2010

Summary of 2010 Health Care Reform Legislation: *The Patient Protection and Affordable Care Act (H.R. 3590) and Health Care and Education Reconciliation Act (H.R. 4872)*

AT A GLANCE

On March 23, 2010, President Obama signed into law H.R. 3590, the *Patient Protection and Affordable Care Act*. The following week, the president signed into law H.R. 4872, the *Health Care and Education Reconciliation Act of 2010*, which made modifications to H.R. 3590. Together, this historic legislation constitutes the largest change to America's health care system since the creation of Medicare and Medicaid. The Congressional Budget Office estimates that the law will expand coverage to 32 million individuals (95 percent of all those legally residing in the U.S., or 92 percent of all those residing in the country) at a cost of \$940 billion over 10 years (federal fiscal years 2010 – 2019).

At Issue:

This Legislative Advisory organizes the health care legislation into the following sections:

Coverage: The new law expands coverage to 32 million people through a combination of public program and private-sector health insurance expansions. Its key provisions include: insurance reforms, including administrative simplification provisions; a mandate for individuals to have insurance; employer responsibility to provide or contribute to health insurance; low-income subsidies to help individuals purchase insurance; an expansion of those eligible for Medicaid; and the creation of state-based health insurance "exchanges." It also calls for new, non-profit, consumer-owned and -oriented plans (or CO-OPs), as well as multi-state health plans overseen by the Federal Office of Personnel Management to compete with other private health plans in the state insurance exchanges.

Key Delivery System Reforms: The law adopts several key delivery system reforms to better align provider incentives to improve care coordination and quality and reduce costs. These reforms include a value-based purchasing system for hospitals; voluntary pilot projects to test bundled Medicare payments; voluntary pilot programs where qualifying providers – including hospitals – can form Accountable Care Organizations and share in Medicare cost savings; and financial penalties for hospitals with "excessive" readmissions. In addition, the law creates a Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models.

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Medicare and Medicaid Payment Changes: The law takes a number of steps to reduce the rate of increase in Medicare and Medicaid spending. Hospitals are estimated to contribute \$155 billion in savings over 10 years through reduced payment updates, decreases in Medicare and Medicaid disproportionate share hospital payments, and financial penalties (see Appendix A for year-by-year payment changes affecting the annual hospital update). The law also provides enhanced payments to rural hospitals, extends a number of expiring Medicare provisions, expands the 340B drug discount program, and provides additional payments to primary care physicians.

Workforce and Graduate Medical Education: The law provides grants and loans to enhance workforce education and training, to support and strengthen the existing workforce, and to help ease health care workforce shortages. It creates the National Health Care Workforce Commission to analyze the supply, distribution, diversity and skill needs of the health care workforce of the future. Most importantly, the law does not reduce indirect medical education funding to teaching hospitals, and allows for a redistribution of unused residency positions as a way to encourage increased training of primary care physicians and general surgeons. Unfortunately, it does not increase sufficiently the overall number of residency training positions, which the AHA will continue to pursue.

Wellness and Prevention: The law invests resources in prevention and wellness, including allocating \$12.9 billion over 10 years to the Prevention and Public Health Fund. It requires public and private insurers to cover recommended preventive services, immunizations and other screenings with zero enrollee cost sharing (no co-payment or deductible). It also initiates policies to encourage wellness in schools, workplaces and communities, and takes steps to modernize the public health care system.

Quality, Disparities and Comparative Effectiveness: The law takes steps toward paying for quality rather than volume of services by implementing “pay-for-reporting” systems across all providers and moving many providers toward value-based purchasing systems in the future. It also applies financial penalties to hospitals with “high” rates of hospital-acquired conditions. The law establishes a national quality improvement strategy, creates a public-private institute to analyze the comparative effectiveness of treatments, and creates a patient safety research center to promote the adoption of best practices. In addition, it contains a number of provisions to improve the delivery of health care services, particularly to low-income, underserved, uninsured minority and rural populations.

Regulatory Oversight and Program Integrity: The law includes a significant number of provisions to reduce waste, fraud and abuse in the Medicare and Medicaid programs. These include extending the Recovery Audit Contractor (RAC) program to Medicare Parts C and D and Medicaid, and implementing additional policies to enhance program integrity in Medicaid. Several new reporting requirements are imposed on tax-exempt hospitals.

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Revenue Provisions: In addition to Medicare and Medicaid provider payment reductions, the new law is financed by taxing high-premium health insurance plans, raising the Medicare tax for high-income individuals and imposing annual fees on the pharmaceutical, medical device, clinical laboratory and health insurance industries.

For more detailed information, and for additional provisions, please refer to the attached 87-page detailed summary.

Our Take:

The AHA recognizes the historic steps the law makes toward expanding health coverage. The new law includes a number of provisions reflected in AHA's *Health for Life* framework – our vision for health care reform in America – and its five essential elements: coverage for all (paid for by all); a focus on wellness; the most efficient and affordable care; the highest quality care; and the best information. As part of our shared responsibility to expand coverage, hospitals provided leadership by making a meaningful contribution toward helping to achieve savings. However, there are a number of areas in which the hospital field will seek changes in the new law, among them changes to the readmissions policy and changes to exclude critical access hospitals from Independent Payment Advisory Board decisions, at a minimum. The impact of these reductions, and other policies contained in the law, will be closely monitored to ensure that hospitals are able to continue to provide high-quality services to the patients and communities we serve.

Next Steps:

We will work closely with the administration in the months and years ahead as it develops the detailed regulations necessary to implement the law's numerous provisions. We also will work with Congress to make improvements to the law.

On March 26, AHA sent members a Legislative Advisory with two calculators – a coverage expansion benefit calculator and a payment impact calculator – to help you estimate the impact of the legislation on your organization. Both are available at <http://www.aha.org/aha/content/2010/spreadsheet/reformcalc.xls>.

Please watch for additional materials, including an implementation timeline, to help you understand the health reform legislation and better communicate its impact to your trustees, employees and community. We also will develop many materials to assist you in implementing health reform.

Questions:

If you have questions, please contact AHA member relations at: 1-800-424-4301.

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April 19, 2010

Detailed Summary of
2010 Health Care Reform Legislation:
*The Patient Protection and Affordable Care Act (H.R. 3590) and Health
Care and Education Reconciliation Act (H.R. 4872)*

COVERAGE AND INSURANCE REFORMS

IMMEDIATE INSURANCE MARKET REFORMS

(Sec. 1001-1105, Sec. 10101-10104, as amended by Sec. 2301 of H.R. 4872)

The new law makes significant insurance market reforms as the first step toward improving access to health insurance coverage. These reforms take effect September 23, 2010 (six months after enactment) and apply to all insurance plans, including grandfathered plans (grandfathered plans are defined as plans that are in existence on the date of enactment including collective bargaining agreements). These reforms:

- Prohibit insurers from rescinding coverage when the covered individual becomes ill.
- Prohibit the imposition of lifetime benefit limits and unreasonable annual limits on the dollar value of benefits. (Complete prohibition of annual limits will begin on January 1, 2014. Prior to January 2014, health insurance plans can impose restricted annual limits on coverage as determined by the Health and Human Services (HHS) Secretary.)
- Prohibit insurers from imposing any pre-existing condition exclusions for children under age 19.
- Require health plans to cover preventive services, without cost sharing, as recommended by the U.S. Preventive Services Task Force (USPSTF), including immunizations and preventive care for infants, children and adolescents (see page 57 of this advisory for more detail).
- Require health plans to extend coverage to dependent children through age 26.
- Require health plans to have an effective internal appeals process for coverage determinations and claims denials and comply with the state's external review process. The Secretary shall establish an external review process for states that do not have such a process and for self-insured plans.

The new law also provides immediate access to insurance for those who cannot get coverage because of pre-existing conditions and those nearing retirement. This access will be through the risk pool and reinsurance programs described below.

Temporary High-Risk Insurance Program for those with Pre-existing Conditions. (Sec. 1101) Beginning June 21, 2010 (90 days from the date of enactment), the HHS Secretary will establish a temporary high-risk insurance program for individuals with a pre-existing condition and who have not had group health coverage for the previous six months. The temporary program runs from June 21, 2010 until January 1, 2014 when the state insurance exchanges become available. Premiums will be set at a standard rate for a standard population and can vary only by age and by no more than a 4:1 ratio. Out-of-pocket limits will be tied to limits applicable for health savings account (HSA) plans (\$5,950 for an individual and \$11,900 for a family in 2010). Funding for the risk pool will be \$5 billion. The law requires the Secretary to establish criteria for determining whether insurers or employer-sponsored health plans dump enrollees into the high-risk pool based on the enrollees' health status. If found to be in violation of this anti-dumping provision, insurers and employer-sponsored health plans will be required to reimburse the high-risk pool for the coverage provided to their former enrollees.

Temporary Reinsurance Program for Early Retirees. (Sec.1102) *Spends \$5 billion over 10 years.* The HHS Secretary will establish a temporary reinsurance program for early retirees by June 21, 2010 (within 90 days of enactment) that will terminate on January 1, 2014 when the state insurance exchanges become available. The program will provide reimbursement to participating employer-sponsored plans for part of the cost of providing coverage to retirees between the ages of 55 and 64 and their families. The program will reimburse participating employer-sponsored plans for 80 percent of the cost of benefits provided enrollees in excess of \$15,000 and below \$90,000 adjusted for inflation each fiscal year. The program is funded at \$5 billion and the funds are available until expended.

Immediate Health Insurance Information to Consumers. The HHS Secretary, in conjunction with the states, and by no later than July 1, 2010, will establish an Internet portal for the public to access information on affordable and comprehensive coverage options at www.healthreform.gov.

The new law also imposes new transparency and administrative simplification standards, and consumer protection requirements for insurance companies. In addition, health plans and hospitals will be required to report on health care costs. These new requirements take effect within six months to 48 months of enactment and include the following provisions described below.

Consumer Protections. (Sec. 1001, 10101) The HHS Secretary, within 12 months of enactment (March 23, 2011) and in consultation with the National Association of Insurance Commissioners (NAIC), will be required to develop a uniform explanation of coverage documents and standard definitions for use by all health plans. Insurers will

be required to comply with these news standards within 24 months of enactment (March 23, 2012).

Effective within six months of enactment (September 23, 2010), plans must allow enrollees to select from participating providers a pediatrician as a primary care provider for a child; plans cannot impose prior-authorization or increased cost sharing for emergency services, whether provided by in-network or out-of-network providers; and plans cannot require authorization or referral for a female patient seeking OB/GYN services. Within one year of enactment (March 23, 2011), the HHS Secretary will make federal grant money available to states to establish or expand health insurance consumer assistance and ombudsman programs.

Health Care Quality Reporting. (Sec. 1002, 10101) The HHS Secretary, within two years of enactment (March 23, 2012) and in consultation with health experts and stakeholders, shall develop health care plan reporting requirements that include: initiatives to improve outcomes such as quality reporting, case management, care coordination and disease management; initiatives to prevent hospital readmissions through a comprehensive program for hospital discharge planning, and post discharge reinforcement by an appropriate health care professional; initiatives to improve patient safety and reduce medical errors; and initiatives on wellness and health promotion. Any wellness or health promotion activity will be prohibited from requiring the disclosure of or collection of any information related to the lawful possession or storage of a firearm. Health plans are required to report annually to the HHS Secretary on whether plan benefits satisfy these quality elements.

Health Plan Transparency Related to Health Costs, Medical Loss Ratio and Premium Review. (Sec. 1003, 10101) All plans, including grandfathered health plans, must report their health care costs on an annual basis. Such reports will include payment policies and rating practices, expenditures for clinical services, health care quality improvement expenditures, and non-claims-based costs and premium revenues. All reports will be made available to the public. Beginning in 2010, plans are required to report the portion of the premiums spent on items other than medical care.

Beginning no later than January 1, 2011, all plans, including grandfathered plans, must provide a rebate to their enrollees if the ratio of premium revenue exceeds expenses for clinical services and activities to improve health care quality. Health plans in large group markets will be required to pay the rebate if they spend less than 85 percent of their premiums on medical care. Health plans in the small group market and the individual market will be required to pay the rebate if they spend less than 80 percent of their premiums on medical care. NAIC will develop the needed methodology and uniform definitions by December 31, 2010.

Effective immediately (March 23, 2010), the HHS Secretary, in conjunction with the states, must establish a process for the annual review of insurance premium increases. Insurers are required to submit a justification to the Secretary and the relevant state for any unreasonable premium increase. All information will be available to the public.

States can access \$250 million in federal grants to assist them in establishing a review process. Once the state exchanges are operational, the Secretary will be required to make recommendations to the exchanges on whether to exclude certain health insurers from participation.

Medical Reimbursement Data Centers (Sec. 10101). Effective March 23, 2010, Medical reimbursement data centers will be established to collect reimbursement data from health insurers and make such information available to the public. The data centers shall develop fee schedules and other data-based tools to reflect market rates for services within geographic areas. Such centers can be non-profit or academic institutions.

Hospital Transparency Related to Health Costs. (Sec. 1003) Hospitals must report annually and make public a list of hospital charges for items and services, including Medicare severity diagnosis-related groups (MS DRGs). The HHS Secretary will establish the guidelines for public reporting beginning in 2010.

Annual Report on Self-insured Plans and Study of Large Group Market. (Sec. 10103) The Secretary of Labor, no later than one year after enactment (March 23, 2011), will prepare an annual report to Congress on self-insured health plans including plan types, number of participants, benefits offered, funding and benefit arrangements. In addition, the reports will include financial filings of self-insured employers including assets, liabilities, contributions, investments and expenses. The HHS Secretary, no later than one year after enactment (March 23, 2011), shall study and report to Congress the effects of insurance reforms on large group markets and self-insured group plans.

INSURANCE MARKET REFORMS BEGINNING 2014

(Sec. 1201-1253, 1341-1343, 10103 and as amended by Sec. 2301 of H.R. 4872)

The new law makes further insurance market reforms that apply to all plans, including grandfathered plans. These reforms apply to plans whether they are offered inside or outside the state health insurance exchanges (state exchanges). In addition, the new laws creates the structure for the state health insurance exchanges as well as establishes several mechanisms designed to balance any adverse or favorable risk selection as the new federal insurance standards are implemented.

Guaranteed Issue, Renewability, Pre-existing Conditions Prohibitions and Premium Rating. (Sec.1201) Effective January 1, 2014, all insurers offering coverage in the individual and group markets will be required to guarantee that they will accept every employer and individual applying for coverage. Insurers are permitted to restrict enrollment to open or special enrollment periods. The insurer will be required to guarantee the renewability of such coverage regardless of health status or utilization of services, including services related to domestic violence. Group health plans and insurers will be prohibited from excluding coverage based on pre-existing conditions or other circumstances such as medical history, claims experience or genetic information. All insurers will be prohibited from dropping coverage when an individual chooses to

participate in a clinical trial and the insurer will be required to cover the cost of routine care associated with the clinical trial.

Fair Premium Rating. (Sec. 1201) Individual and Small Group Market: Effective January 1, 2014, premiums in the individual and small group markets can vary only by family size, geography, actuarial value of the benefit, tobacco use and age (limited to a ratio of 3:1). The state will establish the rating areas within the state subject to HHS Secretarial review and approval. The HHS Secretary, in consultation with NAIC, will define the permissible age bands for premium rating purposes.

Large Group Market Special Rule: If a state permits issuers that offer coverage in the large group market (except self-insured group health plans) to offer coverage through the state exchange, these premium rating rules will apply to all coverage offered by that issuer in the states.

Prohibition on Excessive Waiting Periods. (Sec. 1201) Effective January 1, 2014, insurers of individual and group health plans, as well as grandfathered plans, will be prohibited from applying a waiting period that exceeds 90 days.

Essential Benefits, Cost-sharing and Child-only Plans. (Sec. 1201) Effective January 1, 2014, insurers participating in the individual and group markets will be required to offer the essential health benefits and cost-sharing limits in the new law (see pages 5 and 6 of this advisory). Insurers also will be required to offer child-only plans for those under the age of 21.

Premium Discounts, Rebates or Rewards for Programs that Promote Wellness. (Sec. 1201) Effective January 1, 2014, employer-sponsored health plans will be able to offer financial rewards to enrollees if they participate in qualifying wellness programs. The rewards can come in the form of premium discounts, rebates or waivers of cost-sharing requirements and will not exceed 30 percent of the cost of the coverage (or 50 percent if approved by the HHS, Treasury, and Labor Secretaries). A qualifying wellness program shall be helpful, not overly burdensome, and cannot discriminate based on health status. The HHS Secretary, in consultation with the Secretaries of Labor and Treasury, shall establish a 10 state demonstration project by July 1, 2014 under which states apply the requirements for group health plan wellness programs to the individual insurance market. Beginning in 2017, the HHS Secretary may expand the demonstration to additional states if the demonstration project has been effective.

IMPLEMENTATION OF INSURANCE REFORMS

The new law includes several mechanisms designed to balance any adverse or favorable risk selection as the new federal insurance standards are implemented. These mechanisms also are intended to stabilize premiums during the initial years of the state insurance exchanges. These mechanisms include the establishment of state-level transitional reinsurance programs, risk corridors for the individual and small group

markets and a health plan-level risk adjustment mechanism for the individual and small group markets.

Transitional Reinsurance. (Sec. 1341) Beginning January 1, 2014 and ending December 1, 2016, states will be required to establish a transitional reinsurance program. The non-profit reinsurance entity will collect payments from insurers in the individual and group markets and make reinsurance payments to the insurers in these markets to cover the costs of high-risk individuals. The HHS Secretary, in consultation, with the NAIC, will develop guidelines and the methodology for the transitional reinsurance program. The HHS Secretary will be required to provide the methodology used to determine how much insurers are to contribute to the reinsurance program by January 1, 2012.

Risk Corridors. (Sec. 1342) The HHS Secretary will be required to establish risk corridors for qualified health plans as defined by the legislation for the years 2014 through 2016. If the plan's non-administrative costs exceed 103 percent of total premiums, the Secretary will be required to make payments to the health plan to defray the excess costs. Plan participation is voluntary.

Risk Adjustment. (Sec. 1343) The HHS Secretary, in consultation with the states, will be required to establish a risk-adjustment program for the individual and small group markets. The risk adjustment program will assess charges on health plans with enrollees of lower-than-average risk and make payments to health plans with enrollees of higher-than-average risk. This does not apply to grandfathered plans.

Insurance Reforms and Collective Bargaining Plans and Existing (Grandfathered) Coverage. (Sec.1251) Effective January 1, 2014, the new insurance market reform requirements will apply to only new collective bargaining agreements, but current agreements can be amended to comply with the requirements without triggering a new agreement. All existing forms of coverage (grandfathered coverage) on the date of enactment (March 23, 2010) must be maintained subject to compliance with these new insurance reforms, such as medical loss ratio requirements, no excessive waiting periods, no lifetime coverage limits, no coverage rescissions, and dependent coverage. Grandfathered group health plans must comply with the prohibition on pre-existing condition exclusions and restricted annual limits (as specified by the HHS Secretary).

Implementation Funding. (Sec. 1005 of H.R 4872) A Health Insurance Reform Implementation Fund must be established within HHS, effective on date of enactment (March 23, 2010) to carry out the new law. The fund has an appropriation of \$1 billion to be used for federal administrative expenses until all such funds are spent.

QUALIFIED HEALTH PLANS AND ESSENTIAL BENEFIT REQUIREMENTS (Sec. 1301-1313, as amended by Sec. 10104)

The law sets forth the standards and benefit requirements, such as providing essential health benefits, licensing and ensuring the same premium rate for plans offered inside

and outside the exchange that insurers must meet to get their health plan products certified as qualified health plans for purposes of the state health insurance exchanges.

Qualified Health Plans (QHPs). (Sec. 1301, Sec. 10104) A qualified health plan is defined as a health plan that meets certification criteria issued by the state exchanges and the HHS Secretary, provides the essential health benefits package (described below), and is offered by a health insurer that is licensed in good standing. The licensed health insurer must offer a QHP in the silver level and at least one plan in the gold level) in the state exchange (see benefit section below), and agree to charge the same premium rate for each QHP plan the insurer offers either inside or outside the state exchange. The requirements for QHPs apply to plans offered through the CO-OP program or multi-state plan (see page 10). A QHP can offer coverage through a direct primary medical home plan if the plan meets criteria established by the HHS Secretary and if the services covered by the medical home plan are coordinated with the entity offering the QHP. QHPs, including multi-state QHPs can vary premiums based on rating areas as defined by the HHS Secretary. Current law mental health parity requirements apply to QHPs in the same manner as they apply to insurers and group health plans. Self-insured health plans and Multiple Employer Welfare Arrangements (MEWAS), which are exempt from state law under ERISA, will be exempt from the requirements pertaining to qualified health plan.

Essential Health Benefits Requirements. (Sec. 1302, 10104) The HHS Secretary will define the essential benefit package which must offer a full range of services, such as inpatient and outpatient hospital services; emergency services; rehabilitative services and devices; mental health and substance use disorder services, including behavioral health treatments; prescription drugs; maternity and newborn care services; pediatric services that include oral and vision care; and preventive and wellness services and chronic disease management. Among the elements the Secretary shall consider in defining essential health benefits are the health care needs of diverse segments of the population, as well as non-prior authorization for emergency services and cost-sharing parity for emergency services provided by in- and out-of-network providers. The HHS Secretary shall ensure that the scope of the essential health benefit plan is equal to the scope of a typical employer-sponsored plan (the Secretary of Labor will be required to conduct a survey of employer-sponsored health plans). In determining the essential benefit package, the HHS Secretary will provide an opportunity for public comment and a process to update the essential benefit package.

Benefit Options and Cost Sharing. (Sec. 1302, 10104) Four benefit categories of plans can be offered through the state exchanges and the individual and group markets: bronze, silver, gold and platinum. Plans participating in the individual and small group markets must offer, at a minimum, the silver and gold categories. All plans must include the essential health benefits as determined by the HHS Secretary. Insurers must charge the same price for the same product offered in the service area. The minimum level of creditable coverage (MCC) is the bronze package, defined as equal to 60 percent of the full actuarial value of the benefits provided under the plan. The actuarial value reflects the share of costs for covered services that are paid by the plan:

- The silver benefit package will be equal to 70 percent of the full actuarial value of the MCC with the same out-of-pocket limits as the MCC;
- The gold package will be equal to 80 percent with the same out-of-pocket limits as the MCC; and
- The platinum package will be equal to 90 percent, with the same MCC out-of-pocket limits.

Beneficiary out-of-pocket limits are capped at the HSA (qualified high deductible plan) limit (\$5,950 for an individual and \$11,900 for a family in 2010 and indexed annually for inflation). This amount will be reduced by one-third for individuals and families between 100-200 percent of the federal poverty level (FPL) (i.e., their cap will be \$1,983 for individuals and \$3,967 for families); one-half for individuals between 200-300 percent of the FPL; and two-thirds for individuals between 300-400 percent of the FPL. These out-of-pocket reductions are applied within the actuarial value of the plan without increasing the actuarial value of the plan.

Catastrophic plans will be available to those aged 30 or younger, or individuals exempt from the individual mandate because coverage is unaffordable, or because they have suffered a hardship as defined by the current Internal Revenue Service Code. A catastrophic plan must cover the essential health benefits package with three primary care visits per year and must be tied to the HSA limits.

Abortion Services. (Sec 1303, 10104) States are permitted to prohibit abortion coverage in plans offered through the state exchanges if a state enacts a law to prohibit such coverage. No existing state law regarding abortion will be pre-empted. Plans within a state exchange can elect not to cover abortion services. Public subsidies managed by the state exchanges must be segregated from funds that are used to pay for individuals enrolled in plans that provide abortion coverage. State insurance commissioners must ensure compliance with the process to establish segregated funds in separate accounts. Plans in the state exchange are prohibited from discriminating against a provider because of unwillingness to pay for, provide coverage of, or refer for abortions. Providers' EMTALA obligations remain unchanged.

Qualified Health Plans and Hospitals. (Sec. 1311) Beginning January 1, 2015, qualified health plans in the state exchanges cannot contract with a hospital with more than 50 beds unless that hospital participates in a Patient Safety Organization as established under federal law, and has a comprehensive hospital discharge system. The HHS Secretary can establish reasonable exceptions to these requirements.

Federally Qualified Health Centers (FQHCs). (Sec. 1302) FQHCs participating in plans offered through the state exchanges will be reimbursed at rates at least equal to Medicaid FQHC payment levels.

Definition of Employer. (Sec. 1304 as amended by 10104) A large employer is defined as having over 100 employees. A small employer is defined as having between 1 and

100 employees. Prior to January 1, 2016, a state may define a small employer as having 1 to 50 employees.

STATE-BASED HEALTH INSURANCE EXCHANGES – AMERICAN HEALTH BENEFIT EXCHANGES

(Sec.1311–1343, 10104)

Overview. By January 1, 2014, states will be required to establish exchanges to facilitate the purchase of qualified health plans in the individual and small group markets. The exchanges, known as American Health Benefit Exchanges, may be governmental or non-profit entities. Federal start-up money is available beginning 2011 through 2015 at which time exchanges shall be self-sustaining. HHS shall consult with the NAIC and other stakeholders to develop regulations for the state exchanges. If a state fails to establish an exchange, the HHS Secretary shall establish and operate an exchange within the state. For states with exchanges in operation prior to January 1, 2010, the Secretary will presume they meet the terms of the new law if they meet certain requirements as determined by the Secretary. States can establish more than one exchange within a state as long as a distinct geographic area is served. States have the option of forming a regional exchange with other states. And states can create a Small Business Health Options Program (SHOP) within the exchange to assist qualified small employers in the enrollment of their employees.

