AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

***AMERICA'S HEALTHY FUTURE ACT***
The Senate Committee on Finance
September 22, 2009

**TITLE I – HEALTH CARE COVERAGE**
SUBTITLE A – INSURANCE MARKET REFORMS

*Rating Rules in the Individual Market*
Section Summary: Establishes federal rating, issue, renewability and pre-existing condition rules for the individual market. Issuers in this market could vary premium on tobacco use, age and family composition. In the most controversial feature so far of this section, premiums for the age of the beneficiary could premiums based on age by a ratio of 5:1. In other words, the oldest beneficiaries could be charged as much as five times as the youngest.

Premiums could vary among, but not within, rating areas to reflect geographical differences. The composite ratio for premiums could not be more than 7.5:1.

> **Discussion:** AARP and others have already called for a reduction in the age disparity ratio from 5:1 to 2:1, claiming that these much higher rates are particular problem for older beneficiaries.

*Immediate Assistance for Those with Pre-existing Conditions*
Section Summary: While waiting for the insurance exchange to get started, the currently uninsured who have been denied coverage due to pre-existing conditions can reenroll in a high-risk pool.

*Rating Rules for Small Group Market*
Section Summary: This market would use the same rules as the individual market, except that they would be phased in over a period of up to 5 years.

*Cafeteria Plans for Small Employers*
Section Summary: Current cafeteria plans that offer acceptable eligibility requirements and minimum contribution requirements, offered by a business with an average of 100 or fewer employees will be given safe harbor status regarding nondiscrimination requirements.

*Qualified Long Term Care Insurance*
Section Summary: A cafeteria plan may offer as a qualified benefit contributions to a qualified long-term care insurance contract.





2021 Massachusetts Ave., N.W. • Washington, DC 20036-1011 • 888.794.7481 • 202.232.9033 • Fax: 202.232.9044 • capitol@aafp.org

*Pooling Requirements for Individual and Small Group Markets*
Section Summary: States would be able to apply the new federal rating rules to the individual market and small group market. These markets would be subject to the same system of risk adjustment. All major health insurance issuers would be required to contribute to a reinsurance program for individual policies. Risk corridors modeled after that applied to regional PPOs in Medicare Part D will be provided if a plan chooses to participate.
*State Insurance Commissioners*
Section Summary: They would retain authority to provide oversight of plans with regard to consumer protections (e.g., grievance procedures, external review, agent practices and training, market conduct), rate review, solvency, reserve requirements, premium taxes and all requirements imposed on insured plans.

The National Association of Insurance Commissioners is assigned the responsibility of devising a model federal regulation that will implement health insurance rating, issuance and marketing requirements.

*Rating Areas*
Section Summary: State insurance commissioners would define rating areas.

*Grandfathered Plans*
Section Summary: Those who choose to remain in plans in which they are currently enrolled would be permitted to do so. No tax credits would be offered for grandfathered plans. By 2013, federal rating rules would be phased in for grandfathered policies in the small group market.

*Interstate Sale of Insurance*
Section Summary: The National Association of Insurance Commissioners will develop model rules for the creation of "health care choice compacts:. Beginning in 2015, states may form such compacts to allow for the purchase of individual health insurance across state lines.

*National Plans*
Section Summary: National plans with uniform benefit packages could be offered across state lines, but the plans must be licensed in every state that they choose to operate. Such national plans would preempt state benefit mandates. Premiums for national plans will be determined based on rating rules in each state.

SUBTITLE B – STATE EXCHANGES AND CONSUMER ASSISTANCE

*State Exchanges and Marketing Requirements*
Section Summary: All private insurers in the individual and small group markets must be available in newly established state exchanges. These exchanges must be established by the states for purposes of the individual market and a Small business Health Options Program (SHOP) exchange. There will be a standard enrollment application for eligible individuals and small businesses. The exchange will require a standardized format for presenting insurance options and will develop standardized marketing requirements. The exchange will maintain call center support for customer service, will enable consumers to enroll in health plans in local hospitals and government offices, like DMV, Social Security offices. HHS and the states will develop a model template for a web

portal for use by the state that directs individuals and small business to available insurance options in their state.