Responsibilities of HHS Secretary. The HHS Secretary will be required to establish criteria for the certification of qualified health plans, develop a rating system for the health plans, establish criteria for open enrollment periods and maintain the Internet portal that makes information on health plans available to the public (Sec. 1411). The Secretary will be responsible for establishing a program to verify citizenship for those individuals purchasing insurance in the individual market through the exchanges and claiming public subsidies. Only citizens and lawful residents will be eligible to participate in state exchanges (Sec. 1312).

Functions of the State Exchanges. (Sec. 1311) The functions of the state exchanges are largely to facilitate and manage enrollment, including the use of Web-based resources. The exchanges will be required to provide an initial open enrollment period as determined by the Secretary no later than July 1, 2012. Information on benefits and health plan choices will be presented to the public using a standardized format. The exchanges will certify and rate qualified health plan (QHPs) following guidelines set by the Secretary. The exchanges also will be responsible for managing the tax-based premium subsidies, including eligibility determinations. The exchanges will enroll eligible individuals in Medicaid, CHIP or other available public programs. Exchanges will share with the Treasury Secretary appropriate information including an individual's qualification for an exemption from the individual mandate or an individual's eligibility for public subsidies.

Each exchange shall establish a Navigator program to conduct public education, distribute fair and impartial enrollment information, facilitate enrollment, provide referrals

to consumer insurance information and grievance sources and assist in providing culturally and linguistically appropriate information. The exchange will be required to award grants to entities to perform these navigator responsibilities. States may admit larger firms into the exchange (large firms as defined by state law) beginning in 2017. Members of Congress and their staffs can access federally-sponsored health benefits only through plans offered in the state exchanges.

Single Risk Pool. (Sec. 1312 as amended by Sec. 10104) Insurers offering plans in the individual market, except grandfather plans, will be required to pool risk of all enrollees in all markets where they have plans, regardless of whether the plan is offered in the state exchange. A state can require the individual and small group markets within a state to be merged. The new law pre-empts a state law requiring grandfathered health plans to be included in a single risk pool for the individual or group market.

Empowering Consumer Choice. (Sec. 1312, 10104) Insurers can offer health plans to individuals or employers outside the state exchange. Individuals cannot be compelled to participate and enroll in a qualified health plan offered through the state exchange.

Health Care Cooperative. (Sec. 1322) *Spends \$6 billion in loans and grants.* The Consumer-Operated and -Oriented Plan (CO-OP) program will be established to foster the creation of non-profit, member-run, health insurance companies that will operate inside and outside the state exchange; using \$6 billion in federal grants and start-up funds. The HHS Secretary will be required to make start-up funds, such as loans, available to applicants by July 1, 2013. Qualified CO-OPs shall be non-profit; cannot be an existing insurer, its affiliate or successor; and cannot be sponsored by any government instrumentality (state, county or municipality). The CO-OP insurers can offer qualified health plans in the individual and group markets in the state as well as in the state exchange. The HHS Secretary will award CO-OP grants with the assistance of a temporary advisory board appointed by congressional leaders. The grant awards will give preference to statewide proposals that utilize integrated care models, and those with significant private financing. Multiple awards to CO-OPs within a state will be allowed. If a state does not form a CO-OP, the Secretary can use grant funds to encourage CO-OP formation. Provider rates will be negotiated by the CO-OP.

Multi-State Qualified Health Plans. (Sec. 1334, 10104) The law requires the federal Office of Personnel Management (OPM) to enter into contracts with health insurers to offer at least two multi-state qualified health plans (MSQHP) through the exchanges. One MSQHP must be non-profit. OPM will negotiate the contracts with the MSQHPs under a process similar to the one established for the Federal Employees Health Benefits Program (FEHBP). Contracting provisions may include medical loss ratios, profit margins, premiums or other terms and conditions. MSQHPs must comply with the minimum standards and requirements for FEHBP. OPM can prohibit MSQHPs that do not meet standards for medical loss ratios, profit margins and premiums. Each MSQHP must be licensed by the states. Provider rates will be negotiated by the MSQHP. The FEHBP program will be maintained as a separate program with a separate risk pool.

STATE FLEXIBILITY TO ESTABLISH ALTERNATIVE PROGRAMS

(Sec. 1331-1333, 10104)

The law grants states flexibility in establishing alternatives to providing affordable health coverage within the state.

Basic Health Plan Program. (Sec. 1331) The HHS Secretary will establish a basic health plan program for individuals with incomes below 200 percent of the FPL but who are not eligible for the state Medicaid programs, i.e. individuals with family income above 133 percent of the FPL. States will enter into contracts with the Secretary to offer standard health plans through the basic health plan program that must meet certain premium and cost sharing requirements. Legal immigrants with incomes less than 133 percent of the FPL who are not eligible for Medicaid because of the five-year waiting period are eligible for the Basic Health Plan Program. Plans in the basic health plan program will operate outside the state exchanges.

Health Care Choice Compacts. (Sec. 1333, 10104) The HHS Secretary, by July 1, 2013, will be required to consult with NAIC to issue regulations for interstate health care choice compacts. By January 1, 2016 two or more states may form Health Care Choice Compacts to facilitate the purchase of individual health insurance coverage across state lines. States, subject to HHS approval, will be able to come together to allow licensed qualified health plans to offer plans in all participating states. Issuers of qualified health plans will be subject to the consumer protection laws of the state in which the purchaser resides. These consumer protections include market conduct, trade practices, and network adequacy. The issuer of the qualified health plan will be required to be licensed in each state in which it offers a plan under the compact.

State Waiver of Individual Mandate. (Sec. 1332) Beginning January 1, 2017, states will be allowed to apply to the HHS Secretary for a five-year waiver of all new requirements of the legislation, such as the individual mandate, exchanges, qualified health plans, public subsidies and employer responsibility. The conditions of the waiver require a determination that the states' residents will be provided coverage comparable to coverage without the waiver.

PUBLIC SUBSIDIES FOR INDIVIDUALS

(Sec. 1401-1421, Sec. 10105 as amended by Sec. 1001 and 100 of H.R. 4872 4)
Spends \$350 billion over 10 years.

To assist individuals in the purchase of insurance, public subsidies in the form of premium tax credits, and cost-sharing assistance will be available to individuals with incomes between 133 percent of the FPL (\$14,404 for an individual and \$29,327 for a family of four in 2009) and 400 percent of the FPL (\$43,320 for an individual and \$88,200 for a family of four in 2009).

Individual Premium Tax Credits. A refundable, advanceable premium assistance tax credit will be available to individuals and families with incomes between 133 percent of

the FPL to 400 percent of the FPL for the purpose of purchasing insurance through the state exchanges. Employees, whose employer-sponsored premiums exceed 9.5 percent of their income, or where the benefit provided in the employer-sponsored coverage is less than 60 percent of the benefit cost, are eligible for premium assistance tax credits in the exchange. The value of the premium assistance tax credit is tied to the second-lowest cost silver benefit package (reference plan). The credit is calculated on a sliding scale within each tier of household income and caps the individual's premium contribution based on a percentage of household income. The enrollee's premium contributions will be limited to a share of income: 2 percent for incomes up to 133 percent of the FPL; 3-4 percent for incomes between 133 and 150 percent of the FPL; 4-6.3 percent for incomes between 150-200 percent of the FPL; 6.3–8.05 percent for incomes between 200-250 percent of the FPL; 8.05- 9.5 percent for incomes between 250-300 percent of the FPL; and 9.5 percent for incomes between 300-400 percent of the FPL. Between 2014 and 2018, the premium tax credits will be reduced by the amount by which the premium growth exceeds income growth. After 2018, an individual's premium contribution will be adjusted to reflect the excess of premium growth over Consumer Price Index (CPI) if aggregate premiums and cost sharing reductions exceed 0.504 percent of Gross Domestic Product (GDP) in the preceding calendar year. Individuals who are not lawfully in the US are not eligible for premium tax credits. However, legal immigrants with incomes at or below 100% of the FPL who are not eligible for Medicaid or CHIP due to the 5 year waiting period are eligible for the premium tax credit.

Cost-sharing Subsidies. The combined effect of the various cost-sharing subsidies increases the actuarial value of the basic benefit plan so that beneficiary out-of-pocket spending is capped. Households with family incomes between 100-150 percent of the FPL will pay no more than 6 percent of the plan's cost from their own out-of-pocket funds. Those with household incomes between 150-200 percent of the FPL will pay no more than 13 percent of the plan's cost from their own out-of-pocket funds. Those with household incomes between 200-250 percent of the FPL will pay no more than 27 percent of the plan's cost from their own out-of-pocket funds. Those with household incomes of between 250-400 percent of the FPL will pay no more than 30 percent of the plan's cost from their own out-of-pocket funds. The cost sharing reduction does not apply to benefits offered in excess of the essential health benefits. Special rules for Native Americans eliminate all cost sharing for those Native Americans with incomes below 300 percent of the FPL.

Streamlining Enrollment for Exchange, State Medicaid and CHIP Programs and Health Subsidy Program. The HHS Secretary shall develop an enrollment system that will allow for individuals applying through a state exchange for public subsidies and found to be eligible for Medicaid or CHIP to be enrolled in those programs. The enrollment system will include a streamlined application process with a single form for applications to subsidy programs and will share information among federal programs.

Study of Geographic Variation in Application of FPL. The HHS Secretary shall report to Congress by January 1, 2013 on the feasibility and implications of adjusting the application of FPL for different geographic areas.

PUBLIC SUBSIDIES FOR SMALL BUSINESSES

(Sec. 1421)

Spends \$40 billion over 10 years.

Small employers with up to 25 employees with average annual per-employee wages of less than \$50,000 will be eligible for a tax credit for their contributions toward the purchase of employee health insurance. To be eligible, small employers must contribute 50 percent of the total premium or 50 percent of the benchmark premium, as determined by the Secretary. Phase I of the tax credit is for years 2010-2013. Employers can receive up to 35 percent of their contribution as a tax credit toward the purchase of health insurance premiums. The full credit is available to employers with 10 or fewer employees and average wages of \$25,000 and phases-out as firm size and average wage increase. Tax-exempt small businesses are eligible for tax credits of up to 25 percent of the employer's contribution toward the employee's premium.

Phase II begins in 2014. Credits are limited to two years, but periods prior to 2014 are not counted toward the two-year limit. Employers who purchase coverage through the state exchanges can receive a tax credit of up to 50 percent of their contribution for two years. The full credit is available to employers with 10 or fewer employees and average wages of \$25,000 and phases-out as firm size and average wage increase to 25 employees and average wages of \$50,000. Tax-exempt small businesses are eligible for tax credits of up to 35 percent of the employer's contribution toward the employee's premium.

SHARED RESPONSIBILITY

(Sections 1501-1562, 10106, 10108 as amended by Sec. 1002-1003 of H.R. 4872).

Saves \$69 billion over 10 years.

Individuals will be required to obtain coverage, with the mandate enforced through a tax penalty. Large employers will face a "free rider" assessment if their employees receive health coverage through an exchange with the aid of public subsidies.

Personal Responsibility (Individual Mandate). This law includes a carefully articulated rationale for the imposition of a mandate on individuals to obtain health insurance, largely to thwart constitutional challenges. Beginning in January 1, 2014, all U.S. citizens and legal residents will be required to maintain minimum essential coverage, defined as any plan offered through the individual market; public programs such as Medicare, Medicaid, TRICARE and the Veteran's Health Care Program; employer-sponsored health plans; and other plans. Individuals, insurers and employers will be expected to report coverage status to the Internal Revenue Service (IRS). Failure to maintain "minimum essential coverage" will result in a tax penalty of \$695 per year with a maximum penalty of \$2,085 for a household. It will be phased in at \$95 in 2014, \$325

in 2015, and \$695 in 2016 or a flat fee of 1.0 percent of taxable income in 2014, 2.0 percent of taxable income in 2015, and 2.5 percent of taxable income in 2016. Beginning in 2016, the penalty increases annually by the CPI.

The HHS Secretary will be required to establish an annual open enrollment system for the residents of each state. The Secretary shall ensure that the state exchanges work with the state Medicaid and CHIP programs to enroll anyone coming to the exchange for coverage and found to be eligible for these programs.

Exemptions from the mandate will be available for the following reasons: those who have religious conscience objections; those under age 65 with incomes below the tax filing threshold (\$9,350 for single and \$18,700 for couples in 2009); those for whom the lowest-cost option net contributions or subsidies is more than 8 percent of their adjusted gross income; those facing hardships (as defined by the Secretary); those without coverage for less than three months of the year; those incarcerated; undocumented immigrants; and those who are American Indians.

Employer Responsibility. Employers are not required to offer coverage to their employees. Current tax preferences will apply if the employer offers coverage regardless of whether the employer offers coverage through an exchange or outside the exchange. In general, employees offered coverage are ineligible for premium tax credits unless the health coverage offered is unaffordable. The test of affordability is the employee's premium exceeds 9.5 percent of the employee's income or the employer offering coverage pays less than 60 percent of the employee's premium. Employers will be penalized for "dumping" employees into the high-risk pool based on the employee's health status (as described in the section on high-risk pools under insurance market reforms). Employers will be prohibited from limiting eligibility for coverage based on wages or salaries of full-time employees.

Large Employer Requirements. Large employers that offer at least one health plan and have 200 or more full-time employees will be required to have auto enrollment for employees in their health plans. Large employers must provide information on how employees can get coverage through the state exchange, Medicaid or other qualifying programs.

Inclusion of cost of employer-sponsored health coverage on W-2. (Sec. 9002) The new law requires employers to disclose the aggregate value of all applicable employer-sponsored health benefits provided to an employee (excluding flexible spending account salary reduction contributions), whether paid by the employer or the employee, on the employee's annual W-2 form. Applicable coverage includes coverage to which the high cost health coverage excise tax applies. The requirement begins for taxable years after December 31, 2010.

Prohibition of Discrimination in Favor of Highly-Compensated Individuals. (Sec. 1001 as amended by Sec. 2716) Effective September 23, 2010 group health plans are

required to satisfy Internal Revenue Service requirements prohibiting discrimination in favor of highly paid individuals.

“Free Rider” Assessments. Effective January 1, 2014, an employer with more than 50 employees that does not offer coverage will be assessed a fee for each employee who receives a premium tax credit. This “free rider” assessment will be a payment of \$2,000 per full-time employee, excluding the first 30 employees. An employer that has 50 or more employees and does offer coverage and has at least one full-time employee that receives public subsidies will be assessed the lesser of \$3,000 for each publicly subsidized employee or \$2,000 for each full-time employee. Employers with fewer than 50 employees are exempt from the “free rider” assessment.

Free Choice Vouchers. (Sec. 10108) Effective January 1, 2014, employers that offers minimum essential coverage and contributes to any portion of the premium must provide a free choice premium voucher equal to the employer-premium contribution to qualified employees for their use to purchase coverage through the exchanges. Employees qualify for the voucher if the cost of the employer provided coverage is between 8 percent and 9.8 percent of their income. The value of the voucher must be equal to the premium contribution the employer makes to its own health plan. The voucher helps individuals with incomes too high for the individual mandate exemption and too low to qualify for the hardship waiver that qualifies employees for exchange subsidies. The voucher amount can be used to offset premium costs for the plan in which the employee is enrolled. An employer offering a free choice voucher will not be subject to the “free rider” assessment if its employees receive public premium subsidies. Free choice premium vouchers are excluded from taxation and voucher recipients are not eligible for tax credits.

ROLE OF MEDICAID AND CHIP PROGRAMS

(Sec. 2001 –2801, 10201-10203 as amended by Sec. 1004, Sections 1201-1206 of H.R. 4872)

Spends \$434 billion over 10 years.

Medicaid Program Expansion and Maintenance of Effort (MOE). Beginning January 1 2014, the Medicaid program will expand to cover non-elderly individuals, including parents, children and childless adults up to 133 percent of the FPL (\$14,404 for an individual and \$29,327 for a family of four). An MOE eligibility requirement will be imposed on states for all covered populations at the time of enactment through December 31, 2013. Effective in 2014, Medicaid eligibility will be based on an individual’s modified adjusted gross income, as defined by the state exchange. A 5 percent income disregard will be applied when determining eligibility effectively raising the income threshold for eligibility, to 138 percent of the FPL. Asset tests will no longer apply. Newly eligible, non-pregnant adults will receive a benchmark benefit package that will include at least the minimum essential coverage with mental health parity. States will have the option of expanding coverage to the non-elderly at or above 133 percent of the FPL beginning April 1, 2010 with the current federal matching assistance percentage (FMAP). Between January 1, 2011 and January 1, 2014, a state could be

exempt from the MOE requirement for populations covered above 133 percent of the FPL if it certifies to the HHS Secretary that the state is currently experiencing a budget deficit or projects a budget deficit in the following year. Beginning in 2014, states will be required to offer premium assistance and wrap-around benefits to all Medicaid beneficiaries who are offered employer-sponsored insurance if it is cost effective. State Medicaid and CHIP programs will be required to coordinate enrollment with the state exchange to provide a seamless enrollment process for all programs. States can use a Web-based enrollment process.

Medicaid Federal Assistance to States. Beginning January 1, 2014, states will receive federal assistance to help defray the cost of the newly eligible populations. Federal assistance will take the form of an enhanced FMAP with a specified percentage point increase in a state's FMAP. From 2014 to 2016, all states will receive 100 percent federal funding for the newly eligible adults. From 2017 through 2020, states' FMAP will be reduced: to 95 percent in 2017; 94 percent in 2018; 93 percent in 2019; and 90 percent in 2020 and thereafter. The definition of newly eligible (children, parents, childless adults) also includes individuals as of December 2009 in state-only funded programs and individuals eligible for a capped Medicaid program not enrolled or on a waiting list.

For early-expansion states, additional assistance will be provided to help finance the cost of providing coverage to just the eligible childless adults (not parents) up to 133 percent of the FPL. These states are: Arizona, Delaware, District of Columbia, Hawaii, Maine, Massachusetts, Minnesota, New York, Pennsylvania, Vermont, Washington and Wisconsin. From 2014 to 2019, these states will receive an FMAP increase equal to a percentage difference in the state's current FMAP and the FMAP rates to be established for the newly eligible populations. The annual percentage increases are 50 percent in 2014; 60 percent in 2015; 70 percent in 2016; 80 percent in 2017; 90 percent 2018 and 100 percent thereafter. In 2019, and years thereafter, expansion states will bear the same costs of covering the newly eligibles as non-expansion states.

Medicaid FMAP Payments to Puerto Rico and the Territories. (Sec. 2001, 2005, as amended Sec. 1204 of H.R. 4872) The law increases the applicable FMAP by five percentage points to 55 percent beginning on July 1, 2011. The Medicaid spending cap will allow the cost of covering newly eligibles to count toward the spending caps. Territories that elect to establish a health insurance exchange will be treated as a state and will receive a total of \$ 1 billion in funding between 2014 and 2019, of which \$925 million is for Puerto Rico. The Medicaid spending cap for the territories will increase beginning July 2011 to September 2019 so that, in total, no more than \$6.3 billion is spent.

FMAP Adjustment for States Recovering from a Major Disaster. (Sec. 2006, Sec. 10201) *Spends \$200 million.* The law prescribes an adjustment to the FMAP determination for certain states recovering from a major disaster. Louisiana will receive an extension of federal assistance hurricane disaster relief through an adjustment to their Medicaid FMAP for FY2011-2012.

Children's Health Insurance Program (CHIP). (Sec. 2101, 10203) *Spends \$100 million over 10 years (costs included in coverage estimates).* Federal CHIP funding authorization will be extended two years through FY 2015. Upon enactment, states will be required to maintain their CHIP programs until September 30, 2019. States will receive an enhanced FMAP of 23 percentage points added to their CHIP FMAP up to a cap of 100 percent. CHIP-eligible children not able to enroll due to federal allotment caps will be eligible for public subsidies in the state exchange. The HHS Secretary shall certify transitioning CHIP coverage to the state exchange. Outreach and enrollment grants are increased by \$40 million. Some children of qualifying state and local public employees can enroll in CHIP. Insurers in the exchanges shall report to the Secretary on pediatric quality measures.

Medicaid and CHIP Payment Assessment Commission (MACPAC). (Sec. 2801) MACPAC's initial charge to review how payment policies affect children's access to care will be expanded to include adult access to services, including dual eligibles. MACPAC shall look at how Medicaid and CHIP regulations affect access, quality and efficiency. MAPAC is funded at \$11 million for FY 2010.

Improvements to Medicaid. (Sec. 2201–2702) The law includes numerous provisions to improve the Medicaid program.

- **Presumptive Eligibility for Hospitals (Sec. 2202):** Hospitals participating in the Medicaid program will be permitted to make presumptive eligibility determinations beginning January 1, 2014.
- **Prescription Drug Rebate (Sec. 2501- 2503):** *Saves \$38.7 billion over 10 years.* The legislation makes several changes to the Medicaid drug rebate program that will result in an increase in the rebate percentages for single source, innovative multiple source and multi-source non-innovator drugs. The HHS Secretary will be required to adjust the rebate percentages and require drug manufacturers to pay rebates for beneficiaries in managed care plans. These changes are retroactively applied to January 1, 2010.
- **Improved Coordination and Protection for Dual Eligibles (Sec. 2602):** The Secretary will be required to provide, through an identifiable office or program within the Centers for Medicare & Medicaid Services (CMS), a focused effort to improve coordination between Medicare and Medicaid in the case of all dual eligibles. The office must review all policies under Parts A and B of Title XVIII, Part C Medicare Advantage program and Title XIX. The review must evaluate where policy changes should be made to simplify access, improve care continuity, harmonize regulatory conflicts between Medicare and Medicaid, and improve total cost and quality performance for dual eligibles.
- **Institutions for Mental Diseases (IMD) Demonstration Project (Sec. 2707):** A three-year demonstration project will be established to test reimbursement for

private psychiatric hospitals for emergency psychiatric services will be provided to individuals in the community between the ages of 21 and 65. The demonstration project will be funded at \$75 million and the HHS Secretary shall report to Congress, by 2013, on findings and recommendations.

- **Access Improvements for Children, Families, Elderly and Disabled (Sec. 2301 – 2406, Sec. 10202 as amended by Sec. 1205 of H.R. 4872):** *Spends \$13.7 billion over 10 years.* Medicaid access to services will be improved by requiring coverage for freestanding birth centers, removing barriers for community-based services, creating a state optional benefit for home and community-based attendant services, providing hospice services for children, extending community-based disabled demonstration services, and creating health homes for enrollees with chronic conditions.
- **Clarify the Definition of Medical Assistance (Sec. 2304):** The definition of “medical assistance” within the Medicaid program will include payment for services as well as the service itself.
- **Community First Choice Option (Sec. 2401 as amended by HR 4872 Sec.1205):** Beginning October 1, 2011, state Medicaid programs will have a new option with federal match of FMAP plus 6 percentage points, to provide home and community-based attendant services for Medicaid eligible individuals who require the level of services provided in a hospital, nursing facility, Intermediate Care Facilities (ICF/MR) or Institutions for Mental Disease (IMD). An eligible individual must have income below 150 percent of the FPL or the income level that qualifies the individual for Medicaid coverage in the state.

Long-term Care Insurance/CLASS Program. (Sec. 8002) *Saves \$70.2 billion over 10 years.* The legislation creates a national, voluntary program for purchasing community living assistance services and supports (CLASS program). Currently, the Medicare program covers only short-term skilled nursing services and home health care. The Medicaid program provides long-term services and support, such as general nursing home care, but individuals may not access this funding unless they meet state qualifications based on having incomes and assets at a certain percentage of the FPL.

The CLASS program will be available to employed individuals. Beginning taxable years ending after December 31, 2010, working adults will be enrolled automatically in the program through payroll deductions unless they choose to opt-out. To qualify for benefits, individuals must be 18 years old and have contributed monthly premiums for at least five years. The program will provide a cash benefit of not less than \$50 per day to individuals with functional limitations to purchase non-medical services and supports necessary to maintain community residence. The new program will be known as the CLASS Independent Benefit Plan. The HHS Secretary is required to develop an actuarially sound benefit program that is solvent for 75 years.

Maternal and Child Health (MCH) and Adolescent Services. (Sec. 2951-2955, Sec. 10211-10214) *Spends \$2.2 billion over 10 years.* The law establishes a new block grant program for early childhood home visitation; requires states as a condition of receiving MCH funds to conduct community needs assessments to identify those at risk for poor maternal and child health; establishes a pregnancy assistance fund for teens and adult women; and improves services for pregnant victims of domestic violence.

OTHER COVERAGE-RELATED PROVISIONS

Temporary Adjustment to the Part B Premium Calculation. (Sec. 3402) *Saves \$25 billion over 10 years.* Beginning January 1, 2011 and ending on December 31, 2019, the law freezes income thresholds at 2010 levels for the income-related premium for Part B Medicare.

Special Enrollment Period for Disabled TRICARE Beneficiaries. (Sec. 3110) The law creates a 12-month special enrollment period for military retirees, their spouses (including widows/widowers) and dependent children, who are otherwise eligible for TRICARE and entitled to Medicare Part A based on disability or ESRD, but who have declined Part B. This law is effective for elections made with respect to initial enrollment periods that end after March 23, 2010.

MEDICARE PART C - MEDICARE ADVANTAGE (MA)

(Sec. 3201-3210 as amended by Sec. 1102-1103 of H.R. 4872)

Saves \$135.6 billion over 10 years (changes to MA payments) and spends \$800 million over 10 years (extending MA Special Needs plans).

The law reduces the current 14 percent overpayment made to MA plans to bring payments more in line with those under traditional Medicare fee-for-service. The law creates a set of benchmark payments at different percentages (115 percent, 107.5 percent, 100 percent and 95 percent) of the current average fee-for-service costs in an area. The lowest percentage will apply to the highest-cost areas. Beginning in 2012, these new benchmarks will be phased in over two, four or six years depending on the cost differential of the old and new methodology. For example, if the benchmarks for 2010, as determined under the current methodology and the projected application of the new methodology for 2010, differ by less than \$30, then a two-year phase-in applies (with MA plans receiving half of their current benchmark and half of the new blended benchmark in 2012, and 100 percent of the new benchmark in 2013). If the difference is greater than \$30 then a four-year phase-in will be used. And, if the difference is greater than \$50 then a six-year phase-in will apply. For 2011, MA payments are frozen at 2010 levels. MA plans may receive bonus payments of 1.5 percentage points for 2012, 3.0 percentage points for 2013, and 5.0 percentage points for 2014 and beyond based on quality and enrollee satisfaction. The phase-in of the modified benchmarks and the quality bonuses do not apply to PACE plans. In addition, the law:

- Beginning in 2011, for certain services, limits the cost-sharing that a MA plan may impose to no more than will apply under the traditional fee-for-service program.
- For contract years beginning with 2014, requires MA plans to spend at least 85 percent of revenue on medical costs or other activities that improve quality of care, rather than on profit and overhead, and imposes penalties for those failing to meet this requirement.
- Extends CMS' authority to adjust risk scores for observed differences in coding patterns relative to fee-for-service and phases up the adjustment beginning in 2014.
- Beginning in 2011, simplifies the annual beneficiary enrollment process by lengthening the election period to October 15 through December 7, and allowing beneficiaries to dis-enroll more easily from an MA plan and return to traditional fee-for-service.
- Extends the Special Needs program (SNP) for individuals with chronic conditions through 2013, and implements a number of refinements for these plans.
- Extends Medicare reasonable costs contracts to January 1, 2013, regardless of whether other MA plans are servicing the area.
- Implements a technical correction to MA Private Fee-For-Service (PFFS) plans allowing employer-sponsored PFFS plans with enrollment as of October 1, 2009 to obtain a waiver from the MIPPA network requirements.
- Makes permanent the senior housing facility demonstration project, which allows MA plans that meet certain criteria to limit their service areas to a senior housing facility within a geographic area.
- Authorizes the HHS Secretary beginning in 2011 to deny MA plan bids that propose to significantly increase beneficiary cost sharing or decrease benefits.

MEDICARE PART D – PROVISIONS AFFECTING PRESCRIPTION DRUG PLANS

(Sec 3301 – 3315, as amended by Sec. 1101 of H.R. 4872)

Spends \$54 billion over 10 years.

Part D Program Improvements. The law makes a number of important improvements to the Medicare Part D program, the prescription drug benefit program for Medicare beneficiaries. The key improvements address the gap in coverage that occurs when prescription drug spending reaches \$2,830 and Medicare stops paying for drugs until the spending threshold for the Medicare beneficiary reaches \$4,550. This gap in coverage is known as the “donut hole.” The improvements:

- Provide a \$250 rebate, retroactive to January 1, 2010, to Medicare beneficiaries who have reached the “donut hole.”
- By 2020, phase down the Medicare Part D coinsurance for the “donut hole” from 100 percent to 25 percent.
- Beginning in 2013, require that drug manufacturers provide a 50 percent discount on prescriptions while the beneficiary is in the “donut hole.”

- Phase-in a federal subsidy of 75 percent, by 2020, of generic drug costs for prescriptions filled while the beneficiary is in the “donut hole.” The phase-in begins in 2011.

Part D Premium Subsidy. The law reduces the Part D premium subsidy for high-income beneficiaries with incomes above the Part B income thresholds.

MISCELLANEOUS PROVISIONS

(Sections 1551 – 1563, Sec. 10108)

There are a number of provisions that range from transparency, employee protections, and health information technology to conducting various studies. Three key provisions are summarized below:

- **Government Accountability Office:** The GAO is required to study, within one year of enactment (March 23, 2011), the cost, affordability, and rates of denial of coverage for health plans offered in the state exchanges.
- **Health Information Technology (HIT):** Within 180 days of enactment (September 19, 2010) the HHS Secretary in consultation with the HIT Policy Committee and the HIT Standards Committee shall develop interoperable and secure standards and protocols to facilitate enrollment in federal and state health programs.
- **Transparency in Government:** Not later than April 22, 2010 (30 days after the date of enactment), the HHS Secretary will publish on the HHS web site a list of all the authorities provided to the Secretary under this law (and the amendments made by this law).

KEY DELIVERY SYSTEM REFORMS

HOSPITAL VALUE-BASED PURCHASING (VBP)

(Sec. 3001, 10335)

Budget neutral.

The law establishes a VBP program to pay hospitals for their actual performance on quality measures, rather than just the reporting of those measures, beginning in FY 2013. The VBP program will apply to all acute-care prospective payment system (PPS) hospitals. Certain hospitals are excluded, including those that do not have a sufficient number of patients within the related conditions. A demonstration project will be created for critical access hospitals (CAHs).

Measures will be selected from those used in the Medicare pay-for-reporting program, including measures for heart attack, heart failure, pneumonia and surgical care, and measures assessing patients’ perception of care (HCAHPS). The VBP program is restricted from including readmission measures. The HHS Secretary is directed to include measures of healthcare-associated infections. The Secretary is mandated to include measures assessing efficiency, including measures of Medicare spending per

beneficiary, which will be adjusted for differences in age, sex, race, severity of illness and other factors, as determined by the Secretary, in FY 2014 and beyond. Selected quality measures will need to be considered by a consensus-based organization, such as the National Quality Forum (NQF), although the Secretary will have discretion to implement other measures under certain circumstances.

Funding for the program will be generated by reducing all Medicare inpatient PPS Medicare-severity DRG (MS-DRG) payments to participating hospitals using a phased-in approach. Payments will be reduced by 1 percent in FY 2013; 1.25 percent in FY 2014; 1.5 percent in FY 2015; 1.75 percent in FY 2016; and 2 percent in FY 2017 and beyond. The reduction will be applied to all MS-DRGs but will not affect disproportionate share, indirect medical education, low-volume adjustment or outlier payments. A hospital will be rewarded for quality improvement or quality attainment, whichever level is higher.

A methodology for assessing hospital performance will be developed by the Secretary; a hospital that meets or exceeds the performance standards will be eligible to earn back the initially withheld money. A hospital's total composite performance score will be calculated and used to determine whether the hospital meets the overall performance standard. The payment adjustment will apply only to the relevant fiscal year, based on the prior year's performance, and will not be taken into account in calculating payments in future fiscal years. The program will be budget-neutral; that is, all of the money withheld to fund each year's incentive payments will be returned to hospitals.

In order to track the progress of the VBP program, the Government Accountability Organization (GAO) shall submit an interim report to Congress by October 1, 2015. The Secretary shall submit a report to Congress by January 1, 2016. The GAO shall submit a final report to Congress by October 1, 2017.

Two demonstration projects will be created to test VBP models for CAHs and small hospitals that do not qualify, due to an insufficient number of qualifying cases, for the VBP program. These demonstration projects shall be implemented by March 23, 2012 (two years after enactment) and completed by March 23, 2015. The Secretary shall submit a report to Congress by September 23, 2016 (18 months after the end of demonstration).

NATIONAL PILOT PROGRAM ON PAYMENT BUNDLING (Sec. 3023, 10308)

The law requires the HHS Secretary, beginning in 2013, to establish a national, voluntary pilot program on bundling in order to improve the coordination, quality and efficiency of health care services. The pilot program will be conducted initially for five years. However, at any point after January 1, 2016, if the Secretary determines that expanding the pilot program does not reduce quality, but does reduce costs, or has improved quality and reduced spending, the Secretary can extend its duration and scope indefinitely. Entities comprised of groups of providers including a hospital

(including inpatient rehabilitation facilities (IRFs) and long-term care hospitals (LTCHs)), a physician group, a skilled-nursing facility (SNF) and a home health agency (HHA) may apply to participate in the pilot. In addition, the Secretary has the authority to waive Medicare statutory provisions as necessary to carry out the pilot program.

The Secretary is required to identify a patient assessment instrument that would determine the most clinically appropriate site for post-acute care for a given patient, and to develop episode-of-care and post-acute care quality measures. Participants will be required to submit data on the quality measures in each year of the program. To the extent practicable, the Secretary will specify that this submission occur through a qualified electronic health record. The law specifies that the episode-of-care quality measures will include measures of:

- Functional status improvement;
- Rates of avoidable hospital readmissions;
- Rates of discharge to the community;
- Rates of admission to an emergency room after a hospitalization;
- Incidence of healthcare-acquired infections;
- Efficiency measures;
- Measures of patient-centeredness of care;
- Measures of patient perception of care; and
- Other measures, including measures of patient outcomes, as determined by the Secretary.

The Secretary will select 10 conditions to be included in the pilot program, including:

- A mix of chronic and acute conditions;
- A mix of surgical and medical conditions;
- Conditions for which there is evidence of opportunity for providers to improve quality of:
 - Care while reducing total expenditures;
 - Conditions with significant variation in readmissions and post-acute care spending;
 - Conditions with high volume or high post-acute care spending; and
 - Conditions that are deemed most amenable to bundling across a spectrum of care given current practice patterns.

The pilot program may cover inpatient and outpatient hospital services, physician services (both in the inpatient and outpatient settings), post-acute care services (IRFs, LTCHs, SNFs and HHAs), and other services that the Secretary determines appropriate. The episode of care will start three days prior to a qualifying hospital admission and end 30 days after the patient's discharge. However, the Secretary has the authority to use another timeframe if appropriate.

The law requires the Secretary to test alternative payment methodologies for the pilot program, which may include bundled payments or bids from participating entities. The

payment methodology will include payment for applicable services and other services the Secretary deems appropriate, such as care coordination, medication reconciliation, discharge planning, transitional care services, and other patient-centered activities. The pilot also will include provisions to ensure that payment is made for post-acute care services that are furnished after the episode of care has ended. The law requires that the Secretary consult with representatives of small and rural hospitals, including CAHs, regarding their participation in the pilot program. The Secretary will be required to consider innovative methods of bundling, including how to address challenges due to low volume.

The law also requires the Secretary to test separately the continuing care hospital (CCH) model through a pilot. The episode is defined as a patient's stay in the CCH plus 30 days following discharge. A CCH is one that provides, under common management, the medical and rehabilitation services provided in IRFs, LTCHs and SNFs that are located in a hospital.

The Secretary is required to conduct an independent evaluation of the pilot program and submit reports to Congress at two and three years after implementation. The reports will include an evaluation of the extent to which the pilot program has improved quality measures, health outcomes, beneficiary access to care and reduced spending.

MEDICAID DEMONSTRATION ON BUNDLED PAYMENT

(Sec. 2704)

The law requires the HHS Secretary to establish a Medicaid bundled payment demonstration in up to eight states by January 1, 2012. The demonstration shall end on December 31, 2016 and must focus on an episode of care that includes a hospitalization and concurrent physician services. Each state may select episodes upon which to focus. States are required to submit a rationale for episode selection and monitor outcomes, costs, and quality associated with each episode. Hospitals participating in the demonstration must establish a robust discharge planning program. Payments will be adjusted for severity of illness and other beneficiary characteristics. No additional beneficiary cost sharing will be required. The Secretary may waive any provision of Medicare and Medicaid and Title X. The Secretary is required to submit a report to Congress on the demonstration by December 31, 2017 (not later than one year after the conclusion of the demonstration).

MEDICAID GLOBAL PAYMENT SYSTEM DEMONSTRATION PROJECT

(Sec. 2705)

The Secretary shall begin the Medicaid global payment demonstration by October 1, 2010 (FY 2011) and end the demonstration by September 30, 2012 (FY 2012). States shall adjust payments made to eligible safety-net hospital systems or networks. Not more than five states are eligible to participate in the demonstration and budget neutrality is not required. The CMS Innovation Center is required to evaluate the

demonstration. By October 1, 2013 (12 months after completion), the Secretary is required to submit a report to Congress on the demonstration.

ACCOUNTABLE CARE ORGANIZATIONS (SHARED SAVINGS PROGRAM)

(Sec. 3022, 10307)

Saves \$4.9 billion over 10 years.

Beginning January 1, 2012, groups of qualifying providers – such as physician group practice arrangements, networks of practices, hospital-physician joint ventures and hospitals employing physicians and other clinical professionals (physician assistants, nurse practitioners or clinical nurse specialists) – will have the opportunity to form Accountable Care Organizations (ACOs) and share in the cost savings they achieve for the Medicare program. To qualify as an ACO, an organization will have to meet several criteria. For example, it must:

- Agree to become accountable for the overall care of their Medicare fee-for-service beneficiaries;
- Agree to a minimum three-year participation per cycle;
- Have a formal legal structure enabling it to receive and distribute bonuses to participating providers;
- Provide information on the physicians participating in the ACO;
- Have a management and leadership structure in place;
- Define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures and coordinate care; and
- Demonstrate that it meets any patient-centeredness criteria determined by the HHS Secretary.

To earn incentive payments, ACOs must meet certain quality thresholds. Reporting measures would be set by the Secretary and include: (1) clinical processes and outcomes; (2) patient and caregiver perspectives on care; and (3) utilization and costs. The ACO will then be able to share in any savings generated to the Medicare program at a rate determined by the Secretary. The Secretary will be required to set a minimum threshold of savings that would need to be achieved by the ACO before savings can be shared. Spending benchmarks will be based on total Medicare spending in the most recent three-year period for the beneficiaries that belong to the ACO, plus a dollar amount equal to the risk-adjusted average expenditure growth for beneficiaries nationally. The benchmark will be re-set at the end of the three-year period.

In addition to shared savings, the Secretary also may implement a partial capitation payment with the ACO program. When accepting sites into the ACO program, the Secretary may give preference to those ACOs participating in similar arrangements with other payers and those ACOs that have participated previously in the CMS Physician Group Practice Demonstration.

The Secretary may waive provisions contained in current statute and regulation (such as Civil Monetary Penalty) to allow hospitals and doctors to integrate clinically.

PEDIATRIC ACO DEMONSTRATION PROJECT

(Sec. 2706)

State Medicaid programs can implement demonstration projects that will allow pediatric medical providers to form ACOs and receive incentive payments in the same manner as the Medicare ACO Program (Section 3022). The demonstration projects will run for five years, beginning in 2012. States will apply to participate. ACOs must agree to participate for at least three years. Participating states, with the Secretary, will set annual minimum program savings that must be achieved in order to receive an incentive payment.

COMMUNITY HEALTH TEAMS FOR THE PATIENT-CENTERED MEDICAL HOME

(Sec. 3502, 10321)

The law provides grants to enter into contracts to establish community-based, interdisciplinary health teams that support primary care, including obstetrics and gynecology, within a hospital service area. The grants will provide capitated payments to primary care providers. State or state-designated entities and Indian tribes or tribal organizations are eligible for the grants. Grant applications must submit a plan for achieving long-term financial sustainability within three years and must include prevention initiatives. The primary care teams eligible for capitated payments may include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral and mental health providers, doctors of chiropractic medicine, licensed complementary and alternative medicine practitioners, and physician assistants. Grant recipients must implement and maintain a health IT system and report quality measures.

HEALTH HOMES FOR MEDICAID ENROLLEES WITH CHRONIC CONDITIONS

(Sec. 2703)

Saves \$700 million over 10 years.

The law requires the HHS Secretary to award State Planning Grants to establish a Health Home Program for eligible enrollees by January 1, 2011. Eligible participants must have at least two chronic conditions, such as asthma, diabetes or mental health issues, and must select a designated provider to serve as a health home. States will provide payment for the health homes except for during the first eight fiscal year quarters in which the FMAP is at 90 percent. Payment is not limited to Per Member Per Month (PMPM) and states may propose alternative methods of payment. In addition to the methodology for payment, states also must include the following in the health home proposals:

- Requirement for hospitals to refer participants who seek emergency care to his/her health home provider;
- Plan for coordinating with the Substance Abuse and Mental Health Services Administration (SAMHSA);
- Methodology for tracking readmissions;

- Proposal for using health IT; and
- Report quality measures.

The Secretary is required to survey state participants by January 1, 2014 and submit a report to Congress by January 1, 2017. \$25 million is available for payments to the health homes.

HOSPITAL READMISSIONS

(Sec. 3025)

Saves \$7.1 billion over 10 years.

Beginning in FY 2013, inpatient PPS hospitals with higher-than-expected readmissions rates will experience decreased Medicare payments for all Medicare discharges. Prior to implementation (March 23, 2012 – two years after enactment), the HHS Secretary shall make available a program for eligible hospitals to improve their readmission rates through patient safety organizations. CAHs and post-acute care providers are exempt. Performance evaluation will be based on the 30-day readmission measures for heart attack, heart failure and pneumonia that are currently part of the Medicare pay-for-reporting program and reported on *Hospital Compare*. The base inpatient payment for hospitals with *actual* readmission rates higher than their Medicare-calculated *expected* readmission rates will be reduced by an adjustment factor that is the greater of:

- A hospital-specific readmissions adjustment factor based on the number of readmitted patients in excess of the hospital's calculated expected readmission rate; or
- 0.99 in FY 2013; 0.98 in FY 2014; and 0.97 in FY 2015 and beyond.

This means the largest potential reduction for a hospital would be 1 percent in FY 2013; 2 percent in FY 2014; and 3 percent in FY 2015 and beyond. This reduction will apply to *all* Medicare discharges. Hospitals with a small number of applicable patient cases, as determined by the Secretary, will be excluded from the provision.

Beginning in FY 2015, the Secretary is able to expand the list of conditions to include chronic obstructive pulmonary disorder and several cardiac and vascular surgical procedures, as well as any other condition or procedure the Secretary chooses. The Secretary is directed to seek endorsement from the NQF for all measures used to assess readmissions performance. However, the Secretary has the discretion to proceed without receiving endorsement.

The Secretary is directed to calculate and report all-payer readmission rates for the conditions selected for the readmissions financial penalties program, based on all-payer data submitted by hospitals. No timeline is provided as to when this reporting should begin or when the all-payer data should be submitted.

COMMUNITY-BASED CARE TRANSITIONS PROGRAM

(Sec. 3026)

Spends \$500 million over 10 years.

Beginning in 2011, a five-year Medicare pilot program, the Community-Based Care Transitions Program, will be available to PPS hospitals identified by the HHS Secretary as having high readmission rates, such as under the Hospital Readmissions Reduction Program (Section 3025). Hospitals serving medically underserved populations, small community hospitals and rural hospitals will be given priority for participation, as will hospitals participating in an eligible Administration on Aging program. Hospitals may elect to join the pilot program with community-based organizations or those that provide care transition services.

Under the program, hospitals must engage in at least one evidence-based care transition intervention, such as conducting comprehensive medication review and management, targeted toward Medicare beneficiaries who are at high risk for a readmission or a poor transition from the hospital to their post-hospital site of care.

The program will be funded for \$500 million over five years; the Secretary may continue or expand the program if it reduces projected Medicare spending without reducing quality of care.

CENTER FOR MEDICARE AND MEDICAID INNOVATION (CMI)

(Sec. 3021, 10306)

Saves \$1.3 billion over 10 years.

The law requires the HHS Secretary to create a Center for Medicare and Medicaid Innovation (CMI) within CMS by January 1, 2011. The CMI is authorized to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing quality. In selecting such models, the Secretary may give preference to models that also improve the coordination, quality and efficiency of health care services furnished to beneficiaries, such as patient-centered medical homes and new continuing care hospitals that offer inpatient rehabilitation, long-term care, and home health or skilled nursing care after an inpatient stay. Many more models are listed in the law. Payment models will be evaluated based on the quality of care they incentivize, including patient-level outcomes and patient-centeredness, and the changes in Medicare spending they generate. The tested models will be exempt from budget neutrality and CMS will be able to terminate, modify or expand the scope or duration of the models. Beginning in 2012, and once every other year thereafter, the Secretary shall submit a report to Congress on the progress of the CMI.

In selecting innovations to fund under the CMI, the Secretary has the authority to prioritize the following characteristics:

- Testing within certain geographic areas;

- Medically underserved areas and facilities of the Indian Health Service that focus on telehealth, behavioral health, stroke and non-medical providers;
- Programs that target beneficiaries with two or more chronic conditions; and
- Programs that link the public sector with private sector payers.

INDEPENDENT PAYMENT ADVISORY BOARD

(Sec. 3403, 10320)

Saves \$15.5 billion over 10 years.

The law establishes an Independent Payment Advisory Board that will develop and submit proposals to Congress to extend the solvency of Medicare, slow Medicare cost growth, and improve the quality of care delivered to Medicare beneficiaries. The board will be composed of 15 members, appointed by the President and confirmed by the Senate, who will serve six-year terms. Qualifications will be similar to those for members of the current Medicare Payment Advisory Commission (MedPAC); MedPAC will continue to exist in its current form and advise Congress.

If, beginning in 2013, growth in medical care expenditures of the Consumer Price Index (CPI) is projected by the CMS Office of the Actuary to exceed growth in the average CPI in 2015, the board is required to submit a proposal to Congress that would reduce excess cost growth by 0.5 percentage point in 2015. The board will submit a draft of its proposal to the Secretary and to MedPAC by September 1, 2013, and a final proposal to the President and Congress by January 15, 2014. By April 1, 2014, the Senate Finance Committee, along with the relevant House committees, will be required to report out either the board's proposal or an amended proposal that achieves the same level of reductions in excess cost growth. If a package that meets the level of Medicare savings described above is not enacted by August 15, 2014, the law requires the Secretary to implement the board's original proposal.

The law requires the board to make additional proposals on January 15 of 2015, 2016, 2017 and beyond based on the procedures described above. However, the targeted level of Medicare savings will increase each year:

- The proposal delivered to Congress in 2015 will be required to reduce excess cost growth by 1.0 percentage point in 2016.
- The proposal delivered to Congress in 2016 will be required to reduce excess cost growth by 1.25 percentage points in 2017.
- The proposal delivered to Congress in 2017 and beyond will be required to reduce excess cost growth by 1.5 percentage points in 2018 and beyond.

These proposals cannot include any recommendations to ration health care, raise revenues or Medicare beneficiary premiums, increase Medicare beneficiary cost sharing, or otherwise restrict benefits or modify eligibility criteria. Proposals submitted prior to 2019 also cannot reduce payment rates for providers that are scheduled to receive a reduction in their annual updates in excess of productivity. PPS hospitals, as well as IRFs, LTCHs and inpatient psychiatric facilities, are scheduled to receive such

reductions, and therefore are exempt from payment reduction proposals, but CAHs are not. Hospices also are scheduled to receive a reduction in their annual updates in excess of productivity and are exempt from the payment reduction proposals.

Beginning in 2020, the board is required to make binding biennial recommendations to Congress if the growth in overall health spending exceeds growth in Medicare spending; such recommendations will focus on slowing overall health spending while maintaining or enhancing beneficiary access to quality care under Medicare.

In any year where excess cost growth is not projected, the board will not submit a proposal to Congress with a specific savings target, but will be required to submit an advisory report to Congress on Medicare matters. These advisory proposals would be able to address payments to providers, including hospitals that are scheduled to receive a reduction in their annual updates in excess of productivity, but would not automatically go into effect absent congressional action.

The board will continue indefinitely unless Congress introduces a Joint Resolution to discontinue it by January 31, 2017, with passage by August 15, 2017. Adoption of this Joint Resolution would require a three-fifths majority. If adopted, the board would not be able to submit proposals after January 16, 2018 and would terminate on August 16, 2018.

EXTENSION OF GAINSHARING DEMONSTRATION

(Sec. 3027)

Section 5007 of the *Deficit Reduction Act of 2005* authorized a gainsharing demonstration. The three-year demonstration was delayed, with the first projects awarded 19 months late. To compensate for the delay, all of the deadlines under the demonstration project have been pushed forward by a similar amount of time so that HHS' final report to Congress will be due March 31, 2013. An additional \$1.6 million is appropriated in FY 2010 for completion of the demonstration.

PHYSICIAN-OWNED HOSPITALS AND SELF REFERRAL

(Sec. 6001 and 10601 as amended by Sec. 1106 of H.R. 4872)

Saves \$500 million over 10 years.