To pay for these and other services that the exchanges are required to provide, the federal government will provide initial funding, but they would be required to be self-sustaining in future years.

SUBTITLE C – MAKING COVERAGE AFFORDABLE

*Benefit Options*
Section Summary: Four benefit categories are established. Each insurer must have plan with a bronze, silver, gold and platinum benefit category (each of which is defined by percent of actuarial value) and no plan that did not have at least the top two categories could participate in the individual or small group market. A catastrophic-only policy would be available for individuals 25 or younger.

All plans must provide preventive and primary care, emergency services, hospitalization, physician services, outpatient services, day surgery and related anesthesia, diagnostic imaging and screenings, maternity and new born care, pediatric services (including dental and vision), medical/surgical care, prescription drugs, radiation and chemotherapy, and mental health and substance abuse services that at least meet minimum standards set by federal and state laws.

Plans may not charge co-payments or apply deductibles (or any other cost-sharing) for preventive care services. Plans may not include lifetime limits on coverage or annual limits on any benefits. Any plan that rates on tobacco use must cover tobacco cessation.

*Health Care Affordability Tax Credits*
Section Summary: A refundable tax credit would be available for those who purchase health insurance through state exchanges. Eligibility would be determined by incomes up to 300 percent of the federal poverty level. The credit would be paid to the insurance plan and the individual would be required to pay only the difference between the tax credit and the premium.

Beginning in 2013, tax credits would be available on a sliding scale for those between 134 and 300 percent of the federal poverty level to help offset the cost of private health insurance.

To prevent illegal immigrants from accessing the state exchanges obtaining federal health care tax credits, the bill requires verification of personal data (i.e., name, SSN, date of birth).

> **Discussion:** The last section is considered inadequate by some to prevent access to health insurance by illegal immigrants because the data required for verification can be fraudulent.

*Small Business Tax Credit*
Section Summary: The bill creates a new tax credit for small employers for contributions to purchase health insurance for its employees. The employer is eligible if he or she has no more than 25 FTE and if the fulltime equivalent wages average no more than

$40,000. Beginning in 2013, the credit would only be available for a small employer that purchases health insurance coverage for its employees through the state exchange.

*Application of State and Federal Laws Regarding Abortion*
Section Summary: State laws regarding the prohibition or requirement of coverage or funding for abortions and state laws involving abortion-related procedural requirements are not preempted. The provision provides that federal conscience protections and abortion related antidiscrimination law as would not be affected by the bill. The rights and obligations of employees and employers under Title VII of the Civil Rights Act of 1964 would also not be affected by the bill. In addition, this bill does not affect sate or federal laws requiring health care providers to provide emergency services.

*Abortion Coverage Prohibited as Part of Minimum Benefits Package*
Section Summary: Abortion services cannot be a mandated benefit as part of a minimum benefits package except in those cases for which federal funds are permitted. A qualified health plan would not be prohibited from providing coverage for abortions beyond those for which federal funds are permitted.

*Required Segregation of Public Funds*
Section Summary: No tax credit or cost-sharing credits may be used to pay for abortions beyond those permitted by current federal law. Insurers participating in any state-based exchange that offer coverage for abortion beyond those permitted by federal law must segregate from any premium and costs-sharing credits an amount of each enrollee's private premium dollars that is determined to be sufficient to cover the provision of those services.

HHS will determine an estimated actuarial value by which insurers that provide coverage for abortions beyond those permitted by federal law must demonstrate that no federal premium and cost-sharing credits are used for the purpose of paying for such abortions.

*Actuarial Value of Optional Service Coverage*
Section Summary: HHS will determine the actuarial value of cost of including coverage of abortions beyond those permitted by current federal law under a basic plan.

*Rules Regarding Coverage of and a Tax Credit for Specified Services*
Section Summary: Each state exchange must include at least one plan that provides coverage of abortions beyond those that can be funded under current federal law and at least one plan that does not provide coverage of abortions beyond those that can be funded under current federal law.