The new law amends the *Ethics in Patient Referrals Act*, better known as the "Stark" law, by rescinding the ability of physicians to self-refer to hospitals in which they have an ownership interest if those hospitals were not operating with both physician ownership and a Medicare provider number by December 31, 2010. Also prohibited is the conversion of an Ambulatory Surgical Center to a physician-owned hospital on or after the date of enactment. Existing hospitals meeting this basic requirement will be "grandfathered" and allowed to continue to self-refer, subject to compliance with certain conditions. Those conditions include:

- Ethical investment practice rules to ensure bona fide investment and proportional returns on investment.
- Aggregate physician ownership limited to no more than the percentage ownership or investment interest held by physicians on the date of enactment.
- Disclosure of physician ownership interests in hospitals to patients at the point of referral and again at the earliest point of an admission, to the public through notices on the hospital's Web site, and in reporting to CMS, which is charged with providing ownership information on its Web site.
- Patient safety requirements to ensure that such hospitals are capable of responding appropriately to complications or emergencies and safely transferring patients who need care beyond their ability, as well as patient disclosure at admission if the hospital does not have 24-hour/seven-day, on-site physician coverage.
- Required approval by HHS of any increase in the number of operating rooms, procedure rooms and beds, as well restrictions on growth overall and conditions that must be met for HHS approval. Specifically:
 - Total growth is limited to a doubling of the baseline number of beds, operating rooms and procedure rooms. The baseline is the number of each that is licensed on the date of enactment, or the date of Medicare certification in the case of a facility certified between the date of enactment and December 31, 2010.
 - The HHS Secretary must issue regulations governing the approval process by January 1, 2012 and implement the process on February 1, 2012. The process is required to render decisions on individual expansion requests within 60 days and the decisions are not subject to administrative or judicial review. Expansion requests can be filed no more often that once every two years.
 - There are two ways to qualify for growth approval:
 1. One is to establish that the area in which the hospital is located is experiencing significant population growth, that bed occupancy rates are high, and that the hospital participates in the Medicaid program at a level comparable to other hospitals in their county.
 2. The second way is to establish that the requesting hospital has provided the highest level of Medicaid inpatient admissions in the county for the three most recent years for which there are data, and that the hospital is not the sole hospital in the county.

Under both approaches, the hospital must provide an opportunity for community input on its expansion plan, must limit any expansion to the main campus, and must not discriminate against beneficiaries of federal health programs or allow its physicians to do so.

Finally, the Secretary is required to establish policies and procedures to ensure compliance with the requirements of this section by September 23, 2011 and must conduct compliance audits beginning no later than May 1, 2012.

ADMINISTRATIVE SIMPLIFICATION

(Sec. 1104 and 10109)

Saves \$11.6 billion over 10 years and increases revenues by \$8.2 billion over 10 years.

The law significantly expands efforts to establish uniform standardized transactions and administrative processes among health plans, clearinghouses and providers. It amends the statement of purpose section of the HIPAA administrative simplification provisions to call specifically for uniform standards that achieve administrative simplification and reduce clerical burden on patients, health care providers and plans.

At a more practical level, the law requires the adoption of a single set of “operating rules” for each of the HIPAA transaction standards. Operating rules are intended to reduce variations in how individual health plans and clearinghouses actually implement HIPAA transaction standards and will impose significant penalties on health plans that do not comply with these standards and operating rules by the deadlines outlined in the law. The operating rules will be developed by a non-profit entity through a consensus-based process involving all stakeholders. The rules will then be reviewed by the National Committee on Vital and Health Statistics (NCVHS) and adopted by the HHS Secretary through interim final rules. Health plans will have to undergo certification by an outside entity to demonstrate adherence to the standards and operating rules in sets of specific requirements that span December 31, 2013 through December 31, 2015:

- Eligibility and claims status operating rules must be adopted by July 1, 2011 and take effect January 1, 2013.
- Electronic funds transfers (EFTs), to go along with the HIPAA health claims payment and remittance advice transaction rules, must be adopted July 1, 2012 with enforcement beginning January 1, 2014.
- Unique health plan identifiers must be adopted no later than January 1, 2012.
- Other transaction standards such as claims or encounter information require adoption of operating rules no later than July 1, 2014 and take effect no later than January 1, 2016.

In addition to requiring the adoption of operating rules for transaction standards, the law requires the Secretary to expand into additional areas of administrative simplification:

- New HIPAA transaction standards must be adopted, such as claims attachments, enrollment/disenrollment, health plan premium payments, and referral certification and authorization standards.
- The Secretary is charged with soliciting input by no later than January 1, 2012, and every three years thereafter, regarding whether there are additional opportunities for standardization and reductions in administrative costs. The first evaluation is required to include determining whether:

- Other entities not currently covered under the HIPAA rules (such as automobile liability insurance, workers' compensation and other programs) also should utilize the same standards and operating rules that apply to health plans and providers.
- A standardized form and application process could be used to electronically enroll health care providers in health plans.
- Standardized forms could apply to financial audits required by health plans and federal, state and other programs.
- There could be greater transparency and consistency of methods and processes used to establish claim edits used by health plans.
- Health plans should be required to publish their timeliness of payment rules.

The law also calls for the creation of an expedited process for the maintenance and updating of existing HIPAA transaction standards to newer versions. In doing so, it reaffirms the current role of the NCVHS in this process with respect to reviewing, updating and improving standards and operating rules. It also asks the NCVHS to establish a review committee to coordinate the development of HIPAA administrative standards with the Office of the National Coordinator (ONC) for Health Information Technology (HIT) activities of the HIT Policy and HIT Standards committees. Both the NCVHS and ONC become key advisory agencies to the Secretary.

Finally, the ICD-9-CM Coordination and Maintenance Committee is charged with convening a meeting to provide updated crosswalks (mappings) of ICD-9-CM to ICD-10-CM and ICD-10-PCS no later than January 1, 2011.

INDEPENDENCE AT HOME DEMONSTRATION PROGRAM (Sec. 3024)

This provision creates a Medicare demonstration program targeting physician- and nurse practitioner-directed home-based primary care teams. The teams are accountable for providing comprehensive, coordinated and continuous care to high-need populations at home. The HHS Secretary is required to begin the demonstration by January 1, 2012. The demonstration focuses on:

- Reducing preventable admissions;
- Preventing hospital readmissions;
- Reducing emergency room visits;
- Improving outcomes, commensurate with stage of chronic illness;
- Reducing cost of services; and
- Achieving beneficiary and caregiver satisfaction.

This demonstration requires a legal entity that is able to provide care as part of a team, including physicians, nurses, physician assistants, pharmacists and other social services staff. Each team must service a minimum of 200 beneficiaries during each year of the demonstration, use an electronic health record (EHR) system, and remote

monitoring system, and report quality measures. The team must establish an estimated annual spending target, and may share savings in excess of 5 percent.

A beneficiary with two or more chronic conditions who has had a non-elective hospital admission within the past 12 months, and has received acute or sub-acute rehabilitation services within the past 12 months is eligible to participate. The Secretary shall determine an appropriate method of ensuring beneficiaries have agreed to enroll in the demonstration. The total number of beneficiaries enrolled in the demonstration cannot exceed 10,000. An independent evaluation of the demonstration program is required.

\$5 million is available for appropriations for FYs 2010-2014.

**MODERNIZING COMPUTER AND DATA SYSTEMS OF THE CENTERS FOR
MEDICARE & MEDICAID SERVICES TO SUPPORT IMPROVEMENTS IN CARE
DELIVERY**

(Sec. 10330)

The law requires the HHS Secretary, no later than December 23, 2010 (nine months after the date of enactment), to post a plan on CMS' Web site for modernizing the agency's computer and data systems. The plan shall address HIPAA provisions and support consistent evaluation of the payment and delivery system reforms contained within this new law.

MEDICARE AND MEDICAID PAYMENT CHANGES

MEDICARE DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

(Sec. 3133, 10316 as amended by H.R. 4872 Sec. 1104)

Saves \$22.1 billion over 10 years.

In FY 2014 and beyond, the law reduces Medicare DSH payments to 25 percent of the current level of DSH payments, or the "empirically justified" amount of DSH as defined by MedPAC. However, also in FY 2014 and beyond, a portion of the lost DSH funds will be used to create a new payment to hospitals to reflect their continuing uncompensated care costs. The amount of money available for this payment is the amount of the reduction in DSH payments described above times one minus the percent change in the percentage of the under 65 population that is uninsured in 2013 versus the current year, minus 0.1 percentage point for fiscal year 2014; minus 0.2 percentage point for FYs 2015-2019; and 0.0 percentage point thereafter. In 2018, the percentage change in the percentage of uninsured is determined by census data. To determine an individual hospital's payment, that amount will be multiplied by the hospital's percentage of the total uncompensated care provided by all DSH hospitals.

MEDICAID DSH PAYMENTS

(Sec. 2551, Sec. 10201 as amended by Sec. 1203 of H.R. 4872)

Saves \$14 billion over 10 years.

Beginning in FY 2014, state Medicaid DSH allotments will be reduced, in the aggregate, based on specified amounts: \$500 million in FY 2014; \$600 million in FYs 2015 and 2016; \$1.8 billion in FY 2017; \$5 billion in FY 2018; \$5.6 billion in FY 2019; and \$4 billion in FY 2020. The law directs the HHS Secretary to make reductions in the state DSH allotments based on the numbers of uninsured in the state and how the state treats hospitals with high Medicaid and uncompensated care volumes. The Secretary will impose a smaller percentage reduction on “low DSH” states. The Secretary is instructed to take into account when reducing a state’s DSH allotment the portion of a state’s DSH allotment being used to expand eligibility through a section 1115 waiver as of July 31, 2009. The state of Tennessee will receive a DSH allotment for three quarters of FY 2011 at \$47.2 million and all quarters of FY 2013 at \$53.1 million. Tennessee does not currently have a dedicated DSH allotment program. Hawaii, like Tennessee, does not have a dedicated DSH program. Hawaii received an increase in its DSH allotment for FY 2012 and will be treated as a “low DSH” state for FY 2013 and thereafter.

EXPANSION OF 340B PROGRAM

(Sec. 7101-7103, as amended by Sec. 2302 of H.R. 4872)

For drugs purchased on or after January 1, 2010, the law expands eligible participants in the 340B drug discount program to include CAHs and certain non-PPS children’s hospitals, free-standing non-PPS cancer hospitals, and sole community hospitals (SCHs) and rural referral centers (RRCs) that have disproportionate share adjustment percentages equal to or greater than 8 percent. However, orphan drugs are exempted from the expansion of the 340B program to these hospitals. The program was *not* expanded to include inpatient drugs and current law exemptions for hospitals to purchase inpatient drugs through a group purchasing organization (GPO) will continue. 340B participants may not purchase covered outpatient drugs using a GPO. The HHS Secretary is required to establish new auditing, reporting and other compliance requirements for pharmaceutical manufacturers and 340B-covered entities. The Government Accountability Office (GAO) is required to make recommendations to Congress within 18 months on whether those individuals served by the covered entities under the 340B program receiving optimal health care services and whether the program should be expanded.

INCORPORATING PRODUCTIVITY ADJUSTMENTS INTO ANNUAL INFLATIONARY UPDATES

(Sec. 3401, 10319, 10322, as amended by Sec. 1105 of H.R. 4872)

Saves \$156.6 billion (an estimated \$112.6 billion for hospitals) over 10 years.

Beginning in 2010, the law reduces the annual market basket updates for inpatient and outpatient hospital services, inpatient psychiatric facilities (IPFs), IRFs and LTCHs. In

addition, as outlined in the table below, beginning in 2012, the law also reduces market basket updates for these hospitals by an adjustment for “productivity” growth. The productivity adjustment is the 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity, as projected by the Secretary. The productivity adjustment is permanent, extending beyond the 10-year budget window of the law. This reduction will occur regardless of the percentage of the population that is insured. Productivity growth for FY 2010 is estimated by MedPAC at 1.3 percent, but will be projected every year.

Except for updates for laboratory services, the productivity adjustment may cause a negative update and may result in payment rates for a given year being less than the payment rates for the preceding year. These reductions also are in addition to any reductions for not reporting quality measures or not becoming a meaningful user of EHRs.

The chart below applies to services provided by PPS hospitals for inpatient services, hospital outpatient services, IPFs, IRFs and LTCHs.

Year	Reduction
2010	MB minus 0.25 percentage point
2011	MB minus 0.25*
2012	MB minus (productivity + 0.1)
2013	MB minus (productivity + 0.1)
2014	MB minus (productivity + 0.3)
2015	MB minus (productivity + 0.2)
2016	MB minus (productivity + 0.2)
2017	MB minus (productivity + 0.75)
2018	MB minus (productivity + 0.75)
2019	MB minus (productivity + 0.75)
2020 and beyond	MB minus productivity

*MB minus 0.5 percent for LTCHs

For 2010, the specific implementation dates of these cuts are:

- Outpatient PPS: January 1, 2010
- Inpatient PPS: April 1, 2010
- IRFs: April 1, 2010
- LTCHs: April 1, 2010
- IPFs: July 1, 2010

After 2010, the cuts will take place on the federal fiscal year for inpatient hospital, IRF and LTCH services, on the calendar year for outpatient hospital services, and on the “rate year” (July 1 through June 30) for IPF services.

The law also reduces updates by an annual productivity adjustment for ambulance services, ambulatory surgical centers (ASCs), durable medical equipment (DME) not subject to competitive bidding, SNFs and dialysis facilities. These cuts could reduce the market basket or inflationary update below zero. The specific implementation dates of these cuts are:

- Ambulance services: January 1, 2011 and beyond
- ASCs: January 1, 2011 and beyond
- DME that is not subject to competitive bidding: January 1, 2011 and beyond
- SNFs: October 1, 2011 and beyond
- Dialysis facilities: January 1, 2012 and beyond

Home Health Agencies (HHA). In calendar years 2011-2013, the home health market basket update will be reduced by 1 percentage point. In 2014, home health services will receive a full market basket update. In calendar year 2015 and beyond, the home health market basket update will be reduced by an annual productivity adjustment. These cuts could reduce the market basket update below zero.

Hospice. In FYs 2013-2019, the law will reduce the hospice market basket update by an annual productivity adjustment, plus an additional reduction of 0.3 percentage point. In FY 2020 and beyond, the market basket update will be reduced only by an annual productivity adjustment. These cuts could reduce the market basket update below zero. However, the 0.3 additional reduction could be “given back” in FYs 2014-2019 if the percentage of the population that is insured is more than 5 percentage points below projections at the time of the law’s enactment.

Laboratories. In calendar years 2011 through 2015, the law will cut the laboratory fee schedule update by an annual productivity adjustment plus an additional reduction of 1.75 percentage point. In 2016 and beyond, the market basket update will be reduced permanently by the annual productivity adjustment. If the 1.75 percent reduction results in an update of less than or equal to 0 percent, the productivity adjustment will not apply.

MEDICARE HOSPITAL WAGE INDEX

(Sec. 3137, 3141, 10317)

Spends \$300 million over 10 years.

The law requires the HHS Secretary to provide a plan to Congress by December 31, 2011 to comprehensively reform the Medicare hospital wage index. This plan will take into account the goals in the June 2007 MedPAC report, including establishing a new hospital compensation index system that:

- Uses Bureau of Labor Statistics data, or other data or methodologies, to calculate relative wages;
- Minimizes wage index adjustments between and within metropolitan and statewide rural areas;

- Includes methods to minimize the volatility of wage index adjustments that result from implementation of policy, while maintaining budget neutrality in applying such adjustments;
- Analyzes the effect that implementation of the proposal would have on health care providers and on each region of the country;
- Addresses issues related to occupational mix, such as staffing practices and ratios, and any evidence on the effect on quality of care or patient safety as a result of implementation of policy; and
- Provides for a transition period.

The law also:

- Extends Section 508 reclassifications for one year through September 30, 2010;
- Requires the Secretary to, from FY 2011 through FY 2013, use the wage index reclassification (average hourly wage) thresholds that were in effect prior to FY 2009; and
- Requires the Secretary to apply the wage index rural floor budget-neutrality adjustment on a national basis for FY 2011 and beyond.

PAYMENTS TO QUALIFYING HOSPITALS IN MEDICARE “LOW-COST” COUNTIES

(Sec. 1109 of H.R. 4872)

Spends \$400 million over 10 years.

For FYs 2011 and 2012, the law provides \$200 million in each year to hospitals located in counties that rank in the lowest quartile of Medicare per-beneficiary spending, adjusted by age, sex and race. Each hospital will receive funding in an amount that is proportional to the Medicare inpatient hospital payments made to the individual hospital as a percentage of the Medicare inpatient hospital payments made to all hospitals receiving the funding.

PROTECTIONS FOR FRONTIER STATES

(Sec. 10324)

Spends \$2 billion over 10 years.

In FY 2011 and beyond, the law sets a wage index floor of 1.0 for Medicare inpatient and outpatient PPS payments to hospitals in frontier states and a geographic practice expense index floor of 1.0 for Medicare payments physicians in frontier states. Frontier states are those states where at least 50 percent of the counties have fewer than six people per square mile; under the provision, Alaska and Hawaii are not eligible for the floors. States that are eligible are: Nevada; North Dakota; South Dakota; Montana; Wyoming; and Utah. However, wage indices and geographic practice expense indices in Nevada are already above 1.0.

STUDY ON URBAN MEDICARE-DEPENDENT HOSPITALS (MDH)

(Sec. 3142)

The law requires the HHS Secretary, within nine months of enactment (December 23, 2010), to conduct a study on the need for an additional payment for urban MDHs for inpatient services. The law defines an urban MDH as one that does not receive IME or DSH payments, is not a CAH, RRC, SCH or small rural MDH, and for which more than 60 percent of its inpatient days or discharges for two of the last three cost-reporting periods were attributable to Medicare beneficiaries enrolled in Part A.

STUDY ON MEDICARE BENEFICIARY ACCESS TO HIGH-QUALITY DIALYSIS SERVICES

(Sec. 10336)

The GAO is required to conduct a study on the impact of including specified oral drugs for the treatment of end-stage renal disease (ESRD) in the bundled ESRD PPS on Medicare beneficiary access to high-quality dialysis services. The GAO must submit a report to Congress by March 23, 2011 containing the results of the study, together with recommendations for legislative and administrative actions.

PAYMENTS TO RURAL HOSPITALS

Payment Adjustment for Low-volume Hospitals. (Sec. 3125, 10314) *Spends \$300 million over 10 years.* The law improves the low-volume adjustment for FYs 2011 and 2012. For these years, a low-volume hospital will be defined as one that is more than 15 road miles from another comparable hospital and has up to 1,600 Medicare discharges. An add-on payment will be given to these hospitals in an amount to be determined by the HHS Secretary using a continuous linear sliding scale ranging from 25 percent for low-volume hospitals with Medicare discharges below 200, to no adjustment for hospitals with more than 1,600 Medicare discharges.

Demonstration Project on Community Health Integration Models. (Sec. 3126) The law revises the demonstration project created by the *Medicare Improvements for Patients and Providers Act of 2008* that allows eligible entities to develop and test new models for the delivery of health care services in certain rural counties for the purpose of improving access to, and better integrating delivery of, acute care, extended care and other essential health care services to Medicare beneficiaries. The law removes the existing cap on the number of counties (now six) that can participate in each state. It deletes the requirement for rural health clinic services. It also allows physician services to be included within the scope of the demonstration.

Adequacy of Medicare Payments for Health Care Providers Serving Rural Areas. (Sec. 3127) The law requires MedPAC to report to Congress on Medicare payment adequacy for rural health care providers by January 1, 2011. MedPAC will analyze rural payment adjustments, beneficiaries' access to care in rural communities, adequacy of Medicare

payments to rural providers and quality of care, and make recommendations on appropriate changes to rural payment adjustments.

CAH Payments. (Sec. 3128) The law ensures that CAHs are paid 101 percent of costs for all outpatient services they provide, regardless of the billing method elected, and for providing qualifying ambulance services.

MEDICARE EXTENDERS

Hospital Outpatient Hold-harmless Payments. (Sec. 3121) *Spends \$200 million over 10 years.* The law extends the hospital outpatient hold-harmless payments for small rural hospitals with 100 or fewer beds for one additional year, through December 31, 2010. It also would make all SCHs eligible to receive these hold-harmless payments, regardless of their bed size in 2010 only. Hospitals will receive 85 percent of the difference between outpatient PPS payments and those that would have been made under the prior reimbursement system. This provision is retroactive to January 1, 2010.

Reasonable Cost Reimbursement for Laboratory Services in Small Rural Hospitals. (Sec. 3122) *Spends less than \$50 million over 10 years.* The law reinstates reasonable cost payment for clinical diagnostic laboratory services for qualifying rural hospitals with fewer than 50 beds in certain states with low density rural areas for cost reporting periods *beginning* from July 1, 2010 through June 30, 2011. This could affect services performed as late as June 30, 2012 if a hospital's cost reporting period began on June 30, 2011.

Rural Community Hospital Demonstration Program. (Sec. 3123, 10313) The law extends the Rural Community Hospital Demonstration Program for five additional years through December 31, 2014, increases the maximum number of participating hospitals from 15 to 30 and expands the eligible sites to rural areas in 20 states with low population densities. For hospitals currently in the demonstration, the inpatient payment amount is re-based. *The Medicare Prescription Drug, Improvement and Modernization Act of 2003* created this five-year demonstration program to test the feasibility and advisability of reasonable cost reimbursement for rural hospitals with fewer than 51 beds.

MDH Program. (Sec. 3124) The law extends the MDH program for one year through September 30, 2012.

Medicare Rural Hospital Flexibility Program. (Sec. 3129) The law extends the Medicare Rural Hospital Flexibility Program through 2012 and allows the use of other grant funds to assist rural hospitals with delivery system reform implementation. *The Balanced Budget Act of 1997* established this program, which created the CAH designation under Medicare and authorized a grant program that is administered by the Health Resources and Services Administration.

Increased Payments for Ambulance Services under Medicare. (Sec. 3105, 10311) *Spends \$100 million over 10 years.* The law extends the existing add-on payment for ground ambulance services – a 3 percent add-on for rural areas and a 2 percent add-on for urban areas – through December 31, 2010. It also extends through December 31, 2010 the air ambulance and “super rural” ambulance add-ons. This provision is retroactive to January 1, 2010.

Payment Adjustment for Medicare Mental Health Services. (Sec. 3107) The law extends the 5 percent increase in Medicare physician payments for certain mental health services through December 31, 2010. This provision is retroactive to January 1, 2010.

Section 508 Reclassifications Section. (Sec. 3137, 10317) *Score combined with that for Medicare Hospital Wage Index section.* The law extends Section 508 wage index reclassifications for the inpatient PPS for one year through September 30, 2010. This provision is retroactive to October 1, 2009.

Extension of Medicare Therapy Caps Exceptions. (Sec. 3103) *Spends \$800 million over 10 years.* The law extends the exceptions process for outpatient therapy caps for one year through December 31, 2010. These caps do not apply to hospital outpatient therapy departments. This provision is retroactive to January 1, 2010.

Extension of Treatment of Certain Medicare Physician Pathology Services. (Sec. 3104) *Spends \$100 million over 10 years.* The law extends through December 31, 2010 the grandfathering provision that allows certain independent laboratories to receive direct payments for the technical component for physician pathology services that are furnished to certain hospital inpatients and outpatients. This provision is retroactive to January 1, 2010.

Extension of Long-term Care Hospital Provisions. (Sec. 3106) *Spends \$100 million over 10 years.* The law extends for two years selected LTCH provisions in the *Medicare, Medicaid and SCHIP Extension Act of 2007*. This provision will delay until January 1, 2013 full implementation of the 25 Percent Rule, the short-stay outlier cut, and the one-time budget neutrality adjustment planned by CMS. The current moratorium on new LTCH beds and facilitates, with exceptions, also is extended until January 1, 2013.

Part B Payments to Indian Hospitals and Clinics. (Sec. 2902) *Spends \$200 million over 10 years.* *Section 630 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)*, which expired on December 31, 2009, allowed Indian Health Service (IHS) facilities to bill for Medicare Part B services that were not previously covered. It also expanded the scope of items and services for which payment under Medicare Part B would be made to IHS providers, suppliers, physicians and other practitioners. The health care reform law permanently extends Section 630 of the MMA, retroactive to January 1, 2010.

PAYMENTS TO PHYSICIANS AND PRACTITIONERS

Sustainable Growth Rate (SGR). (Sec. 3101, 10310) The law does not address the flawed physician payment formula. A previous version of the health reform legislation called for a 0.5 percent increase in Medicare physician payments in 2010, rather than the scheduled 21.2 percent reduction, but this provision was removed in the final law. Congress continues to delay the implementation of the 21.2 percent reduction in physician payments. This negative update was postponed until March 1 by a provision in the *Defense Appropriations Act of 2009*, and again until March 31, in the *Temporary Extenders Act of 2010*. On April 15, President Obama signed into law the *Continuing Extension Act of 2010* (H.R. 4851), which extends through May 31, 2010 the zero percent update to the Medicare physician fee schedule, retroactive to April 1, 2010. Congress is debating another bill that would extend the zero percent update to the Medicare Physicians Fee Schedule through September 30, 2010. All discussions to date, however, would provide short-term, temporary fixes to the physician payment formula; none would provide a permanent solution. A 25 percent reduction in physician payments is estimated for CY 2011.

Medicare Bonus for Primary Care/General Surgery Providers. (Sec. 5501) *Spends \$3.5 billion over 10 years.* Primary care services delivered by a primary care practitioner will receive a 10 percent bonus payment (on a monthly or quarterly basis) under the Medicare fee schedule for five years, beginning January 1, 2011. The groups of qualifying evaluation and management codes include office visits, home visits, nursing facility visits and rest home and custodial care services. The bonus will be available only to primary care practitioners in the specialties of family medicine, internal medicine, geriatric medicine, pediatric medicine, nurse practitioners, clinical nurse specialists, and physician assistants who furnish 60 percent of their services in these codes. In addition, qualifying practitioners providing care in a health professional shortage area (HPSA) also will receive the 10 percent bonus on hospital visit codes that are typical of primary care medicine, though only 10 percent of these visits will count toward the 60 percent threshold above. In addition, general surgeons providing care in a HPSA will receive a 10 percent bonus on major procedure codes for five years, beginning January 1, 2011.