*No Discrimination on the Basis of Provision of Abortion*
Section Summary: Health plans participating in state exchanges cannot discriminate against any health care provider or facility because of its willingness or unwillingness to provide, pay for, provide coverage of, or refer for abortions.

> **Discussion:** These six sections are designed to make sure that individuals can purchase health insurance that covers abortion services, but that no federal funds are used for these purposes. However, opponents believe that since tax credits are fungible, any assistance provided to individuals who purchase insurance that pays for abortion services subsidizes those services.

SUBTITLE E – CREATION OF HEALTH CARE COOPERATIVES

*Consumer Operated and Oriented Plan (CO-OP) Program*
Section Summary: The Chairman's Mark authorizes $6 billion in funding the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of non-profit, member-run health insurance companies that serve individuals in one or more states. CO-OP grantees would compete in the reformed individual and small group insurance markets. Federal funds would be distributed as loans and grants. Loans would be provided to assist with start-up costs, and grants would be provided to meet state solvency requirements.

To be eligible for federal funds under the CO-OP program, an organization must meet the following requirements.

1. It must be organized as a non-profit, member corporation under State law.
2. It must not be an existing organization that provides insurance as of July 16, 2009, and must not be an affiliate or successor of any such organization.
3. Its governing documents incorporate ethics and conflict of interest standards protecting against insurance industry involvement and interference.
4. It must not be sponsored by a State, county, or local government, or any government instrumentality.
5. Substantially all of its activities must consist of the issuance of qualified health benefit plans in the individual and small group markets in each State in which it is licensed to issue such plans.
6. Governance of the organization must be subject to a majority vote of its members (i.e., beneficiaries).
7. As provided in regulations promulgated by the Secretary of Health and Human Services (HHS), it must be required to operate with a strong consumer focus, including timeliness, responsiveness, and accountability to members.
8. Any profits made would be required to be used to lower premiums, improve benefits, or for other programs intended to improve the quality of health care delivered to members.

Organizations participating in the CO-OP program would be permitted to enter into collective purchasing arrangements for services and items that increase administrative and other cost efficiencies, especially to facilitate start-up of the entities, including claims administration, administrative services, health information technology, and actuarial services. A purchasing council may be established to execute these collective purchasing agreements. The council shall be prohibited from setting payment rates for health care facilities and providers. There shall be no representatives of Federal, state, or local government or any employee or affiliate of an existing private insurer on the council. The council would be subject to existing anti-trust statutes.

SUBTITLE F – TRANSPARENCY AND ACCOUNTABILITY

*Ombudsman Office*
Section Summary: In 2010, states would be required to establish an ombudsman office to act as a consumer advocate for those with private coverage in the individual and small group markets. Policyholders whose health insurers have rejected claims and who have exhausted internal appeals would be able to access the ombudsman office for assistance.

*Uniform Information*
Section Summary: To provide uniform, meaningful and actionable information to consumers concerning health insurance coverage, this provision mandates the development and utilization of uniform outline of coverage documents.
SUBTITLE G – ROLE OF THE PUBLIC PROGRAMS

*Medicaid Quality Measurement Program*
Section Summary: Similar to the quality provisions enacted in CHIPRA, the Chairman's Mark would direct the Secretary of HHS, in consultation with the states, to develop an initial set of health care quality measures specific to adults who are eligible for Medicaid. The Mark would establish the Medicaid Quality Measurement Program which would expand upon existing quality measures, identify gaps in current quality measurement, establish priorities for the development and advancement of quality measures and consult with relevant stakeholders. The Secretary, along with states, would regularly report to Congress the progress made in identifying quality measures and implementing them in each state's Medicaid program. States would receive grant funding to support the development and reporting of quality measures.

*Bundled Payment Demonstration Project in Medicaid*
Section Summary: The Chairman's Mark would establish a bundled payment demonstration project under Medicaid in up to eight states. Under the demonstration, the unit of payment for acute care provided in hospitals would be redefined and expanded to include post-acute care provided in acute care hospitals and nonhospital settings, and/or hospital and concurrent physicians' services. Hospitals would receive a single bundled payment from Medicaid for such services. For purposes of this demonstration, the Secretary may waive restrictions imposed by title XI of the Social Security Act. The demonstration would begin October 1, 2011.