Medicaid Payment to Primary Care Providers. (Sec. 1202 of H.R. 4872) *Spends \$8.3 billion over 10 years.* The law requires states to increase Medicaid payment rates to Medicare levels in 2013 and 2014 for primary care physicians who furnish certain primary care services, and provides 100 percent federal funding for the two-year incremental costs to states. Qualifying primary care physicians are those with a specialty designation of family medicine, general internal medicine or pediatric medicine, and qualifying services include evaluation and management services and immunization administration.

Extension of Floor on Medicare Work Geographic Adjustment. (Sec. 3102, as amended by Sec. 1108 of H.R. 4872) *Spends \$2.2 billion over 10 years.* The Medicare physician fee schedule payment rates are based on three components: work relative value units

(RVUs); practice expense RVUs; and malpractice RVUs. Each of these three components is adjusted by a geographic practice cost index (GPCI) to account for geographic variation in the cost of practicing medicine in different areas of the country. The law extends the MIPPA-mandated 1.00 floor for the geographic index for physician work for an additional year through December 2011. The law also provides an additional \$400 million for the *practice expense* geographic adjustment through December 2011. Specifically, for physician services furnished in 2010 and 2011, the employee wage and rent portions of the practice expense geographic index will reflect half the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national average of such employee wages and rents. There is a hold-harmless provision for any negative effects in 2010 and 2011. Adjustments made in 2012 are to be budget neutral. The law also instructs the HHS Secretary to analyze and make appropriate adjustments to the practice expense geographic adjustment to ensure accuracy of the geographic adjustments across fee schedule areas beginning January 1, 2012.

Misvalued Codes under the Physician Fee Schedule. (Sec. 3134) The law requires the Secretary to periodically identify physician services as being potentially misvalued, and make appropriate adjustments to the relative values of such services under the Medicare physician fee schedule. Codes would be identified based on certain factors, including codes with the fastest growth. Adjustments to misvalued procedures would be subject to budget-neutrality requirements.

Permitting Physician Assistants to Order Post-Hospital Extended Care Services. (Sec. 3108) The law allows a physician assistant who does not have a direct or indirect employment relationship with a SNF, but who is working in collaboration with a physician, to certify a Medicare patient's need for skilled nursing services, beginning January 1, 2011.

Improved Access for Certified Nurse-Midwife Services. (Sec. 3114) Beginning January 1, 2011, the law increases reimbursement for certified nurse-midwives' services from 65 percent to 100 percent of a physician's reimbursement for the same service.

PAYMENTS TO HOME HEALTH AGENCIES

(Sec. 3131)

In addition to the market basket reductions and productivity adjustments for home health agencies, the law makes the following changes. Collectively, these changes will reduce payments to home health agencies by \$39.7 billion over 10 years.

- **Rebasing Payments:** Starting in CY 2013, the HHS Secretary is required to rebase home health payments to reflect the number and mix of home health services, the level of intensity of services and the average cost of providing care, as well as differences between hospital-based and freestanding home health providers, urban/rural providers, and for profit/non-for-profit providers. The new system is to be phased-in over four years in equal increments, with the new,

rebased rates fully in effect for CY 2016. Annual adjustments in Medicare home health spending shall be no greater than 3.5 percent per year during this transition. MedPAC is directed to report to Congress by January 1, 2015 on the impact of the new system.

- **Cap on Outlier Payments:** Starting in CY 2011, the Secretary is required to establish a provider-specific cap on annual outlier payments at 10 percent of the agency's total payments; and reduce the overall outlier pool from 5.0 to 2.5 percent of total prospective payments.
- **Reinstatement of Rural Home Health Payment Adjustment:** The law provides a 3 percent add-on payment for home health providers serving rural areas for episodes ending on April 1, 2010 and before January 1, 2016.
- **Study to Ensure Access to Care and Quality Service:** The law requires the Secretary, with input from stakeholders, to conduct a study and provide a report to Congress by March 1, 2011 on the cost of providing home care to beneficiaries with varying levels of severity and those who are low-income or in medically underserved areas. The study will also examine the quality of home health care, including recommendations on reforms to payments and case mix adjustments.

PAYMENTS FOR SKILLED NURSING FACILITIES

(Sec. 10325)

The implementation of certain SNF Resource Utilization Groups “(RUGS) IV,” as proposed by CMS in the final SNF rule for FY 2009, will be delayed one year to October 1, 2011. However, the provision does not delay implementation of Medicare Data Set 3.0 beyond the scheduled October 1, 2010 implementation timeline. The law requires the Secretary to implement on October 1, 2010 the concurrent therapy changes and changes to the “look back” period to ensure that only services furnished after admission to a SNF are used in determining case mix classification.

PAYMENTS FOR HOSPICE

(Sec. 3132)

Saves \$100 million over 10 years.

The law requires the Secretary to collect, beginning in 2011, additional data and information in order to revise hospice payments not earlier than FY 2014, after consulting with stakeholders and MedPAC. Any changes are to be implemented in a budget-neutral manner. In addition, beginning in January 2011, hospices are required to have patients visited by a physician or advanced practice nurse prior to the 180th day, and for subsequent recertifications, to assess medical need for continued stays. For certain hospices with high rates of stays over 180 days, all stays exceeding 180 days will require medical review by CMS or its contractors.

DURABLE MEDICAL EQUIPMENT, PROSTHETICS AND SUPPLIES (DMEPOS)

(Sec. 3109, 3136, 6402, 6405, 6407 and 6410)

Saves \$2.4 billion over 10 years.

Starting January 1, 2010, the law limits the option to purchase a power-driven wheelchair with a lump sum payment. A lump sum payment shall be used only for complex rehabilitative power wheelchairs. The number of metropolitan areas for round two of the DMEPOS competitive bidding program (beginning in 2011) is expanded from 71 to 91 (by including the next 21 largest metropolitan statistical areas (MSA)), and to all remaining areas by 2016. Certain areas, such as rural areas, remain exempt.

The law allows pharmacies furnishing DMEPOS items and services until January 1, 2011 to submit evidence that they meet certain quality standards for accreditation. It exempts pharmacies from the quality-related accreditation requirements applicable to DMEPOS suppliers provided certain conditions are met, including a requirement that the pharmacy submit an attestation that its total Medicare DMEPOS billings are and continue to be less than a rolling three-year average of 5 percent of its total pharmacy sales.

The law requires DME suppliers and home health agencies to obtain a surety bond in excess of \$50,000 that is commensurate with the volume of billing. Effective July 1, 2010, DME or home health services must be ordered by a Medicare-enrolled health professional or physician. Beginning January 1, 2010, the Secretary has authority to dis-enroll, 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, certification for home health services or referrals for other items and services. In addition, the provisions require physicians to have a face-to-face encounter with a patient to certify the need for home health or DME services.

PAYMENTS FOR EMERGENCY CARE/TRAUMA

Design and Implementation of Regionalized Systems for Emergency Care. (Sec. 3504)

The law requires the HHS Assistant Secretary for Preparedness and Response to award at least four multi-year contracts or competitive grants to states and/or local governments, or to Indian tribes, to support pilot projects that design, implement and evaluate innovative models of regionalized, comprehensive and accountable emergency care and trauma systems. States awarded grants must make available non-federal contributions, directly or through donations from public or private entities, in the amount of \$1 for every \$3 of federal funds provided. Awardees must report to the Secretary no later than 90 days after completion of a pilot project, and the Secretary must disseminate findings to the public and Congress, as appropriate. The law authorizes appropriations of \$24 million for each FY from 2010-2014.

The law also supports federal programs administered by the National Institutes of Health (NIH), Agency for Healthcare Research and Quality (AHRQ), Health Resources and Services Administration (HRSA), Centers for Disease Control and Prevention

(CDC) and other agencies involved in improving the emergency care system to expand and accelerate research in emergency medical care systems and emergency medicine and pediatric emergency medical care systems and pediatric emergency medicine. In addition, the law supports research to determine the estimated economic impact of, and savings resulting from, the implementation of a coordinated emergency care system. The law authorizes such sums as are necessary to carry out this requirement for FYs 2010-2104.

Trauma Care Centers and Service Availability. (Sec. 3505) The law establishes three programs to award grants to qualified public, nonprofit IHS, Indian tribal, and urban Indian trauma centers. These programs would: (1) assist in defraying substantial uncompensated care costs; (2) further their core missions; and (3) provide up to four years of emergency relief to ensure continued and future availability of trauma services. For the purpose of carrying out this section, \$100 million is authorized to be appropriated for FY 2009 and such sums as may be necessary for each of FYs 2010 through 2015.

The HHS Secretary also is required to provide funding to states to enable them to award grants to eligible entities for the purpose of promoting universal access to trauma care services provided by trauma centers and trauma-related physician specialties. Each state may award grants to eligible entities – defined as public or nonprofit trauma centers; safety-net public or nonprofit trauma centers or hospitals in underserved areas – that seek to undertake specified activities that support trauma care services in the state. The law authorizes appropriations for this program of \$100 million for each of FYs 2010-2015.

Reauthorization of Emergency Medical Services for Children Program. (Sec. 5603) The law reauthorizes the program to award grants to states and medical schools to support the improvement and expansion of emergency medical services for children needing trauma or critical care treatment. Funding for the program is authorized in the amount of \$25 million for FY 2010; \$26.25 million for FY 2011; \$27.56 million for FY 2012; \$28.94 million for FY 2013; and \$30.39 million for FY 2014.

PAYMENTS FOR LABORATORY, IMAGING, DRUGS AND BIOLOGICS

Treatment of Certain Complex Diagnostic Laboratory Tests. (Sec. 3113) *Spends \$100 million over 10 years.* The law establishes a two-year demonstration project, beginning on July 1, 2011, under which the HHS Secretary would pay laboratories separately for certain complex diagnostic laboratory tests that are conducted using specimens obtained from individuals while they are hospital inpatients, and for which payment would otherwise be bundled into the hospital inpatient payments. Direct payment may be made to a hospital-based or independent laboratory. The Secretary must submit a report to Congress on the demonstration project within two years of its completion. Five million dollars is provided from the Part B Trust Fund for administering and evaluating the demonstration.

Payments for Advanced Imaging Services under the Physician Fee Schedule. (Sec. 3135 as amended by Sec. 1107 of HR 4872) *Saves \$2.3 billion over 10 years.* The law reduces payments under the physician fee schedule for advanced imaging services by assuming a higher rate of utilization of equipment in the calculation of the fee schedule reimbursement rate from 50 percent to 75 percent for 2011 and beyond. In addition, the law will increase the payment reduction from 25 percent to 50 percent for the technical component of services when sequential imaging services on contiguous body parts are furnished during the same encounter. Both payment changes are exempt from the traditional budget-neutrality for Part B services. In addition, the CMS Actuary is required to publish by January 1, 2013 an analysis of whether the total Medicare savings to be produced by these policies over the 2010-2019 period will exceed \$3 billion.

Payment for Bone Density Tests. (Sec. 3111) *Spends \$100 million over 10 years.* The law restores payment for dual-energy X-ray absorptiometry (DXA) services furnished during 2010 and 2011 to 70 percent of the Medicare rate paid in 2006. IOM will study the impact of payment reductions on beneficiary access in 2007 through 2009 to DXA bone mass scan services.

Disclosures Related to Referrals for Radiology Services. (Section 6003) For services furnished on or after January 1, 2010, physicians referring patients for radiology services under an in-office ancillary services exception to the physician self-referral (“Stark”) law must inform patients in writing at the time of referral of any ownership interest in certain imaging services to which the physician refers the patient, and of the availability of other suppliers who may provide such services. They must also furnish a written list of suppliers who provide the services in the area where the patient resides.

Payment for Biosimilar Biological Products. (Sec. 3139) *Savings for this section are included in Title VII, Subtitle A, Biologics Price Competition and Innovation, which saves \$7 billion over 10 years.* The payment amount under Medicare Part B for a biosimilar product is set at the product’s own average sales price (ASP) (or a volume-weighted ASP of all the product’s national drug codes if it has more than one) plus 6 percent of the ASP of the reference “brand name” biologic product, as calculated for a single source biologic product. The law takes effect on the first day of the second calendar quarter after enactment of law providing for a biosimilar pathway (as determined by the HHS Secretary). Sec. 7002 enacts such a pathway, so we estimate that the effective date for this provision is October 1, 2010.

Approval Pathway for Biosimilar Biological Products. (Sec. 7001, 7002, 7003) *Saves \$7 billion over 10 years.* The law enacts the *Biologics Price Competition and Innovation Act of 2009*, which authorizes the Food and Drug Administration (FDA) to regulate and approve generic versions of biologic products (so-called biosimilar or interchangeable products). The law provides that brand-name biologic product makers have 12 years of market exclusivity before biosimilar or interchangeable products can go on the market. The HHS Secretary is required, no later than October 1, 2010, to develop recommendations to Congress with respect to user fees for the review of biosimilar

biological product applications. The law also describes a Sense of the Senate that Congress should authorize the collection of user fees by October 1, 2012. Further, the Secretary of the Treasury, in consultation with the HHS Secretary, is required in each fiscal year to determine the amount of savings to the federal government as a result of these provisions; such savings are to be applied to deficit reduction.

Part D Medication Therapy Management Program Improvements. (Sec. 10328) Beginning with Part D prescription drug plan years that begin on or after March 23, 2012, drug plan sponsors will be required to offer medication therapy management (MTM) services to targeted beneficiaries (i.e., those who have multiple chronic diseases, are taking multiple covered part D drugs and are identified as likely to incur high annual costs for covered Part D drugs). These MTM services include an annual face-to-face (or telehealth) comprehensive review of medications by a licensed pharmacist or other qualified provider, a written summary of the review, and follow-up face-to-face interventions based on the findings of the review. Drug plan sponsors will be required to assess, on at least a quarterly basis, the medication use of individuals who are at risk but not enrolled in the MTM program. Plans also must enroll beneficiaries who qualify on a quarterly basis and allow enrollees to opt out.

PAYMENTS TO OTHER PROVIDERS

Treatment of Certain Cancer Hospitals. (Sec. 3138) Directs the HHS Secretary to study whether existing cancer hospitals that are exempt from the inpatient PPS have costs under the outpatient PPS that exceed costs of other hospitals, and to make an appropriate budget neutral payment adjustment effective January 1, 2011, if their costs are found to be higher under the outpatient PPS based on that analysis.

Medicare Federally Qualified Health Center (FQHC) Improvements. (Sec. 5502, as amended by Sec. 10501) The HHS Secretary is required to develop and implement a PPS for Medicare-covered services furnished by FQHCs for cost reporting periods beginning on or after October 1, 2014. The Secretary shall vary payments to FQHCs based on the type, duration, and intensity of services they deliver. The PPS may include adjustments, including geographic adjustments, as determined to be appropriate by the Secretary. Payments in the first year of the FQHC PPS would equal 100 percent of the estimated amount of reasonable costs (determined without the application of a per visit payment limit or productivity screen and prior to the application of 20 percent coinsurance) that would otherwise have been made in that year if the PPS had not been implemented. In the first year after implementation, FQHC PPS payments will be updated by the rate of the Medicare Economic Index. In subsequent years, FQHC PPS payments will be updated by a FQHC market basket percentage increase, or if such an index is not available, by the percentage increase in the MEI for the year involved. FQHCs must begin to submit information, including reporting services by the Health Care Procedure Coding System codes, by January 1, 2011. Beginning January 1, 2011, the remaining Medicare-covered preventive services will be added to the list of services eligible for reimbursement when furnished by an FQHC.

Indian Health Care Improvement. (Sec. 10221) The law incorporates, with amendment S. 1790, “A bill to amend the *Indian Health Care Improvement Act* to revise and extend that Act, and for other purposes.” In doing so, the law reauthorizes the *Indian Health Care Improvement Act*, including programs to increase the Indian health care workforce, new programs for innovative care delivery models, behavioral health care services, new services for health promotion and disease prevention, efforts to improve access to health care services, construction of Indian health facilities, and an Indian youth suicide prevention grant program. There is an explicit prohibition on applying to the Indian Health Services any limitations on providing abortions.

WORKFORCE AND GRADUATE MEDICAL EDUCATION

INNOVATIONS IN THE HEALTH CARE WORKFORCE

National Health Care Workforce Commission. (Sec. 5101, 10501) The law creates a National Health Care Workforce Commission to develop a national strategy to address workforce shortages and encourage training in key areas. The commission will be comprised of 15 individuals, including health professionals, employers (including small business and self-employed), payers, consumers, representative from labor unions, state or local workforce investment boards, educational institutions, and health care-related researchers. No later than September 30, 2010, members, including a designated chairman and vice chairman, will be appointed by the Comptroller General to serve three-year terms.

Beginning October 1, 2011, and every October 1 thereafter, the commission will make recommendations to Congress and the Administration concerning national health care workforce priorities, goals and policies. Beginning April 1, 2011, and every April 1 thereafter, the commission will make recommendations on a minimum of one high-priority area. The initial high-priority areas include:

- Integrated health care workforce planning;
- The nature, scopes of practice, and demands for health care workers in the enhanced information technology and management workplace;
- The alignment of Medicare and Medicaid graduate medical education policies with national workforce goals;
- Recommendations for eliminating barriers to entry and retention in primary care, including provider compensation; and
- The education and training capacity, projected demands, geographic distribution and integration with the health care delivery system of the nursing, oral health care, mental and behavioral health care, allied health and public health care, and emergency medical service workforces.

In addition, the commission is tasked with:

- Studying effective mechanisms for financing education and training for careers in health care;
- Recommending improvements to the safety, health and worker protections in the workplace for the health care workforce; and
- Reviewing the state health care workforce development grant program (Sec. 5102 below) and other grant programs in the law.

The commission will have a director and staff, and may employ other experts and consultants. It is tasked with consulting with other federal agencies, such as HHS, MedPAC and MACPAC, and it will have unrestricted access to information at the GAO.

State Health Care Workforce Development Grants. (Sec. 5102) In consultation with the National Health Care Workforce Commission above, HRSA and HHS will award, through a competitive process, grants to states for health care workforce development planning and implementation. These grants will enable state partnerships to complete coherent workforce planning and to carry out activities leading to comprehensive health care workforce development strategies at the state and local levels, including innovative approaches to increase the number of skilled health care workers, such as career pathways for young people and adults. For FY 2010, \$8 million is authorized for one-year planning grants (with states required to match 15 percent of the funding) and \$150 million for two-year implementation grants (with states required to match 25 percent of grant funding). The law authorizes such funds as necessary for each subsequent fiscal year.

Centers for Health Care Workforce Analysis. (Sec. 5103-5104) The law codifies the existing National Center for Health Care Workforce Analysis and establishes State and Regional Centers for Health Workforce Analysis to provide data on workforce-related issues. The national center will collaborate with federal agencies and the new state and regional centers to collect statistical workforce information and other related data for the commission. The national center will include three advisory groups: 1) an advisory committee on training in primary care medicine and dentistry; 2) an advisory committee on interdisciplinary community-based linkages; and 3) an advisory council on graduate medical education. The law authorizes \$7.5 million for each of FYs 2010-2014 for the national center and \$4.5 million for each of FYs 2010-2014 for the state and regional centers. In addition, the law creates an interagency task force to assess and improve access to health care in Alaska.

INCREASING THE SUPPLY OF THE HEALTH CARE WORKFORCE

(Sec. 5201-5210)

To help with critical workforce shortages, the law implements a number of policies to ease the financial burden of pursuing a career in health care.

- Sec. 5201-5202 provide higher loan amounts and more flexible loan repayment programs for primary care physicians, nurses, allied health professionals and the public health workforce beginning in FY 2010. It also decreases the non-compliance provision to make primary care student loan programs more attractive to medical students.
- Sec. 5203 establishes a pediatric subspecialty loan repayment program for qualifying individuals who agree to provide two years of pediatric medical subspecialty, pediatric surgical subspecialty, or child and adolescent mental and behavioral services in an area with a shortage of pediatric subspecialty services, a HPSA, a medically underserved area, or an area serving medically underserved populations. The loan amount is up to \$35,000 a year for each year of agreed-upon service, not to extend beyond three years. The law authorizes \$30 million for each of FYs 2010-2014 for pediatric medical and surgical subspecialists and \$20 million for each of FYs 2010-2014 for qualified health professionals in child and adolescent mental and behavioral health.
- Sec. 5204 establishes the Public Health Workforce Loan Repayment Program for qualifying individuals who agree to provide at least three years of service in federal, state, local or tribal public health agencies. The loan amount is up to \$35,000 a year for each year of agreed-upon service, and is available to public health students and workers. The law authorizes \$195 million for FY 2010, and additional funding as necessary for each of FYs 2011-2015.
- Sec. 5205 establishes the Allied Health Loan Forgiveness Program for certain allied health professionals employed in public health agencies and settings located in HPSAs, medically underserved areas, or settings serving medically underserved populations.
- Sec. 5206 provides \$60 million in scholarships in FY 2010 (and funding necessary for each of FYs 2011-2015) for state and local programs to encourage mid-career public health and allied health professionals to receive additional training.
- Sec. 5207 authorizes specific increased funding for the National Health Service Corps through FY 2015. For FY 2016 and beyond, it increases the funding amount by a formula that factors in the percentage increase based on the costs of health professions education and the number of individuals residing in HPSAs.
- Sec. 5208 provides \$50 million for FY 2010, and additional funds as necessary for each of the FYs 2011-2014, for the development and operation of nurse-managed health clinics.
- Sec. 5209-5210 eliminate the cap on the number of Commissioned Corps members so that the Corps may expand to meet national public health needs. In

doing so, it also establishes a Ready Reserve Corps within the Commissioned Corps for service in times of national emergency.

ENHANCING HEALTH CARE WORKFORCE EDUCATION AND TRAINING
(Selected Sec. 5301-5316)

Hospitals, schools of medicine and other public or private nonprofit entities will be eligible for various grants to develop, expand and enhance educational training programs in primary care, dentistry, geriatrics, mental and behavioral health, advanced nursing, nursing, public health and other health-related careers.

- To support and develop primary care training programs, Sec. 5301 authorizes \$125 million for FY 2010 and funds as necessary for each of FYs 2011-2014 for grants and contracts to support training in family medicine, general internal medicine, or general pediatrics, as well as physician assistant training. Priority is given to programs that educate students in team-based approaches to care, including the patient-centered medical home. Fifteen percent of this amount for each fiscal year is specifically allocated to physician assistant training programs.
- To support new training opportunities for direct care workers employed in long-term settings, such as nursing homes and skilled nursing facilities, Sec. 5302 authorizes \$10 million for FYs 2011-2013. Eligible individuals agree to work in the fields of geriatrics, disability services or chronic care management.
- To support training in dentistry, Sec. 5303-5304 authorize \$30 million for FY 2010 and funds as necessary for each of FYs 2011-2015. In addition, it provides grants to 15 eligible entities (including a public hospital or health system) to establish a demonstration program to train or employ alternative dental health care providers to increase access to dental health services in rural, tribal, and underserved communities.
- To support geriatric education and training, Sec. 5305 provides a variety of grants and awards, including \$10.8 million in grants for FYs 2011-2014 to create not more than 24 geriatric education centers and \$10 million in awards for FYs 2011-2013 to health professionals to foster greater interest in the field of geriatrics, long-term care and or chronic care management. As a condition of the award, the individual must agree to continue to teach or practice in the field of geriatrics, long-term care or chronic care management for a minimum of five years.
- To support mental and behavioral health education and training, Sec. 5306 authorizes, for FY 2010-2013, \$8 million for training in social work; \$12 million for training in graduate psychology; \$10 million for training in professional child and adolescent mental health; and \$5 million for in-service training to paraprofessionals in child and adolescent mental health.

- To support cultural competency, prevention and public health and individuals with disability training, Sec. 5307 authorizes such sums as necessary for each of FYs 2010-2015. The funds will support the development, evaluation and dissemination of model curricula for cultural competency and other factors including aptitude for working with disabled individuals.
- To support nurse education and retention, Sec. 5308-5309 reinstitute the nurse retention grants from 2003-2007 under Section 831 of the *Public Health Service Act* (PHSA) and appropriates such sums as necessary for each of FYs 2010-2012. These grants are available to accredited schools of nursing, health care facilities, or partnerships between schools and facilities. The grants must be used to: 1) promote career advancement for individuals (including licensed practical nurses and other members of the health care workforce) to become baccalaureate-prepared registered nurses or advanced practice nurses; 2) to encourage mentoring and the development of nursing specialties; or 3) to provide individuals with the education and training necessary to enter the nursing profession and advance within the profession. The HHS Secretary is required to submit a report to Congress on the grants awarded under this section before the end of each fiscal year. In addition, Sec. 5310 allows faculty at nursing schools to be eligible individuals for loan repayment and scholarship programs.
- To increase the number of qualified nurse faculty, Sec. 5311 provides loans not to exceed \$10,000 per calendar year for individuals who have completed a master's (or equivalent) degree in nursing and not to exceed \$20,000 per calendar year for individuals who have completed a doctorate (or equivalent degree) in nursing and agree to serve as full-time faculty in an accredited school of nursing for at least four years. Total payments may not exceed \$40,000 during FYs 2010-2011 for individuals with a master's degree, and may not exceed \$80,000 during FY 2010-2011 for individuals with a doctorate degree. The law authorizes the appropriations of such sums as necessary for each of FYs 2010-2014 to carry out this section.
- To support the community health workforce, Sec. 5313 authorizes the Director of the CDC in collaboration with the HHS Secretary to award grants to eligible entities, including hospitals, to promote positive health behaviors and outcomes for populations in medically underserved communities. Grants will be used to support community health workers that help connect underserved populations with the most appropriate services at the most appropriate time. Priority will be given to geographic areas with a high percentage of uninsured or underinsured residents, those with a high percentage of chronic disease, or those with a high infant mortality rate. The law authorizes such sums as necessary for each of FYs 2011-2014.
- To support training in public health, Sec. 5314 authorizes \$39.5 million for each of FYs 2010-2013 to expand the existing fellowship programs operated through the CDC to alleviate shortages in the areas of applied public health epidemiology,

public health laboratory science and public health informatics, and to expand the Epidemic Intelligence Service.