**TITLE II – PROMOTING DISEASE PREVENTION AND WELLNESS**
SUBTITLE A – MEDICARE

*Preventive Services*
Section Summary: The Chairman's Mark would encourage evidence-based coverage of preventive services by giving the Secretary the authority to use the same standards of evidence that apply to any new preventive services to existing preventive services. The Secretary would be allowed to modify coverage of existing preventive services to the extent that the modification is consistent with USPSTF recommendations. The Mark would also allow, but not require, the Secretary to withdraw Medicare coverage for services rated "D" or harmful by USPSTF. The Mark would provide funding for CMS to improve provider education and patient awareness of covered preventive services. The Mark would also require a GAO study to determine if any barriers exist that prevent the optimal utilization of covered primary, secondary and tertiary preventive services.

*Incentives to Medicare Beneficiaries for Healthy Lifestyle*
Section Summary: The Chairman's Mark would authorize and appropriate $100 million over five years for the Secretary to establish an initiative to provide incentives to Medicare beneficiaries who successfully complete certain healthy lifestyle programs. Programs would target the following risk factors: high blood pressure, high cholesterol; tobacco use, overweight or obesity, diabetes and falls. The Secretary would establish a system to monitor beneficiary participation and validate the results, as well as set

standards and health status targets for participating beneficiaries. Prior to establishing the initiative, the Secretary would review evidence concerning healthy lifestyle programs and providing incentives to individuals for participating in such programs. The initiative would be implemented on January 1, 2011.

SUBTITLE B – MEDICAID

*Medicaid State Plan Option Promoting Health Homes and Integrated Care*

Section Summary: The Tax Relief and Health Care Act of 2006 (TRCHA, P.L. 109-432) mandated CMS to establish a Medicare medical home demonstration project. However, there is currently no such provision under the Medicaid program. The Chairman‘s Mark would create a new Medicaid state plan option under which Medicaid enrollees with at least two chronic conditions or with one chronic condition and at risk of developing another chronic condition, could designate a provider as their health home. Qualifying providers would have to meet certain standards established by the Secretary, including demonstrating that they have the systems and infrastructure in place to provide comprehensive and timely high-quality care either in-house or by contracting with a team of health professionals. The designated provider or a team of health professionals would offer the following services: comprehensive care management; care coordination and health promotion; comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; patient and family support; and referral to community and social support services, if relevant and as feasible use health information technology to link such services. Teams of providers could be free-standing, virtual, or based at a hospital, community health center, clinic, physician‘s office, or physician group practice. Designated providers would be required to report to the state on all applicable quality measures in the state Medicaid program. The state would develop a mechanism to pay the health home for services rendered. The state plan amendment would include a plan for tracking avoidable hospital readmissions and plan for producing savings resulting from improved chronic care coordination and management. The Mark will provide an enhanced match of 90 percent FMAP for two years for states that take up this option. In addition, small planning grants may be available to help states intending to take up this option. FMAP rules would apply.

The Mark would require the Secretary to survey states and report to Congress on the nature, extent, and use of this option, particularly as it pertains to hospital admission rates, chronic disease management, and coordination of care for the chronically ill. The state option would be available beginning on January 1, 2011. After two years there would be an independent evaluation of the impact of this option on reducing hospital admissions.

*Childhood Obesity Demonstration Project*

Section Summary: The Chairman‘s Mark would appropriate $25 million for the Secretary to carry out the demonstration project.

**TITLE III – IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE**

SUBTITLE A – TRANSFORMING THE HEALTH CARE DELIVERY SYSTEM

*Hospital Value-Based Purchasing*

Section Summary: The Chairman‘s Mark would establish a Hospital Value-Based Purchasing (VBP) program in Medicare that moves beyond pay-for-reporting on quality measures, to paying for hospitals‘ actual performance on these measures.

*Physician Value-Based Purchasing – Physician Quality Reporting Initiative.*
Section Summary: Beginning with the 2011 reporting period, CMS would be required to make PQRI incentive payments available for two successive years to eligible professionals who voluntarily complete the following on a biennial (every two years) basis. The Secretary shall allow eligible professionals to qualify if they: (1) participate in a qualified American Board of Medical Specialties certification, known as Maintenance of Certification (MOC), or equivalent programs; and (2) complete a qualified MOC practice assessment. A qualified MOC practice assessment would include an initial assessment of a participant's practice, designed to demonstrate the physician's use of evidence-based medicine, and would seek to improve quality of care through follow-up assessments. The methods, measures, and data used for the MOC would be submitted by the Boards to CMS in accordance with requirements established by the Secretary in consultation with the Boards.

The Chairman's Mark would extend PQRI incentive payments beyond 2010. Eligible professionals who successfully report in 2010 would receive a two percent bonus in 2011. Eligible professionals who failed to participate successfully in the program would face a 1 percent payment penalty in 2012.

The Mark would also require CMS to develop a plan to integrate the PQRI program with the standards for meaningful use of certified electronic health records as created in the American Recovery and Reinvestment Act of 2009.

*Quality Infrastructure*
Section Summary: The Chairman's Mark would provide additional resources to HHS to strengthen and improve quality measure development processes for purposes of improving quality, informing patients and purchasers and guiding payment under Federal health programs. AHRQ and the Centers for Medicare and Medicaid Services (CMS) would implement the provisions in this proposal.

*National Strategy to Improve Health Care Quality.*
Section Summary: The Chairman's Mark would direct the Secretary to establish a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health through a transparent and collaborative process. In developing these priorities, the Secretary would consider how the priorities would: address health care needs of those with high-cost chronic diseases; improve strategies and best practices to improve patient safety and reduce medical errors, preventable hospital admissions and readmissions, and health care-associated infections; have the greatest potential for improving the health outcomes, efficiency and patient-centeredness of health care; reduce health care disparities across populations and geographic areas; address gaps in quality, efficiency and outcomes measures and data aggregation techniques; identify areas in the delivery of health care services that have the potential for rapid improvement in the quality and efficiency of patient care; improve payment policy under Federal health programs to emphasize quality and efficiency; enhance the use of health care data to improve quality, efficiency, transparency, and outcomes; and other areas as determined appropriate by the Secretary.

The national strategy would also include a comprehensive strategic plan to achieve the priorities described above. At a minimum, the strategic plan would include provisions for addressing coordination among agencies within HHS; agency specific strategic plans, where appropriate, along with annual benchmarks to achieve the priorities; strategies to

align incentives among public and private payers with regard to quality and patient safety efforts; and other requirements deemed appropriate by the Secretary.

In developing the national strategy and priorities, the Secretary would take into consideration recommendations submitted by a qualified consensus-based entity as set forth in MIPPA. To develop these recommendations, the qualified consensus based entity would convene a multi-stakeholder group.

*Quality Measure Development.*
Section Summary: The Secretary would identify, not less than triennially, gaps where no quality measures exist, or where existing quality measures need improvement, updating or expansion consistent with the national strategy and priorities. The qualified consensus-based entity set forth in MIPPA would be required to submit an annual report to the Secretary describing areas where gaps in quality measures exist and areas in which evidence is insufficient to support endorsement of quality measures related to the priority areas identified by the Secretary in the national strategy. This report would also include information on the economic and quality impact of the use of endorsed measures, where available. In identifying gaps, the Secretary would take into consideration the gaps identified by the consensus based entity. The Secretary would then be required to develop measures that would fill identified gaps.

An entity that receives a grant under this section would use such funding to develop quality measures that: build on measures required to be reported pursuant to Title XVIII of the Social Security Act; can be collected using health information technologies, to the extent practicable; is free of charge to users of such measures; and is publicly available on an Internet website. The Secretary may use amounts available under this section to update and test, where applicable, quality measures endorsed by the qualified consensus-based entity as identified in MIPPA.