- To provide new nurse practitioners with clinical training to enable them to serve as primary care providers in FQHCs and nurse-managed health clinics, Sec. 5316 establishes a training demonstration program for family nurse practitioners. The law authorizes such sums as necessary for each of FYs 2011-2014 to carry out this program.

U.S. PUBLIC HEALTH SCIENCE TRACK

(Sec. 5315)

Beginning with FY 2010, the law directs the Surgeon General to establish a U.S. Public Health Sciences Track to train a specific number of physicians, dentists, nurses, physician assistants, nurse practitioners, behavioral and mental health professionals and public health professionals annually. The track will emphasize team-based service, public health, epidemiology and emergency preparedness, and will be located at existing health professions education training programs at academic health centers. Students will receive tuition (or tuition remission) and a stipend to serve for a period of time within the Commissioned Corps of the Public Health Services, with a two-year service commitment for each year of school covered. The HHS Secretary will transfer funds as necessary from the Public Health and Social Services Emergency Fund to carry out this section.

GRADUATE MEDICAL EDUCATION

Spends \$1.1 billion over 10 years.

Indirect Medical Education (IME). The law does not propose any changes to existing Medicare IME payments to teaching hospitals.

Redistribution of Unused Residency Positions. (Sec. 5503) The law will redistribute unused residency training positions as a way to encourage increased training of primary care physicians and general surgeons. For cost-reporting periods beginning on or after July 1, 2011, hospitals will lose 65 percent of their unused or unfilled residency positions (based on the three most recent cost-reporting periods ending March 23, 2010) and qualifying hospitals will be able to request up to 75 new positions. Certain hospitals, including rural teaching hospitals with fewer than 250 beds, will be exempt from redistribution of any of their unused positions. Priority for the new positions will be distributed such that:

- 70 percent of positions will be allocated to hospitals in states with resident-to-population ratios in the lowest quartile; and
- 30 percent of positions will be allocated to hospitals located in rural areas and hospitals located in the top 10 states in terms of population living in a HPSA relative to the general population.

If there are positions that are not redistributed by July 1, 2011 based on the priority above, then the remaining positions will be given to hospitals that demonstrate the likelihood that they will fill the positions within the first three cost-reporting periods beginning on or after July 1, 2011, and to hospitals that have an accredited rural training track residency program.

For five years, hospitals receiving additional positions are required to maintain at least their current level of primary care residents in their training programs averaged over the three most recent years. Additionally, at least 75 percent of the increased positions must be designated for primary care or general surgery (as determined by the HHS Secretary). The redistributed positions will receive DGME payments and IME payments in the same manner and/or at the same level as for existing positions.

Counting Resident Time in Non-provider Settings. (Sec. 5504) In order to help promote resident training in outpatient settings, the law provides increased flexibility in the laws and regulations governing GME funding. Currently, hospitals receive DGME funding if they incur “all, or substantially all” of the costs for the training program in that setting. Effective for cost reporting periods beginning on or after July 1, 2010, if the hospital continues, or in the case of a jointly operated residency program the involved entities continue, to incur the costs of a resident’s stipends and benefits, then all time spent by a resident in patient care activities in a non-hospital setting will count toward the calculation of Medicare IME and DGME payments. Hospitals must maintain and make available to the HHS Secretary records regarding the amount of time residents spend in non-provider settings, including in comparison to a base year to be determined by the Secretary. The Secretary must implement this provision without re-opening hospital cost reports unless a prior appeal on IME or DGME payments is pending on March 23, 2010.

Counting Resident Time for Didactic and Scholarly Activities. (Sec. 5505) Currently, hospitals receive Medicare GME payments only if residents in non-hospital settings spend their time in patient care activities. For cost reporting periods beginning on or after July 1, 2009, the law will allow DGME payment for certain non-patient care activities in non-hospital settings, including didactic conferences and seminars, but will not reimburse for research that is not associated with the treatment of a particular patient. In addition, Medicare will count all vacation, sick leave and other approved leave spent by a resident in an approved training program, as long as his/her leave time does not extend the program’s duration. For cost reporting periods beginning on or after October 1, 2001, Medicare will adopt the same rules about counting residents’ leave time for IME payment purposes.

Resident Cap Positions from Closed Hospitals. (Sec. 5506) Effective for medical residency programs that closed on or after March 23, 2008, the resident cap positions from the closed hospital will be distributed to other hospitals based on the priority order below:

- Hospitals located in the same or contiguous core-based statistical area;

- Hospitals located in the same state;
- Hospitals located in the same region of the country; and
- Priorities determined under the section on redistribution of unused GME positions.

Hospitals must demonstrate the likelihood of filling the residency positions within three years. Previously, these types of Medicare-funded residency positions were eliminated.

Teaching Health Centers' GME Programs. (Sec. 5508) *Spends \$200 million over 10 years.* The law amends title VII of the *Public Health Service Act* to allow the HHS Secretary to provide grants to eligible “teaching health centers” from FY 2010-2012 to establish new or expand existing accredited primary care residency programs in family medicine, internal medicine, pediatrics, internal medicine-pediatrics, obstetrics and gynecology, psychiatry, general and pediatric dentistry, and geriatrics. Teaching health centers include federally qualified health centers, community mental health centers, rural health clinics, and health centers operated by the Indian Health Service.

The law also provides \$230 million from FY 2011-2015 to reimburse qualified teaching health centers for their DGME and IME costs, using a methodology to be determined by the Secretary. This amount is in addition to any graduate medical education payments made under the *Social Security Act* to teaching hospitals. The Secretary is given extensive auditing authority and may reduce payments to teaching health centers for failure to submit complete and accurate information.

Graduate Nurse Education Demonstration. (Sec. 5509) *Spends \$200 million over 10 years.* The law appropriates \$50 million for each of FYs 2012-2015 for up to five hospitals to participate in a Medicare demonstration project to receive reasonable cost reimbursement for providing qualified clinical training to advanced practice nurses (clinical nurse specialists, nurse practitioners, certified registered nurse anesthetists and certified nurse-midwives). Eligible hospitals must have a written agreement in place with one or more applicable schools of nursing and two or more applicable non-hospital community-based care settings (such as FQHCs or rural health clinics). The law requires that half of the advanced practice nurse training be provided in non-hospital, community-based care settings, although the HHS Secretary may waive this requirement for hospitals located in rural or medically underserved areas. The hospital is required to reimburse its partners for their costs. By October 17, 2017, the Secretary will submit a report to Congress that includes an analysis of the growth in advanced practice registered nurses and their specialties, and the costs to the Medicare program.

SPENDING FOR FEDERALLY QUALIFIED HEALTH CENTERS (FQHC)
(Sec. 5601)

The law increases funding for FQHCs by specified amounts for FYs 2010-2015. For FY 2016 and beyond, spending will increase by a formula that considers the previous year’s funding amount, the average percentage increase in cost per patient served, and the average percentage increase in the total number of patients served. Certain rural

hospitals that contract with community health centers may receive funds through this section as long as the hospital has a sliding scale fee schedule for low-income patients and does not discriminate based on a patient's ability to pay.

PHYSICIAN TRAINING IN UNDERSERVED COMMUNITIES

(Sec. 5606)

The law authorizes \$4 million for each of FYs 2010-2013 for the HHS Secretary, acting through HRSA, to establish a grant program to assist schools of allopathic or osteopathic medicine in: recruiting students most likely to practice medicine in underserved rural communities; providing rural-focused training and experience; and increasing the number of recent medical school graduates who practice in underserved rural communities. This section also authorizes \$43 million for FY 2011, and such sums as may be necessary for each of FYs 2012-2015, to award grants or enter into contracts with eligible entities (including hospitals) to provide training to graduate medical residents in preventive medicine specialties.

INFRASTRUCTURE TO EXPAND ACCESS TO CARE

(Sec. 10502)

The law appropriates \$100 million for FY 2010 (to remain available until FY 2012) to be used for debt service on, or direct construction or renovation of, a health care facility that provides research, inpatient tertiary care, or outpatient clinical services, and which meets certain requirements. The governor of the state must submit an application for the funding and certify, among other requirements, that the new health care facility is critical to improving access to health care within the state. The facility must be affiliated with an academic health facility at a public research university that contains a state's sole public academic medical center and dental school (11 states meet this requirement according to HHS).

SPENDING FOR COMMUNITY HEALTH CENTERS (CHC)

(Sec. 5708, 10503 as amended by H.R. 4872 Sec. 2303)

Spends \$12.3 billion over 10 years (also includes funding for the National Health Service Corps).

The law establishes a fund for an expanded and sustained national investment in CHCs, including new construction and renovation of CHCs. Beginning FY 2011, the law increases mandatory funding for community health center funding to \$11 billion over five years. Specifically, it provides \$1 billion in FY 2011, \$1.2 billion in FY 2012, \$1.5 billion in FY 2013, \$1.6 billion in FY 2014, and \$3.6 billion in FY 2015.

WELLNESS AND PREVENTION

COVERAGE OF PREVENTIVE HEALTH SERVICES

(Sec. 2713)

As mentioned in the coverage section earlier (page 1), beginning immediately, the law requires group health plans and private health insurers offering group or individual health insurance to cover preventive services recommended by the U.S. Preventive Services Task Force (USPSTF), immunizations recommended by the Centers for Disease Control and Prevention (CDC), and certain children's services and women's preventive services and screenings with zero enrollee cost sharing (no co-payment or deductible would apply). The HHS Secretary will establish a minimum interval for the screenings and services, which will not be less than one year between the date on which a guideline or recommendation is issued and the effective plan year. In addition, the Secretary may develop guidelines to permit plans to utilize value-based insurance designs.

GRANTS FOR WORKPLACE WELLNESS

(Sec. 10408)

As mentioned earlier on page 5, in 2014 employer-sponsored plans can offer financial rewards to enrollees who participate in wellness programs. Beginning in FY 2011, the law provides incentives for small businesses to offer comprehensive workplace wellness programs. Specifically, it provides \$200 million over five years to eligible employers with fewer than 100 employees who work 25 hours or more a week, that do not offer a workplace wellness program as of March 23, 2010. Qualified program criteria will be developed by the HHS Secretary, but it will include four key components: health awareness; employee engagement; behavioral change; and a supportive environment.

EFFECTIVENESS OF FEDERAL WELLNESS INITIATIVES

(Sec. 4402)

The law calls for the HHS Secretary to conduct an evaluation of existing federal health and wellness initiatives to determine the extent to which they affect the health status of the American public, but specifically the federal workforce, including issues related to absenteeism, productivity, workplace injury and medical costs, and whether they have been successful in achieving their stated goals. It requires the Secretary to submit a report to Congress with the departments' evaluation and conclusions concerning the reasons such initiatives are successful or unsuccessful. (Dates are not specified.)

IMPROVING WOMEN'S HEALTH

(Sec. 3509)

Beginning in FY 2010, the law creates an Office on Women's Health within HHS headed by a Deputy Assistant Secretary for Women's Health. The office will set goals and objectives related to women's health to improve prevention, treatment and research in women's health programs, establish a Coordinating Committee on Women's Health, and establish a National Women's Health Information Center. In addition, Offices of Women's Health will be established throughout the department, including within the CDC, AHRQ, HRSA and the FDA, with the directors of these offices serving on the

coordinating committee. Not later than March 23, 2011, and every second year thereafter, the Secretary will submit a report to Congress describing the activities of the offices. The law authorizes such sums as necessary for each of FYs 2010-2014 to carry out this section.

MODERNIZING DISEASE PREVENTION AND PUBLIC HEALTH SYSTEMS

National Prevention, Health Promotion and Public Health Council. (Sec. 4001) The law creates the National Prevention, Health Promotion and Public Health Council chaired by the Surgeon General and composed of the heads of the various federal agencies, including the secretaries of HHS, Agriculture, Education, Transportation and Labor, among others. The council will:

- Provide coordination and leadership at the federal level with respect to prevention, wellness and health promotion practices in the U.S.;
- Develop a national prevention, health promotion, public health and integrative health care strategy with input from relevant stakeholders to improve the health status of Americans;
- Provide recommendations to the President and Congress regarding changes in federal policy to achieve public health goals;
- Consider and propose evidence-based models, policies and innovative approaches for the promotion of transformative models of public health; and
- Establish processes for continued public input, submitting reports and carrying out other activities as necessary.

The law creates an Advisory Group on Prevention, Health Promotion, and Integrative and Public Health. The advisory group will be composed of 25 non-federal members, including a diverse group of health professionals, appointed by the President. It will develop policy and program recommendations and advise the council. By March 23, 2011, the Surgeon General, in consultation with the council, will develop and make public a national prevention, health promotion and public health strategy. In addition, the council will issue a report not later than July 1, 2010, and annually thereafter through January 1, 2015, that describes its activities and efforts, its priorities, its progress, and its plans to improve health promotion and disease prevention.

Prevention and Public Health Fund. (Sec. 4002) *Spends \$12.9 billion over 10 years.* Beginning in FY 2010, the law allocates \$12.9 billion over 10 years to create a Prevention and Public Health Fund, administered through the Office of the HHS Secretary, to provide for expanded and sustained national investment in prevention and public health programs, and help restrain the rate of growth in public and private sector health care costs.

Clinical and Community Preventive Services. (Sec. 4003) Beginning immediately, the law expands the duties of and improves the coordination between two task forces which provide recommendations on preventive services – the USPTSF and the Community Preventive Services Task Force. More detailed guidance for the creation and role of

both task forces is provided. It clarifies that AHRQ will provide administrative, research and technical support for the operations of the task forces, but that recommendations made by the task forces are independent.

Education and Outreach Campaign for Preventive Benefits. (Sec. 4004) Beginning immediately, the law directs the HHS Secretary to develop and implement a national public-private partnership to provide outreach and education to raise public awareness of health improvement across the life span. The campaign will focus on proper nutrition, regular exercise, smoking cessation, obesity reduction and the five leading diseases in the U.S. and their prevention. It will include the launch of a media campaign and the development of a Web site with “personalized prevention plans” so that individuals can determine their risk of developing certain diseases and learn about actions they can take to help prevent them. The Secretary will disseminate health promotion and disease prevention information to health care providers who participate in federal programs.

In addition, the provision specifically calls for the Secretary to provide information to states and health care providers regarding preventive and obesity-related services available to Medicaid enrollees. Each state is directed to design a public awareness campaign to educate Medicaid enrollees about the availability and coverage of these services. The first report on the status and effectiveness of efforts to increase awareness of coverage of obesity-related services is due to Congress no later than January 1, 2011, and every three years thereafter.

INCREASING ACCESS TO CLINICAL PREVENTIVE SERVICES

School-based Health Centers. (Sec. 4101) *Spends \$200 million over 10 years.* The law provides \$50 million in grant funding from FY 2010-2013 to support the operation of school-based health centers, with preference given to those in underserved areas and those that serve a large population of low-income children and those in underserved areas. Funds may be used only for facilities or equipment, not for personnel or the provision of health services. These clinics would provide comprehensive primary health services, including physical and mental health assessments, treatment for minor, acute and chronic medical conditions, and referrals to health care providers. Eligible entities must match 20 percent of the grant funding to carry out the activities supported by the grant, but the matching requirement may be waived in cases of serious hardship.

Oral Healthcare Prevention Activities. (Sec. 4102) The law, subject to the availability of appropriations, will establish a five-year national public education campaign focused on oral healthcare prevention and education targeted toward children, the elderly and pregnant women. The HHS Secretary shall immediately begin conducting planning activities for the campaign, and implement the five-year campaign no later than March 23, 2012. The law also provides demonstration grants to community-based providers of dental services (as defined by the Secretary) to demonstrate the effectiveness of research-based dental cavity disease management activities.

Medicare Annual Wellness Visit. (Sec. 4103) *Spends \$3.6 billion over 10 years.* In addition to the one-time “Welcome to Medicare” comprehensive physical exam, the law provides Medicare beneficiaries with annual wellness visits with zero cost-sharing (no co-payment or deductible would apply), effective January 1, 2011. Services may be furnished by a physician, nurse practitioner, clinical nurse specialist or physician assistant, or a team of medical professionals. These annual visits will include “personalized prevention plan services,” which include a health risk assessment, detection of any cognitive impairment, a schedule for preventive services, identification of conditions for which interventions are recommended, and referrals for follow-up services. In addition, by March 23, 2011, the Secretary will establish guidelines for health risk assessments, in consultation with relevant groups and entities.

Removal of Barriers to Preventive Services in Medicare. (Sec. 4104, 10406) *Spends \$800 million over 10 years.* The U.S. Preventive Services Task Force (USPSTF) reviews scientific evidence to determine the benefit and harm associated with preventive services, and makes the following recommendations: "A" (strongly recommends); "B" (recommends); "C" (no recommendation for or against); "D" (recommends against); or "I" (insufficient evidence to recommend for or against). Beginning January 1, 2011, the law requires Medicare to eliminate cost sharing requirements, including beneficiary co-payments and deductibles in all settings, including outpatient settings, for preventive screenings and services receiving a recommendation of “A” or “B” by the USPSTF and for all colorectal cancer screenings, regardless of coding, subsequent diagnosis or ancillary tissue removal during screening.

Evidence-based Coverage of Preventive Services in Medicare. (Sec. 4105) *Saves \$700 million over 10 years.* The *Medicare Improvements for Patients and Providers Act of 2008* gave the HHS Secretary the authority to cover *new* preventive services if they were recommended by the USPSTF. Beginning January 1, 2010, the law allows the Secretary to modify coverage of *existing* preventive services based on USPSTF recommendations. It also would allow, but not require, the Secretary to provide no Medicare payment for services rated “D,” or harmful, by the USPSTF.

Improving Access to Preventive Services in Medicaid. (Sec. 4106) *Spends \$100 million over 10 years.* Effective January 1, 2013, a 1 percentage point increase to a state’s federal portion of its FMAP is provided if its Medicaid program provides coverage of clinical preventive services receiving a recommendation of “A” or “B” from the USPSTF and vaccines approved by the Advisory Committee on Immunization Practices of the CDC and waives enrollee cost-sharing for these services.

Tobacco Cessation Services for Pregnant Women in Medicaid. (Sec. 4107) *Saves \$100 million over 10 years.* Effective October 1, 2010, the law requires states to provide Medicaid coverage for counseling, pharmacotherapy and other services to pregnant women for cessation of tobacco use and eliminates cost sharing for these services.

Incentives for Prevention of Chronic Diseases in Medicaid. (Sec. 4108) *Spends \$100 million over 10 years.* Beginning no later than January 1, 2011, the HHS Secretary will award five-year grants to states to provide incentives to Medicaid beneficiaries who participate in healthy lifestyle programs and demonstrate changes in health risk and outcomes. The Secretary will conduct an outreach and education campaign to make states aware of the grants under this section. An initial report on the effectiveness of the program and whether it should be expanded or extended beyond 2016 is due January 1, 2014 and a final report with recommendations for legislative and administrative action is due July 1, 2016.

CREATING HEALTHIER COMMUNITIES

(Sections 4201-4207)

Spends \$100 million over 10 years.

The law adopts a number of initiatives, mainly effective from FY 2010-2014, to create healthier communities, including:

- *Community Transformation Grants* to state and local government agencies and community-based organizations for evidence-based community preventive health activities to improve individual and community health, reduce the incidence of chronic disease, create healthier school environments and reduce racial and ethnic disparities. The law requires that at least 20 percent of the grants go to rural and frontier areas. (Sec. 4201)
- *Healthy Aging, Living Well* grants to states or local health departments to conduct community-based pilot programs for the pre-Medicare population (age 55-64) to identify and treat individuals at risk of developing chronic disease. The state or local health department may enter into contracts with community health centers, rural health clinics and mental health and substance use disorder service providers to assist in the referral and treatment of at-risk patients. The Secretary will report no later than September 30, 2013 on the ability of the programs to reduce the risk of disease and control future Medicare costs in the community. (Sec. 4202)
- Removing barriers and improving access to *wellness for individuals with disabilities*. Not later than March 23, 2012, the Architectural and Transportation Barriers Compliance Board must issue regulatory standards to ensure that medical diagnostic equipment used in physicians' offices, clinics, emergency rooms and hospitals is accessible to, and usable by, individuals with accessibility needs. Equipment includes exam tables, chairs, X-ray machines and other radiological equipment. (Sec. 4203)
- Initiatives to improve *immunization* rates in communities, including allowing states to purchase recommended vaccines from the federal government at discounted rates negotiated by the Secretary. The law authorizes the Secretary to negotiate and enter into contracts with vaccine manufacturers. The law also

requires GAO to report on Medicare beneficiary access to vaccines by June 1, 2011. (Sec. 4204)

- *Labeling of standard menu items at chain restaurants.* This requirement would require chain restaurants with more than 20 sites to disclose caloric information for menu items, and, upon request, to provide additional nutritional information related to such things as the amount of fat, cholesterol, sodium, sugars, protein and fiber contained in the item. This requirement also applies to food sold from chain vending machines. The Secretary will promulgate regulations to carry out this provision by March 23, 2011. (Sec. 4205)
- *Demonstration programs for individualized wellness plans for at-risk populations* at 10 community health centers to test the impact of wellness plans on reducing risk factors for preventable conditions. The plans may include nutritional counseling, stress management or alcohol/smoking cessation services. (Sec. 4206)
- *Reasonable break time for nursing mothers,* which requires employers with more than 50 employees to provide break time and an appropriate place for breastfeeding mothers to express milk for up to one year after the child's birth. Employers are not required to compensate employees for this break time, and this requirement can be waived for employers with less than 50 employees if it imposes undue hardship. (Sec. 4207)

PUBLIC HEALTH AND PREVENTION INNOVATIONS

(Sec. 4301-4306)

The law calls for a number of initiatives to improve research related to public health services and chronic disease management by directing the HHS Secretary to:

- Provide funding for research to optimize the delivery of public health services, including the translation of interventions from academic settings to real-world settings, and issue an annual report to Congress on its research findings (Sec. 4301);
- Direct the CDC to provide employers with tools and technical assistance to expand the use of employer-based wellness programs (Sec. 4303);
- Award grants to states and public health agencies to improve surveillance and response to infectious diseases and other important public health conditions (Sec. 4303);
- Contract with the Institute of Medicine (IOM) to convene a conference on pain care management to improve recognition of pain as a significant public health problem (Sec. 4305); and

- Appropriate \$25 million over FYs 2010-2014 to fund a childhood obesity demonstration project (Sec. 4306).

OTHER PREVENTION AND WELLNESS ACTIVITIES

(Sec. 10407, 10409-10413)

The new law also:

- Requires the HHS Secretary, in conjunction with the CDC, to prepare and make available to the public on a biennial basis a National Diabetes Report Card that tracks trends in health outcomes for individuals with diabetes. To help improve diabetes care, the law also calls for improving the collection of diabetes mortality data and studying the appropriate level of diabetes medical education necessary for practitioners and providers.
- Establishes a new office within NIH called the Cures Acceleration Network, appropriating \$500 million in FY 2010 and such funds as necessary in subsequent years. This office will award grants and contracts to accelerate the development of “high need cures,” defined as drugs, devices and biological products for which incentives in the commercial market are unlikely to result in their adequate or timely development.
- Provides five-year competitive grants to eligible entities to establish as many as 30 national centers of excellence for depression. Authorizes \$1.25 billion over 10 years beginning in FY 2011.
- Authorizes appropriations for FYs 2011-2015 for the development of new programs related to congenital heart disease, including a surveillance system to facilitate further research into the types of health services patients use and to identify possible areas for educational outreach.
- Extends the *Automated Defibrillation in Adam’s Memory Act* through 2014.
- Appropriates \$9 million for each of FYs 2010-2014 to support a number of programs for young women’s breast health awareness and support of young women diagnosed with breast cancer, including conducting prevention research, establishing an education campaign to increase breast cancer awareness, and providing support for those diagnosed with the disease.

QUALITY, DISPARITIES AND COMPARATIVE EFFECTIVENESS

NATIONAL QUALITY STRATEGY

(Sections 3011-3015, 10302-10305)

Spends \$100 million over 10 years.

The law calls for the HHS Secretary to establish a national quality improvement strategy that includes priorities that have the greatest potential to improve patient outcomes, patient-centeredness and efficiency. These priorities are to apply to all patients, including children and vulnerable populations. In setting the priorities, the Secretary is mandated to take into consideration recommendations submitted by the National Priority Partners that have been convened by the National Quality Forum (NQF). The Secretary also must develop a comprehensive strategic plan to achieve priority improvements and coordinating activities among HHS agencies and with the state Medicaid programs to help achieve these goals.