*Consultation for Selection of Endorsed Quality Measures for Use in Reporting and Payment Programs.*
Section Summary: The Secretary would also develop a process for consultation with the qualified consensus-based entity as identified in MIPPA and the multi-stakeholder group referenced above related to the selection of measures for use in reporting to and payment under Federal health programs. The Secretary would be required to establish a pre-rulemaking process to obtain input from the consensus-based entity and multi-stakeholder group on the selection of quality measures. Under this process, by not later than December 1st of each year, starting in 2011, the Secretary shall make public a list of measures being considered for selection with respect to Medicare reporting and payment systems. The Secretary may include in this list measures that have and have not been endorsed by the consensus-based entity. Not later than February 1st, the consensus-based entity must transmit to the Secretary its recommendations regarding the proposed measures. The qualified consensus-based entity would convene the multi-stakeholder group to provide consultation on making these recommendations. The entity would ensure an open and transparent process.

*Accountable Care Organizations*
Section Summary: The Medicare program would allow groups of providers who voluntarily meet certain statutory criteria, including quality measurements, to be recognized as ACOs and be eligible to share in the cost-savings they achieve for the Medicare program. Beginning on Jan. 1, 2012, eligible ACOs would have the opportunity to qualify for an incentive bonus. Eligible ACOs would be defined as groups of providers

and suppliers who have an established mechanism for joint decision making, such as for capital purchases. The following groups of providers and suppliers would be eligible for participation: practitioners in group practice arrangements; networks of practices; partnerships or joint-venture arrangements between hospitals and practitioners; hospitals employing practitioners; and such other groups of providers of services and suppliers as the Secretary determines appropriate. Practitioners would be defined as physicians, nurse practitioners, physician assistants, clinical nurse specialists, and other practitioners or suppliers as the Secretary determines appropriate.

To qualify as an ACO, an organization would have to meet at least the following criteria: (1) agree to become accountable for the overall care of their Medicare fee-for-service beneficiaries; (2) agree to a minimum three-year participation; (3) have a formal legal structure that would allow the organization to receive and distribute bonuses to participating providers; (4) include the primary care physicians for at least 5,000 Medicare fee-for-service beneficiaries; (5) provide CMS with information regarding primary care and specialist physicians participating in the ACO as the Secretary deems appropriate; (6) have arrangements in place with a core group of specialist physicians; (7) have in place a leadership and management structure, including with regard to clinical and administrative systems; (8) define processes to promote evidence-based medicine, report on quality and costs measure, and coordinate care; and (9) demonstrate to the Secretary that it meets patient-centeredness criteria determined by the Secretary, such as use of patient and caregiver assessments or the use of individualized care plans.

To earn the incentive payment the organization would have to meet certain quality thresholds. In determining the quality of care furnished by an ACO, the Secretary would be required to use measures such as: (1) clinical processes and outcomes; (2) patient and caregiver perspectives on care; and (3) utilization and costs (such as rates of ambulatory-sensitive admissions and readmissions). ACOs would be required to submit data, at the group and individual provider level, on measures the Secretary determines necessary to evaluate the quality of care furnished by the ACO. The Secretary would be required to establish performance standards for measures of the quality of care furnished by ACOs. The Secretary would be required to seek to improve the quality of care furnished by ACOs over time by specifying higher standards for purposes of assessing quality of care.

The Secretary would be authorized to incorporate reporting requirements and incentive payments and penalties related to the physician quality reporting initiative (PQRI), electronic prescribing, electronic health records, and other similar initiatives into the reporting requirements for ACOs.

CMS would assign Medicare fee-for-service beneficiaries to ACOs based on their use of Medicare items and services in preceding periods. The achievement thresholds and rewards for the ACO would be as follows. The spending baseline would be determined on an organizational level by using the most recent three years of total per beneficiary spending for those beneficiaries assigned to the ACO. The target would be set by the baseline amount plus a flat-dollar amount that is equal to the risk-adjusted average expenditure growth per beneficiary nationally. Baselines would be re-set at end of the three-year period.