The national strategy will be updated every three years at most, with the first report due to Congress by January 1, 2011. The selected priorities would become the basis for further work to develop and implement measures to foster improvement and public reporting, including public reporting on hospital quality on *Hospital Compare*. In selecting the measures to use in public reporting and hospital payment under value-based purchasing, the Secretary must choose measures that have been considered by a consensus based organization, such as the NQF, and are recommended by a multi-stakeholder group, such as the Hospital Quality Alliance (HQA).

The legislation also requires the Secretary to:

- Develop not less than 10 acute/chronic outcome measures (targeting the five most prevalent in each category) by March 23, 2012 (no later than 24 months after enactment);
- Develop not less than 10 primary/preventive outcome measures (targeting healthy children, chronically ill adults or infirm elderly) by March 23, 2013 (no later than 36 months after enactment);
- Develop and update (not less than every three years) provider-level outcome measures for hospitals and physicians, as well as other providers that address: (a) risk adjustment; (b) accountability; (c) sample size; and (d) the full scope of services that comprise a cycle of care;
- Select efficiency measures; and
- Establish and implement an overall strategic framework to carry out the public reporting of performance information.

PAYMENT ADJUSTMENT FOR CONDITIONS ACQUIRED IN HOSPITALS

(Sec. 3008)

Saves \$1.4 billion over 10 years.

The provision applies a financial penalty to hospitals with high risk-adjusted rates of the hospital-acquired conditions identified by CMS for use in the inpatient PPS hospital-acquired conditions policy, or any other condition selected by the Secretary. Prior to implementation, the Secretary shall submit a report to Congress (January 1, 2012) on the state of the current Hospital-Acquired Conditions Program and possible expansion of the program to other facilities, such as LTCHs, IRFs, SNFs, ASCs and hospital outpatient departments. Beginning in FY 2015, hospitals in the top quartile of national

hospital-acquired condition rates will receive 99 percent of their otherwise applicable Medicare payments for all discharges. The Secretary is required to develop and use a risk-adjustment methodology when calculating the hospital-acquired condition rates. Prior to FY 2015, the Secretary will calculate and share confidentially with hospitals their hospital-acquired condition rates. The Secretary will report hospital-specific hospital-acquired conditions information on the *Hospital Compare* Web site, after allowing hospitals to review the information and to submit corrections.

VALUE-BASED PURCHASING (VBP) FOR SNFs, HHAs, ASCs

(Sec. 3006, 10301)

Budget Neutral

The legislation directs the Secretary to submit to Congress implementation plans for VBP programs for SNFs and HHAs by October 1, 2011, and for ASCs by January 1, 2011. These plans will be created in consultation with stakeholders and will address the development, measurement and modification of quality and efficiency measures; the reporting, collection and validation of quality data; the structure of proposed value-based payment adjustments; criteria for both reductions and incentives and methods for public dissemination. The Secretary will consider experiences with demonstrations that are relevant to VBP in each setting.

QUALITY REPORTING FOR IPFs, IRFs, LTCHs AND HOSPICE

(Sec. 3004, 10322)

Saves \$100 million over 10 years.

By October 1, 2012, the HHS Secretary must publish quality measures for reporting by IPFs, IRFs, LTCHs and hospices. Providers that fail to report these measures will have their market basket updates reduced by 2.0 percentage points, beginning July 1, 2013 (rate year (RY) 2014), for IPFs, and October 1, 2013 for IRFs, LTCHs and hospices.

QUALITY REPORTING FOR PPS-EXEMPT CANCER HOSPITALS

(Sec. 3005)

By October 1, 2012, the HHS Secretary must publish quality measures for reporting by PPS-exempt cancer hospitals. By October 1, 2014, PPS-exempt cancer hospitals must report the quality measures.

PILOT TESTING VBP FOR CERTAIN MEDICARE PROVIDERS

(Sec. 10326)

The law requires the HHS Secretary, by January 1, 2016, to conduct VBP pilot programs for psychiatric hospitals and units, LTCHs, IRFs, PPS-exempt cancer hospitals and hospice programs. Further, no earlier than January 1, 2018, the Secretary may expand the duration and scope of these VBP pilot programs based on whether Medicare spending is reduced, quality is maintained or increased, and coverage or beneficiary benefits are not limited or denied.

VBP FOR PHYSICIANS

(Sec. 3007)

Budget Neutral.

The law institutes a budget-neutral VBP adjustment to the physician fee schedule by directing the HHS Secretary to evaluate physicians' quality of care compared to cost and apply a payment modifier under the physician fee schedule based on the evaluation. The Secretary is required to publish specific measures of quality and cost by January 1, 2012. The implementation of the modifier will begin during the 2013 rulemaking process and an initial performance period will begin in 2014. The payment change will be implemented beginning in 2015 for specific physicians and groups of physicians, as determined by the Secretary, and will expand to all physicians and groups of physicians in 2017, including other eligible health care practitioners, as determined by the Secretary.

IMPROVEMENTS TO THE PHYSICIAN QUALITY REPORTING SYSTEM

(Sec. 3002, 10327)

Spends \$300 million and saves \$200 million over 10 years.

The law extends the physician quality reporting initiative (PQRI) through 2014 and establishes a mandatory physician quality reporting program beginning in 2015. The law modifies the PQRI program to:

- Allow eligible professionals to receive incentive payments if they participate in a qualified Maintenance of Certification (MOC) program by submitting quality measures into a registry or through an alternative form and manner determined by the HHS Secretary;
- Define a qualified MOC as a program that requires physicians to comply with the following:
 - Maintenance of a valid, unrestricted medical license;
 - Participation in continuing education;
 - Passing a formalized secure examination;
 - Having the following practice assessment procedures in place:
 - Use of evidence-based medicine;
 - Surveying of patient experience of care; and
 - A quality improvement process to address practice weaknesses.
- Establish an appeals process for providers who participated in the program but did not qualify for incentive payments by January 1, 2011;
- Require CMS to provide more timely feedback to providers on their performance;
- Extend the PQRI incentive program beyond 2010; and
- Develop a plan for integrating quality reporting with the meaningful use of electronic health records by January 1, 2012.

Eligible professionals (physicians, nurse practitioners, physician assistants, clinical psychologists, physical and occupational therapists, and speech-language pathologists and audiologists) who successfully report in 2010 will receive a 1.0 percent bonus

payment in 2011 and a 0.5 percent bonus payment in 2012 through 2014. Eligible professionals who elect not to participate will be penalized 1.5 percent of their Medicare payment in 2015 and two percent of their payment in 2016 and beyond.

IMPROVEMENTS TO THE PHYSICIAN FEEDBACK PROGRAM

(Sec. 3003)

Budget Neutral.

The law requires the HHS Secretary, beginning in 2012, to provide feedback reports to physicians that compare their resource use with that of other physicians or groups of physicians. It also requires the Secretary to develop an episode grouper by January 1, 2012. The grouper will combine separate but clinically-related services into an episode of care for which a physician is accountable. The Secretary will make the methodology available to the public and seek endorsement from the consensus based organization with which it has a contract, such as the NQF. The feedback program will be coordinated with the value-based payment modifier.

PUBLIC REPORTING OF PERFORMANCE INFORMATION

(Sec. 10331)

The law requires the HHS Secretary to develop a *Physician Compare* Internet Web site for physicians and other professionals participating in the PQRI program by January 1, 2011. Beginning January 1, 2013, the Secretary shall publicly report physician performance measures regarding the following:

- PQRI measures;
- Assessment of beneficiary outcomes and functional status;
- Care coordination;
- Episodes of care;
- Risk-adjusted resource use;
- Patient experience of care; and
- Safety and effectiveness.

In addition, the Secretary shall:

- Make data available to the public, including risk-adjustment mechanisms;
- Provide opportunity for reasonable review of the data;
- Capture robust and accurate portrayal of a physician's performance;
- Include all-payer data;
- Appropriately attribute care;
- Provide timely statistical performance feedback;
- Publicly report only valid, reliable and accurate data; and
- Attain feedback from stakeholders.

The Secretary shall submit a report to Congress on the progress of *Physician Compare* by January 1, 2015. Further, the Secretary may establish a demonstration program to

provide financial incentives to Medicare beneficiaries who are furnished services by high-quality physicians (no earlier than January 1, 2019).

NURSING HOME COMPARE MEDICARE WEB SITE

(Sec. 6103)

The law requires the Secretary to provide a comparison of nursing homes on the *Nursing Home Compare* Medicare Web site. The Secretary shall modify or revamp *Nursing Home Compare* by March 23, 2011 (not later than one year after enactment). The revisions shall include reporting of the following:

- Staffing data for each facility;
- Links to state Web sites regarding the state survey and certification programs;
- Standardized complaint form developed under section 1128(f) [physician ownership or investment interests];
- Number, type, severity and outcome of substantiated complaints;
- Number of adjudicated instances of criminal violations;
- Number of civil monetary penalties levied; and
- Consumer rights information page.

The Secretary is required to consult with state long-term care ombudsmen, consumer advocacy groups and provider stakeholder groups, and to review the accuracy of the information reported on *Nursing Home Compare*. Each state shall submit information on any survey or certification made with respect to a SNF. This provision requires SNFs/NFs to: (1) have reports from surveys, certifications and complaint investigations made during the three preceding years available for any individual to review upon request; and (2) post notice of the availability of such reports.

The Secretary shall conduct a special focus facility program for those SNFs that have failed to meet applicable requirements. The Secretary shall conduct surveys of each special focus facility not less than every six months.

ELDER JUSTICE ACT

(Sec. 6701-6703)

The law requires the HHS Secretary, in consultation with the departments of Justice and Labor, to award grants and carry out activities that provide greater protection to those individuals seeking care in facilities that provide long-term services and supports, and to provide greater incentives for individuals to train and seek employment at such facilities. It requires owners, operators and certain employees of these facilities to report suspected crimes of elder abuse. It also requires owners and operators of these facilities to submit written notification to the HHS Secretary and to the state on an impending closure of a facility within 60 days prior to the closure. It establishes an Elder Justice Coordinating Council to advise federal, state and local governments on the proper response to elder abuse. Grants are authorized through HHS to help reduce incidences of elder abuse.

AVAILABILITY OF MEDICARE DATA FOR PERFORMANCE MEASUREMENT

(Sec. 10332)

By January 1, 2012, the Secretary shall make available to qualified entities performance measurement data. Claims data shall be made available under Medicare parts A, B and D for items and services furnished under such parts for one or more specified geographic areas and time periods, and it shall be made available upon request. The fee for obtaining such data shall be equal to the cost of creating the data set. Qualified recipients of the data must submit a description of methodologies for intended data use. Those methodologies should include: calculation of standard performance measures; calculation of alternative measures approved by the HHS Secretary; and a plan for confidentially releasing the data to the providers of the services. The Secretary also must consider release of data from sources other than claims.

PATIENT SAFETY RESEARCH CENTER

(Sec. 3501)

The law establishes a Center for Quality Improvement and Patient Safety within AHRQ that will conduct research to identify best practices for quality improvement and health care system redesign processes that improve patient safety, promote the successful adoption of such best practices, and build capacity at the state and community levels to lead quality and safety efforts. The center will award technical assistance grants to entities to assist providers in adopting the best practices identified through the center's research. Grantees must coordinate with HIT regional extension centers of the Office of the National Coordinator for Health Information Technology.

MEDICATION MANAGEMENT SERVICES IN TREATMENT OF CHRONIC DISEASES

(Sec. 3503)

The HHS Secretary shall create the Medication Management Program by May 1, 2010. The Patient Safety Research Center shall administer grants or contracts for services provided by licensed pharmacists to treat chronic diseases. Further, grant recipients must coordinate with local community health teams. The grant recipients are responsible for the following functions:

- Health and functional status assessments;
- Formulating medication treatment plans;
- Initiating and modifying medication therapy;
- Monitoring for medication safety and effectiveness; and
- Comprehensive medication review.

Beneficiaries who have two or more chronic diseases, take any high-risk medications, take four or more prescribed medications, or who have undergone a transition of care recently are eligible to participate. One goal is to improve patient adherence to therapies while reducing acute care costs and hospital readmissions.

MEDICAID QUALITY

Adult Health Medicaid Quality Measures. (Sec. 2701) *Spends \$300 million over 10 years.* This provision directs the HHS Secretary, in consultation with the states, to develop an initial set of health care quality measures specific to adults who are eligible for Medicaid. By January 1, 2011, the Secretary shall identify, for comment, a recommended core set of adult health quality measures for Medicaid eligible adults and by January 1, 2012, the Secretary shall publish the final set of measures. The section establishes the Medicaid Quality Measurement Program (no later than January 1, 2013), which will expand upon existing quality measures, identify gaps in current quality measurement, and establish priorities for the development and advancement of quality measures and consult with relevant stakeholders.

The Secretary, along with states, will report regularly to Congress on the progress made in identifying quality measures and implementing them in each state's Medicaid program. The initial Report to Congress on adult and children's quality measures is due January 1, 2014, and every three years thereafter.

By September 30, 2014 (and annually thereafter), the Secretary shall collect, analyze and make publicly available the information reported by states. By January 1, 2015, the Secretary shall publish changes to the recommended core measure set. States will receive grant funding to support the development and reporting of quality measures. This provision adds a Treasury appropriation of \$60 million for each of FYs 2010-2014; funds will remain available until expended.

Medicaid Non-payment for Health Care-acquired Conditions. (Sec. 2702) The law prohibits Federal payments to states for Medicaid services related to health care-acquired conditions, effective July 1, 2011. The HHS Secretary, through regulation, will identify conditions consistent with Medicare, but will not be limited to conditions acquired in hospitals, and will take into account the differences between the Medicare and Medicaid programs. The Secretary will consider existing state policies that limit payment for health care acquired-conditions. State Medicaid programs will be required to adopt policies that will not result in higher payments to hospitals should a patient have a health care-acquired condition during the hospital stay (similar to the Medicare hospital-acquired conditions policy).

Exemption of Certain Pharmacies from Accreditation Requirements. (Sec. 3109) The law allows pharmacies with less than 5 percent of revenues from Medicare DMEPOS billings to be exempt from accreditation requirements until the HHS Secretary develops pharmacy-specific standards.

MINORITY HEALTH AND REDUCING HEALTH DISPARITIES

(Sec. 4201, 4302, 5307, 10333, 10334, 10403)

Spends \$200 million over 10 years for Sec. 4302 (costs of other provisions are subsumed under broader sections or have no change in expenditures).

Minority health and reducing health disparities provisions are incorporated throughout the new law. Some provisions are indirect and others are direct and specifically targeted. For example, the expansion of coverage, especially to low-income populations, is likely to have a significant effect on reducing health disparities. The coverage provisions also include several provisions to ensure that the information provided by insurance exchanges and the plans offered through them are culturally appropriate to the populations being served. Furthermore, the quality incentive program for health plans under the insurance exchanges will include incentives for the implementation of activities to reduce health and health care disparities, such as the use of language services, community outreach and cultural competency training.

Similarly, there are a variety of broader provisions in the bill that require attention to disparities (among other things) in their execution, such as the development of a national strategy to improve health care quality, the establishment of the national health care workforce commission, improvements to the maternal, infant and early childhood home visiting programs, the establishment of community health teams to support patient-centered medical homes, comparative effectiveness research, and funding priority for school-based health center grantees that serve large populations of medically underserved children.

There are a variety of health professions education and other workforce provisions focused on diversity and improving access to care in underserved areas. For example:

- Sec. 5307 reauthorizes and expands programs to support the development, evaluation, and dissemination of model curricula for cultural competency, prevention, and public health proficiency and aptitude for working with individuals with disabilities training for use in health professions schools and continuing education programs.
- Sec. 5401 raises the funding levels for The Centers of Excellence program, which develops a minority application pool to enhance recruitment, training, and other support for minorities.
- Sec. 5402 reauthorizes and increases funding for diversity in health professions training, including scholarships for disadvantaged students who commit to work in medically underserved areas as primary care providers, and loan repayment assistance and fellowships for faculty positions.
- Sec. 5403 amends the Area Health Education Centers to expand grant authorizations to support interdisciplinary, community-based linkages that target underrepresented minorities and individuals from urban and rural medically underserved communities seeking careers in the health professions.
- Sec. 5404 expands the allowable uses of nursing diversity grants to include completion of associate degrees, bridge or degree completion programs or advanced degrees in nursing.

Other provisions focus directly on minority health and reducing health disparities. Specifically:

- Sec. 10334 elevates the Office of Minority Health (currently within the Office of Public Health and Science within the Public Health Service) to the HHS Secretary's office, to be headed by a new Deputy Assistant Secretary for Minority Health reporting directly to the HHS Secretary. It also establishes a network of new minority health offices in agencies under HHS. These offices will monitor health, health care trends, and quality of care among minority patients and evaluate the success of minority health programs and initiatives. A similar elevation will move minority health at the NIH from a Center to an Institute.
- Sec. 4302 requires that all federally funded data collection efforts on health care or public health include collection of data on race, ethnicity, primary language, sex, disability and any other indicator of disparity to better understand disparities. The HHS Secretary is required to develop standards for data collection; for race and ethnicity, the Secretary is required to use Office of Management and Budget standards. HHS also is required to collect access and treatment data for people with disabilities. Public reporting of health care quality data by race, ethnicity, primary language, gender and disability is required. Federally funded studies and surveys are required to collect sufficient data to yield statistically reliable results, and HHS is required to share health disparities data, measures and analyses with other relevant agencies.
- Sec. 4201 and Sec. 10403 provide Community Transformation Grants to state and local governments and community organizations for evidence-based community preventive health activities. These grants will be used to help reduce the incidence of chronic disease and develop strategies to reduce racial and ethnic disparities, including social, economic and geographic determinants of health. The law requires that at least 20 percent of the grants go to rural and frontier areas.
- Sec. 10333 provides assistance to minority populations through grant funding to community-based collaborative care networks that provide comprehensive, coordinated and integrated health care services to low-income populations. Entities eligible for grants are consortia of providers with joint governance structures, DSH hospitals and FQHCs. The funds must be used to support efforts to help low-income individuals access appropriate services, enroll in health coverage programs and obtain a regular primary care provider or medical home. Funds also can be used to provide case management and care management, perform health outreach, provide transportation, and expand capacity through such approaches as telehealth, after-hours services or urgent care, and other direct patient care services.

COMPARATIVE EFFECTIVENESS RESEARCH AND EVIDENCE-BASED MEDICINE

(Sec. 6301-6302, as amended by Sec. 10602)

Spends \$2.5 billion and saves \$0.3 billion over 10 years.

Patient-centered Outcomes Research Institute. The law creates an independent Patient-Centered Outcomes Research Institute that is neither an agency nor an establishment of the U.S. Government. The tax-exempt institute will conduct comparative *clinical* effectiveness research to evaluate the clinical effectiveness, risks and benefits of two or more medical treatments, services and items, including health care interventions, protocols for treatment, care management and delivery, procedures, medical devices, diagnostic tools, pharmaceuticals and integrative health practices.

The institute will assist patients, clinicians, purchasers and policymakers in making informed health decisions by advancing the evidence by which diseases and other health conditions can effectively and appropriately be prevented, diagnosed, treated and managed. Specifically, the institute will:

- Identify research priorities and establish a research project agenda;
- Carry out the research project agenda, including managing contracts, reviewing and updating evidence, and taking into account potential differences;
- Collect data from CMS and other federal, state or private entities;
- Appoint expert advisory panels, especially for clinical trials and rare diseases;
- Support patient and consumer representatives;
- Establish a 15-member methodology committee, which would include the directors of the AHRQ and NIH;
- Provide for a peer-review process for primary research;
- Release research findings;
- Adopt the national priorities, the research project agenda, the methodological standards, and other processes and protocols; and
- Submit annual reports to the Congress, the President and the public.

The institute's 19-member board will consist of patients and health care consumers, physicians and providers – including one hospital representative – private payers, pharmaceutical, device and diagnostic manufacturers, members representing state or federal government and others. It also will include the directors of AHRQ and NIH, or their respective designees. Board members will be appointed by the Comptroller General of the United States to hold six-year terms, serving a maximum of two terms. The board will employ an executive director and other staff. The Comptroller General has a number of oversight responsibilities with respect to the institute.

The institute will review existing research and conduct new research. It will be allowed access to data from federal, state and private entities, including data from clinical databases and registries. It also may enter into contracts with federal agencies, such as AHRQ, and private entities. Its research will be prioritized based on disease incidence and prevalence, evidence gaps in terms of clinical outcomes, practice

variations and health disparities, the potential to improve health and quality of care, and expenditures associated with a health care treatment strategy or condition, among others. The research will be designed to take into account differences among sub-populations and in treatment modalities.

The law also creates an Office of Communication and Knowledge Transfer at AHRQ, in consultation with NIH, to broadly disseminate research findings. All research will be conducted under a set of requirements to ensure transparency, public input, adherence to ethical standards, and disclosure of any conflicts of interest.

The law establishes several limitations around the use of the institute's comparative effectiveness research findings:

- The institute may not mandate coverage, reimbursement or other policies for any public or private payer, and none of its reports or research findings should be construed as mandates, practice guidelines or policy recommendations.
- The Secretary is prohibited from making coverage determinations based solely on the institute's research or findings, but can use the evidence for coverage determinations if it includes an iterative and transparent process with public comment and consideration of the effect on subpopulations.
- The Secretary is prohibited from determining coverage or reimbursement that would lower the value of extending the life of an elderly, disabled or terminally ill individual over that of an individual who is younger and healthier.
- The institute is prohibited from developing a "dollars per quality-adjusted life year" (or similar measure) to determine what health care services or treatments are cost-effective or recommended. And it would be prohibited from using such a measure as a threshold to determine coverage, reimbursement or incentive programs.

The law creates a Patient-Centered Outcomes Research Trust Fund (PCORTC) to fund the institute and its activities. The PCORTC is financed in a public/private manner using general funds from the U.S. Treasury, an assessment per Medicare beneficiary, and a fee for insured and self-insured health plans. The fee on health plans would be based on an amount per number of lives covered by the plan and would sunset after FY 2019.

The Federal Coordinating Council created under the *American Recovery and Reinvestment Act of 2009* was terminated as of March 23, 2010.

Program to Establish Shared Decision Making. (Sec. 3506) The purpose of this program is to facilitate collaborative processes between patients, caregivers and clinicians in decision making; to provide information about their treatment options, including the advantages and disadvantages among options; and to facilitate incorporation of patient preferences and values into the medical plan. The HHS

Secretary shall coordinate with CDC and NIH to establish a program to award grants or contracts to develop, update and produce patient decision aids, test such aids and educate providers on the use of such aids. The Secretary shall contract with NQF to identify and develop standards for patient decision aids and endorse such aids. Further, the Secretary shall fund grants in order to provide technical assistance to care givers.

Presentation of Prescription Drug Benefit and Risk Information. (Sec. 3507) The HHS Secretary shall coordinate with the FDA to determine if the addition of quantitative summaries of the benefits and risks of prescription drugs in a standardized format (drug fact boxes) to promotional labeling or print advertising improves health care decision making by clinicians, patients, and consumers. The Secretary shall consult with drug manufacturers, clinicians, patients, consumers, experts in health literacy, representatives of racial and ethnic minorities, and experts in women's and pediatric health in assessing the summaries. The Secretary shall submit a report to Congress on the summaries by March 23, 2011 (not later than one year after enactment). By March 23, 2014 (not later than three years after release of the report to Congress), the Secretary shall promulgate proposed regulations as necessary.

Primary Care Extension Program. (Sec. 5405) The law creates a Primary Care Extension Program to educate and provide technical assistance to primary care providers about evidence-based therapies, preventive medicine, health promotion, chronic disease management and mental health. AHRQ will award planning and program grants to state hubs, including at least one health professions school.

Demonstration Program to Integrate Quality Improvement and Patient Safety Training Into Clinical Education of Health Professionals. (Sec. 3508) The HHS Secretary, through AHRQ, may award grants to academic institutions to develop and implement an academic curriculum that integrates quality improvement and patient safety into the clinical education of health professionals. The following programs are eligible for the grants:

- Health professions schools;
- Schools of public health;
- Schools of social work;
- Schools of nursing;
- Schools of pharmacy;
- Institutions with a graduate medical education program; and
- Schools of health care administration.

Selected participants must match funds at a rate not less than \$1 for each \$5 of federal funds. The Secretary shall submit a report to Congress on the demonstration program by March 23, 2012 (not later than two years after enactment; and annually thereafter).

Patient Navigator Program. (Sec. 3510) The HHS Secretary will collaborate with HRSA to award grants (not to exceed four years) to programs for patient navigators to

coordinate health care services and to assist patients in overcoming barriers to health care services, coordinate provider referrals, provide information on clinical trials, and conduct outreach to health disparity populations. The applications shall define minimum core proficiencies for patient navigators. This provision includes an appropriation of \$3,500,000 for FY 2010.

REGULATORY OVERSIGHT AND REFORM

MEDICAID RECOVERY AUDIT CONTRACTORS

(Sec. 6411)

The new law requires each state Medicaid program, by December 31, 2010, to contract with one or more Recovery Audit Contractors (RACs) to identify underpayments and overpayments to providers and recoup overpayments. Each state is required to coordinate RAC efforts with other contractors or entities performing audits of Medicaid providers. The law also expands the RAC program by December 31, 2010 to include audits of Medicare parts C and D and requires RACs to ensure that Medicare Advantage Plans and Prescription Drug Plans implement anti-fraud plans. The law requires CMS to submit an annual report to Congress on the effectiveness of the RAC program and recommendations on expanding and improving the program.

MAXIMUM PERIOD FOR SUBMISSION OF MEDICARE CLAIMS

(Sec. 6404)

Beginning with services furnished on or after January 1, 2010, the maximum period for submission of Medicare claims would be reduced from three years to not more than one year after the date of service. The Secretary may specify exceptions to the one-year period.

MEDICAL LIABILITY

(Sec. 10607)

The HHS Secretary is authorized to make demonstration grants to states for the development, implementation and evaluation of alternatives to current tort litigation. There is an authorization for \$50 million to be appropriated for a five-fiscal year period, beginning with FY 2011. The Comptroller General is designated to appoint and convene a review panel to consult with the Secretary in reviewing applications. The law establishes criteria for eligible projects and specifies the complement of experts to serve on the review panel. The Secretary is directed to evaluate the effectiveness of the projects and submit reports to Congress. MedPAC and MACPAC are directed to review the funded projects for their impact on federal programs and beneficiaries.

NATIONAL INDEPENDENT MONITOR DEMONSTRATION PROJECT

(Sec. 6112)

The HHS Secretary and Inspector General are required to test and implement an independent monitor program to oversee interstate and large intrastate chains of skilled nursing facilities and nursing facilities. This is a two-year demonstration. Independent monitors are responsible for:

- Conducting periodic reviews and preparing root-cause quality and deficiency analyses;
- Conducting sustained oversight of the efforts of the chain;
- Analyzing the management structure;
- Reporting findings and recommendations; and
- Publishing the results.

The law requires a report to be issued no later than 10 days after receipt of a finding and a recommendation to be issued no later than 10 days after receipt of a report. The chain shall be responsible for a portion of the costs associated with appointment of an independent monitor. The Secretary shall submit a report to Congress not later than 180 days after completion of the demonstration.

TAX-EXEMPT HOSPITAL REQUIREMENTS

(Sec. 9007 as amended by sec. 10903 of H.R. 3590)

The law applies several new requirements to section 501(c)(3) hospitals that are in addition to, and not in lieu of, the requirements otherwise applicable for tax exemption. The Secretary of the Treasury is authorized to issue, as necessary, regulations and guidance to implement these new requirements.

These new requirements generally apply to any section 501(c)(3) organization that operates a facility which is required by a state to be “licensed, registered or similarly recognized as a hospital.” In addition, they are applicable to *any other organization* that, as determined by the Secretary of the Treasury, has the principal function or purpose of providing hospital care as the basis for its tax-exemption status. For organizations that operate more than one hospital facility, these new requirements apply separately to each such facility and any specific facility that fails to separately meet any requirement will not be treated as a tax-exempt charitable organization.

The new requirements, with the exception of the requirement related to community health needs assessment, are applicable for tax years that begin after March 23, 2010.

- **Community Health Needs Assessment:** Each hospital is required to conduct a community health needs assessment at least once every three years and adopt an implementation strategy to meet the needs identified through the assessment. The assessment must include input from individuals who represent the broad interests of the community served by the hospital, including individuals with

special knowledge and expertise in public health. In addition, the assessment must be made widely available to the public.

The community needs assessment requirement applies to tax years that start after March 23, 2012. Under the law, a hospital can meet the requirement by conducting a compliant assessment and adopting an implementation strategy in that tax year or in either of the two immediately preceding tax years. Thus, to meet its initial compliance obligation, a hospital will be required to complete a needs assessment and adopt an implementation plan based on that assessment at some time during the period between the start with its first tax year that begins after March 23, 2010 and the end of its tax year that begins after March 23, 2012. For example, a calendar year taxpayer could conduct the needs assessment in 2011, 2012 or 2013. A \$50,000 penalty will be imposed on any hospital that fails to comply with the community needs assessment requirement in that initial – and any subsequent – applicable three-year period.

- **Financial Assistance Policy and Limits on Charges:** Each hospital is required to adopt, implement, and widely publicize (within the community the hospital serves) a written financial assistance policy. The policy must include: (1) eligibility criteria for financial assistance and whether the assistance includes free or discounted care; (2) the basis for calculating amounts patients are charged; (3) how to apply for financial assistance; and (4) any actions that may be taken for non-payment, including collections actions and reporting to credit agencies if the organization does not have a separate billing and collections policy. In addition, each hospital must have a written policy that obligates it to provide emergency medical care, without discrimination, to individuals regardless of whether or not they qualify for assistance under the hospital's financial assistance policy.

Under the law, a hospital is permitted to bill patients who qualify for financial assistance no more than the amounts generally billed to individuals who have insurance coverage for such care. A hospital may not use gross charges when billing individuals who qualify for financial assistance.

- **Debt Collection:** A hospital facility (or its affiliates) may not undertake extraordinary collection actions against a patient without first making “reasonable efforts” to determine whether the individual is eligible for the hospital's financial assistance policy. The law specifically authorizes the Secretary of the Treasury to provide guidance about what are “reasonable efforts.”
- **Reporting and Disclosure:** Hospitals are required to report annually to the IRS how they are meeting identified community needs, including a description of any needs not being addressed and the reasons why they are not, and provide audited financial statements. Hospitals also will need to report any penalties to be paid for failure to meet the new community health needs assessment requirement. The IRS must review information about a hospital's community

benefit activities (currently reported on Form 990, Schedule H) at least once every three years. The Secretary of the Treasury, in consultation with the HHS Secretary, will make an annual report to Congress on the levels of charity care, bad debt expenses, unreimbursed costs of means-tested and non-means tested government programs incurred by private tax-exempt, taxable, and governmental hospitals as well as the cost of community benefit activities incurred by private tax-exempt hospitals. In addition, the Secretary of the Treasury, in conjunction with the HHS Secretary, will study the trends in these amounts and will provide the results of this study to Congress before March 23, 2015.

PROGRAM INTEGRITY

KEY MEDICARE, MEDICAID AND CHIP PROVISIONS

Provider Screening. (Sec. 6401) Applications for Medicare provider enrollment will be expanded to require more information (as determined by the HHS Secretary). A fee will be assessed to pay for screening costs and, under Sec. 6402, penalties will apply for false statements made on the application. Some new providers may be granted a provisional participation agreement with enhanced oversight, such as pre-payment review and payment limitations. The states are given authority to impose similar screening procedures in Medicaid; those without effective screening programs can have their FMAP reduced.

Database Creation and Data Matching. (Sec. 6402) CMS is required to establish a new comprehensive program integrity (“One PI”) database. The new, single database is intended to allow the integration of existing and new sources of data, including survey and certification data, encounter data and adverse actions data and enhance sharing of claims and payment data across federal and state Medicaid programs, as well as across other federal departments (HHS, the Social Security Administration, the departments of Veterans Affairs, Defense and Justice, and the Federal Employees Health Benefits Program).

Provider Compliance and Penalties. Medicare and Medicaid providers, as a condition of participation, are required to have a compliance program in place with core elements determined by the HHS Secretary in consultation with the Office of the Inspector General (OIG) (Sec. 6401).

The Civil Monetary Penalties (CMP) law is expanded and the amounts of many existing penalties are increased (Sec. 6402, 6408). The Secretary, in consultation with HHS OIG and CMS, may suspend payments to providers and suppliers pending an investigation of credible allegations of fraud (Sec. 6402).

Reporting and Returning of Overpayments. (Sec. 6402) An overpayment from the Medicare or Medicaid program must be returned within 60 days of the date it was identified, or the date any corresponding cost report is due. The appropriate

government authority must also be provided notice of the reason for the overpayment. Failure to meet the deadline can result in liability under the False Claims Act.

Self-referral Disclosure Protocol. (Sec. 6409) The HHS Secretary is required to establish within six months a process for voluntary disclosures of actual or potential violations of the physician self-referral law. Under the process, the Secretary has the authority to determine the amount due, taking into account certain factors. Under current law, any payment for a service provided in violation of the self referral law was an overpayment and the full amount was subject to repayment without regard to the nature or extent of the violation.

Antikickback Law. (Sec. 6402) The intent standard is clarified for imposing criminal penalties. Actual knowledge of this section of the law or a specific intent to violate it is not required. In addition, violations of the Antikickback law also may be subject to penalties under the False Claims Act.

False Claims Act. The False Claims Act is amended to remove the requirement that a “whistleblower” who brings a lawsuit based on publicly disclosed allegations have “direct and independent knowledge” of the fraud. Instead, the individual may act based on “knowledge that is independent of and materially adds to the publicly disclosed allegations.” Even if the whistleblower is not an original source, the Attorney General can step in and prevent the court from dismissing the whistleblower’s claim. In addition, only disclosures in federal proceedings or reports are considered “public disclosures” – meaning that disclosures to the state or in state reports could be relied on by a whistleblower.

Program Integrity Funding. (Sec. 6402) Funding is increased for Medicare and Medicaid program integrity and anti-fraud activities, as well as for better coordination of reporting requirements between the two programs.

ADDITIONAL MEDICAID PROGRAM INTEGRITY PROVISIONS

State Plan Amendments. (Sections 6501-6503, 6505, 6508) State Medicaid programs are required to amend their plans for medical assistance to add certain new program integrity provisions that provide for:

- Termination of participation in the state’s Medicaid program for any individual or entity that also is terminated from participation in Medicare or any other state plan under Title XIX (Sec. 6501).
- Termination of participation in the state’s Medicaid program for any individual or entity that owns, controls or manages an entity that (or, if such entity is owned, controlled or managed by an individual or entity that): (1) has delinquent unpaid Medicaid overpayments; (2) is suspended, excluded or terminated from participation in Medicaid; or (3) is affiliated with an individual or entity that has

been suspended, excluded or terminated from participation in Medicaid (Sec. 6502).

- Registration with the state and the HHS Secretary of any agent, clearinghouse or other alternate payee that submits claims on behalf of a health care provider. The Secretary is charged with determining the form and manner of registration and defining “alternate payee” (Sec. 6503).
- Prohibition on making payments for items or services furnished under the state plan (or under a waiver) to any financial institution or entity located outside of the U.S. (Sec. 6505).

These provisions requiring amendments to the states’ plan for medical assistance are effective January 1, 2011, regardless of whether final regulations to implement any of the provisions have been issued. The law provides for a delay (i.e., to the first day of the first calendar quarter beginning after the close of the first regular legislative session that begins after March 23, 2010) if state legislation other than an appropriation of funding is required to amend the state’s plan for medical assistance or the Title XXI child health plan (Sec. 6508).

Additional Data Reporting by State Medicaid Programs. (Sec. 6504) States also will have to report to HHS additional data that the HHS Secretary determines to be necessary for program integrity, program oversight and administration beginning January 1, 2010. The Secretary is to determine the frequency of such reporting. States also must include in all Medicaid managed care contracts a provision that ensures sufficient patient encounter data to identify the physician who delivers a patient’s care is provided to the HHS Secretary. This requirement applies to contract years beginning on or after January 1, 2011. The Secretary is to specify the level of detail and the frequency of reporting.

Mandatory State Use of the National Correct Coding Initiative. (Sec. 6507) States must begin using as part of their Medicaid claims processing systems methodologies from the National Correct Coding Initiative or any successor correct coding initiative for any claims filed on or after October 1, 2010. By September 1, 2010, the HHS Secretary must identify the initiative’s methodologies that are compatible with and appropriate for Medicaid claims, without limiting the identification of specific methodologies to those that also apply to Medicare claims, and notify the states of what methodologies have been identified and how they are to be incorporated into Medicaid claims processing.

The Secretary of HHS also must submit by March 1, 2011 a report to Congress that includes the notice to the states and an analysis supporting the agency’s identification of the correct coding methodologies for Medicaid claims processing from the initiative.

Extension of Period to Recover Medicaid Overpayments. (Sec. 6506) States now will have a one-year period, instead of 60 days, in which to recover identified Medicaid overpayments before any adjustment to account for these overpayments is made in the

federal payments a state receives. This expanded recovery period applies to overpayments discovered on or after March 23, 2010.

The law provides that the federal payment adjustment generally will be made at the end of the one-year period, regardless of whether the state has recovered the overpayments. However, there is an exception to the automatic end-of-the-one-year-period adjustment in the situation where a state is unable to recover a fraudulently made overpayment (or any portion thereof) made to an individual or entity because there is no final determination from an administrative or judicial process, including as a result of a pending appeal. In such a circumstance, the adjustment in the federal payment cannot be made before 30 days following the date of the final judgment, including, if applicable, any final determination on the appeal.

The law requires the HHS Secretary to develop regulations that require states to correct ongoing and recurring federally identified claims overpayments with new Medicaid Management Information System (MMIS) edits, audits or other appropriate corrective actions.

REVENUE PROVISIONS

40 PERCENT EXCISE TAX ON INSURERS THAT OFFER HIGH-PREMIUM PLANS

(Sec. 9001 as amended by Sec. 1401 of H.R. 4872)

Raises \$32 billion over 10 years.

For taxable years beginning after December 31, 2017 (CY 2018), insurance policies with relatively high total premiums will be subject to a 40 percent excise tax on the amount by which the premium exceeds a specified threshold. Except as described below, the threshold is set (beginning in CY 2018) at \$10,200 for individual policies and \$27,500 for family policies. After 2018, those amounts will be indexed to overall inflation (CPI-urban (U)), except for 2019 when they are indexed by CPI-U plus 1 percentage point. An additional threshold amount of \$1,650 for singles and \$3,450 for families is available for retired individuals age 55 and older and for plans that cover employees engaged in high-risk professions. Adjustments to the threshold are allowed for employers with significantly different age/gender employee compositions from that of the national workforce. The full premium will continue to be excluded from enrollees' taxable income and, thus, will not be subject to income or payroll taxes. All tax-excluded contributions toward flexible spending arrangements, health reimbursement arrangements, and health savings accounts are to be included in the determination of the total premium that is subject to the tax. The excise tax is payable by insurers, applies to self-insured plans and is not deductible for federal income tax purposes. Separate dental and vision coverage policies are excluded from the premium amounts subject to the tax.

MODIFY THE DEFINITION OF QUALIFIED MEDICAL EXPENSES

(Sec. 9003)

Raises \$5 billion over 10 years.

This provision generally conforms the definition of “medical expenses” to the definition used in determining itemized deduction amounts for medical expenses. Beginning in CY 2011, the legislation redefines allowable medical expenses for the purposes of employer-provided health coverage, including health reimbursement arrangements, health flexible spending arrangements, and Archer medical savings accounts, to exclude over-the-counter medicines, unless prescribed by a physician.

HEALTH SAVINGS ACCOUNTS

(Sec. 9004)

Raises \$1.4 billion over 10 years.

This provision increases the additional tax for health savings account withdrawals prior to age 65 that are not used for qualified medical expenses from 10 percent to 20 percent, beginning in CY 2011.

LIMIT ON HEALTH FLEXIBLE SPENDING ARRANGEMENT CONTRIBUTIONS

(Sec. 9005 as amended by Sec. 1403 of H.R. 4872)

Raises \$13 billion over 10 years.

The provision limits pre-tax contributions to flexible spending arrangements (FSAs) to \$2,500 per year beginning in 2013. Additionally, the provision indexes the limit amount to the CPI-U beginning in CY 2014, rounded to the next lowest multiple of \$50.

CORPORATE INFORMATION REPORTING

(Sec. 9006)

Raises \$17.1 billion over 10 years.

Beginning on January 1, 2012, the provision requires businesses that pay any amount over \$600 per year to corporate providers of property and services to file an information report with each provider and with the IRS. Information reporting is already required on payments for services to non-corporate providers.

PHARMACEUTICAL MANUFACTURERS' FEE

(Sec. 9008 as amended by Sec. 1404 of H.R. 4872)

Raises \$27 billion over 10 years.

This provision imposes an annual flat fee on the pharmaceutical manufacturing sector, beginning in CY 2011. The fee applies to manufacturers or importers of branded prescription drugs. Orphan drugs are excluded. Prescription drugs and biologics sold to or covered by government programs are included. The fee is credited to the Medicare Part B Trust Fund. The non-deductible fee would be allocated across the industry according to market share and would not apply to companies with sales of

branded pharmaceuticals of \$5 million or less. The amount of the aggregate sector fee varies by year:

CY 2011	\$2.5 billion
CY 2012	\$2.8 billion
CY 2013	\$2.8 billion
CY 2014	\$3 billion
CY 2015	\$3 billion
CY 2016	\$3 billion
CY 2017	\$4 billion
CY 2018	\$4.1 billion
CY 2019 and thereafter	\$2.8 billion

MEDICAL DEVICE MANUFACTURERS’ FEE

(Sec. 1405 of H.R. 4872)

Raises \$20 billion over 10 years.

Beginning in CY 2013, the provision imposes a tax on the sale of taxable medical devices by a manufacturer, producer or importer equal to 2.3 percent of the sales price. Taxable medical devices include any device as defined in Section 201(h) of the *Federal Food, Drug, and Cosmetic Act* intended for humans. Exempted are eyeglasses, contact lenses, hearing aids and any other device determined by the HHS Secretary to be a type which is generally purchased by the general public at retail for individual use. Certain manufacturers’ exemptions for excise taxes do not apply.

HEALTH INSURANCE PROVIDERS’ FEE

(Sec. 9010 as amended by Sec.1406 of H.R. 4872)

Raises \$60.1 billion over 10 years.

This provision imposes an annual flat fee of \$6.7 billion on the health insurance sector, beginning in FY 2014. This non-deductible fee would be allocated across the industry according to market share. It excludes employers that self-insure health benefits and governmental entities. It exempts certain non-profit insurers that receive more than 80 percent of gross revenue from governmental programs. It also exempts accident-only, disability-only, specified disease, fixed-indemnity, long-term care, and Medicare supplemental insurance from the fee. CO-OPs and the national plan will be subject to the insurance provider fee as well.

The annual fee varies by year:

CY 2014	\$8 billion
CY 2015	\$11.3 billion
CY 2016	\$11.3 billion
CY 2017	\$13.9 billion
CY 2018	\$14.3 billion

Beginning in CY 2019, the fee will be the amount for the preceding year, increased by the rate of premium growth for the preceding calendar year. Fees are not deductible for U.S. income tax purposes.

ELIMINATE DEDUCTION FOR EMPLOYER PART D SUBSIDY

(Sec. 9012 as amended by Sec. 1407 of H.R. 4872)

Raises \$4.5 billion over 10 years.

The provision eliminates the deduction of the subsidy for employers who maintain prescription drug plans for their Medicare Part D eligible retirees beginning in CY 2013.

MODIFICATION OF ITEMIZED DEDUCTION FOR MEDICAL EXPENSES

(Sec. 9013)

Raises \$15.2 billion over 10 years.

Beginning in CY 2013, the provision increases the adjusted gross income threshold for claiming the itemized deduction for medical expenses from 7.5 percent to 10 percent. Individuals age 65 and older will be able to claim the itemized deduction for medical expense at 7.5 percent of adjusted gross income through CY 2016.

LIMITATION ON EXCESSIVE REMUNERATION PAID BY CERTAIN HEALTH INSURANCE PROVIDERS

(Sec. 9014)

Raises \$600 million over 10 years.

The provision limits the deductibility of executive compensation under Section 162(m) for insurance providers if at least 25 percent of the insurance provider's gross premium income from health business is derived from health insurance plans that meet the minimum essential coverage requirements in the legislation ("covered health insurance provider"). The deduction is limited to \$500,000 per taxable year and applies to all officers, employees, directors and other workers or service providers performing services for or on behalf of a covered health insurance provider. The provision is effective for compensation beginning after December 31, 2012 for services performed in taxable years after 2009.

ADDITIONAL HOSPITAL INSURANCE TAX ON HIGH-INCOME TAXPAYERS

(Sec. 9014, as amended by Sec. 1402 of H.R. 4872)

Raises \$53.8 billion over 10 years.

The provision increases the hospital insurance tax rate by 0.9 percentage point on an individual's wages in excess of \$200,000 (\$250,000 for married couples filing jointly). It also applies to self-employed earnings.

Additionally, the provision imposes a 3.8 percent Medicare contribution tax on individuals, estates or trusts of the lesser of net investment income or the excess of modified adjusted gross income over the threshold amount. The threshold amount is

\$250,000 for joint returns, \$125,000 for married individuals filing separately or \$200,000 for any other case. The tax applies to a trade or business if the trade or business is a passive activity for the taxpayer or it consists of trading financial instruments or commodities. Investment income does not include distributions from qualified retirement plans or amounts subject to Self Employment Contributions Act (SECA) taxes. The tax is subject to the individual estimated tax provisions and is not deductible for federal income tax purposes.

SPECIAL DEDUCTION FOR BLUE CROSS BLUE SHIELD (BCBS)

(Sec. 9016)

Raises \$400 million over 10 years.

Beginning in CY 2010, the provision requires that non-profit BCBS organizations have a medical loss ratio of 85 percent or higher in order to take advantage of the special tax benefits provided to them under Internal Revenue Code (IRC) Section 833, including the deduction for 25 percent of claims and expenses and the 100 percent deduction for the unearned premium reserves.

EXCISE TAX ON INDOOR TANNING SERVICES

(Sec. 10907)

Raises \$5.8 billion over 10 years.

The provision imposes a 10 percent tax on amounts paid by individuals for indoor tanning services, beginning July 1, 2010. Indoor tanning services are defined as services employing any electronic product designed to induce skin tanning and which incorporate one or more ultraviolet lamps and are intended for the irradiation of an individual by ultraviolet radiation, with wavelengths in air between 200 and 400 nanometers. Any phototherapy service performed by a licensed medical professional is not included. The tax is to be paid by the individual receiving the service, collected by the provider at time of payment for the service, and remitted by the provider to the IRS on a quarterly basis. The Secretary is given discretion over the manner of the payment.

APPENDIX A

Year-by-Year Payment Changes Affecting Annual Updates for Inpatient PPS Hospitals

Inpatient Prospective Payment System (IPPS) Policy	Fiscal Year									
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Market Basket (MB) Cuts for Productivity Adjustment (P) ¹ and Medicare Savings	MB – 0.25	MB – 0.25	MB – (P + 0.1)	MB – (P + 0.1)	MB – (P + 0.3)	MB – (P + 0.2)	MB – (P + 0.2)	MB – (P + 0.75)	MB – (P + 0.75)	MB – (P + 0.75)
Reporting Hospital Quality Data for the Annual Payment Update ² (Pay for reporting)	MB – 2.0 If Failure to Report	MB – 2.0 If Failure to Report	MB – 2.0 If Failure to Report	MB – 2.0 If Failure to Report	MB – 2.0 If Failure to Report	MB – ¼ of MB If Failure to Report	MB – ¼ of MB If Failure to Report	MB – ¼ of MB If Failure to Report	MB – ¼ of MB If Failure to Report	MB – ¼ of MB If Failure to Report
Hospital Value-Based Purchasing ³				MB – 1.0 Potential for Earn Back	MB – 1.25 Potential for Earn Back	MB – 1.5 Potential for Earn Back	MB – 1.75 Potential for Earn Back	MB – 2.0 Potential for Earn Back	MB – 2.0 Potential for Earn Back	MB – 2.0 Potential for Earn Back
Readmissions ⁴				MB – Hosp-specific amount capped at 1.0	MB – Hosp-specific amount capped at 2.0	MB – Hosp-specific amount capped at 3.0	MB – Hosp-specific amount capped at 3.0	MB – Hosp-specific amount capped at 3.0	MB – Hosp-specific amount capped at 3.0	MB – Hosp-specific amount capped at 3.0
Hospital Acquired Conditions						MB – 1.0 For Bottom Quartile Hospitals	MB – 1.0 For Bottom Quartile Hospitals	MB – 1.0 For Bottom Quartile Hospitals	MB – 1.0 For Bottom Quartile Hospitals	MB – 1.0 For Bottom Quartile Hospitals
Health Information Technology Meaningful Use ⁵ (MU)						MB – ¼ of MB If Failure to Meet MU	MB – ½ of MB If Failure to Meet MU	MB – ¾ of MB If Failure to Meet MU	MB – ¾ of MB If Failure to Meet MU	MB – ¾ of MB If Failure to Meet MU

Note: all numeric reductions represent a percentage point reduction from the market basket rate. For example if the market basket is projected to be 3% and the reduction is 2 percentage points, then the remaining amount for the update is 1%.

¹ The productivity adjustment (P) is the 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity, as projected by the Secretary. The productivity adjustment is permanent, extending beyond the 10-year budget window of the law.

² Hospital quality reporting requirements tied to the update were enacted by the Medicare Modernization Act of 2003. The American Recovery and Reinvestment Act (ARRA) of 2009 modified the reduction when penalties for not meeting “meaningful use” of electronic health record adoption were enacted.

³ VBP is funded by a reduction in the update, growing from 1 percentage point in 2013 to 2 percentage points in 2017 and beyond. The potential for “earn back” derives from these reductions and will be based on individual hospital performance. The VBP is budget neutral.

⁴ If a hospitals’ readmission rate is higher than expected, the hospital’s update is reduced by a hospital-specific amount, not to exceed 1 percentage point in 2013 and not to exceed 3 percentage points in 2016 and beyond.

⁵ The ARRA requires hospitals to become “meaningful users” of electronic health records in order to avoid update reductions.