ACOs with three-year average Medicare expenditures that are determined by CMS to be below their benchmark for the corresponding period would be eligible for shared savings

at a rate determined appropriate by the Secretary. The Secretary would be required to set a minimum threshold of savings that would need to be achieved by an ACO before savings would be shared. The Secretary would have the authority to adjust the savings thresholds to account for the varying sizes of participating ACOs. If the Secretary determines that an ACO has taken steps to avoid at-risk patients in order to reduce the likelihood of increasing costs, the Secretary would be authorized to impose an appropriate sanction, including terminating agreements with participating ACOs.

*CMS Innovation Center*
Section Summary: The Chairman's Mark would require the Secretary to create an Innovation Center within the Centers for Medicaid and Medicare Services (CMS). The Innovation Center will be a new office established within CMS that is authorized to test, evaluate, and expand different payment structures and methodologies which aim to foster patient-centered care, improve quality, and slow the rate of Medicare cost growth. The Mark would also make permanent the authority granted to the Secretary under Section 646 of the MMA (section 1866C of the Social Security Act).

The Center would be required to conduct an evaluation of each model tested, including an analysis of the extent to which the model results in: (1) coordination of health care services across treatment settings; (2) reduction of preventable hospitalizations; (3) prevention of hospital readmissions; (4) reduction of emergency room visits; (5) improvement in quality and health outcomes; (6) improvement in the efficiency of care; (7) reduction in the cost of health care services covered under this title; and (8) achievement of beneficiary and family-caregiver satisfaction.

In order to facilitate the timely design, implementation, and evaluation of payment models by the Center, the Mark exempts the Center from budget-neutrality requirements for an initial testing period. The Center would be given the authority to terminate or modify the design of models at any time during a testing period.

To support its work, including the Center's evaluation component, the Center would be required to consult regularly with outside experts and stakeholders, including the Medicare Payment Advisory Commission (MedPAC), health professionals with demonstrated expertise in chronic care management of older adults, and representatives of patients and caregivers.

The Secretary would be given the authority to expand the duration or the scope of any project undertaken by the Center if the Secretary determines that doing so would improve the quality of patient care and reduce the rate of growth of Medicare fee-for-service expenditures. The expected reduction in future Medicare expenditures must be certified by the CMS Office of the Actuary before an expansion could occur.

The Center would be required to test and evaluate patient-centered delivery and payment models. The Center would review models that have shown evidence of success in the Medicare population. The Center would consider models that target beneficiaries who are dually-eligible for both Medicare and Medicaid, and beneficiaries with multiple chronic conditions and at least one of the following: (1) an inability to perform 2 or more activities of daily living; and (2) a cognitive impairment, including dementia.

In addition, the Center would be required to consider for testing, at a minimum, models that achieve at least one of the following criteria:

1. Promote broad payment and practice reform in primary care, including patient-centered medical home models for high-need beneficiaries, medical homes that address women's unique health care needs, and models that transition primary care practices away from fee-for-service based reimbursement and toward comprehensive payment;
2. Contract directly with groups of providers and suppliers to promote innovative care delivery models, such as through risk-based comprehensive payments;
3. Support care coordination for chronically-ill Medicare beneficiaries at high risk of hospitalization through a health IT-enabled network that includes a chronic disease registry, home tele-health technology, and care oversight by the beneficiary's treating physician;
4. Vary payment to physicians ordering advanced diagnostic imaging services according to the physician's adherence to appropriateness criteria for the ordering of such services, as determined in consultation with physician specialty groups and other relevant stakeholders;
5. Utilize medication therapy management services;
6. Establish community-based health teams to support small-practice medical homes by assisting the principal primary care practitioner in chronic care management activities;
7. Fund physician, nurse practitioner, or physician assistant-led home-based primary care programs with demonstrated experience in serving high-cost beneficiaries with multiple chronic illnesses and functional disabilities;
8. Establish a program to assist beneficiaries in making informed health care choices by paying providers for using patient decision-support tools that improve beneficiary and caregiver understanding of their medical treatment options;
9. Allow states to test and evaluate fully integrating care for dually eligible members, including the management and oversight of all Medicare and Medicaid funds for this population;
10. Allow states to test and evaluate systems of all-payer payment reform for medical care of residents in each participating State, including individuals dually eligible for Medicare and Medicaid;
11. Align nationally-recognized, evidence-based guidelines of cancer care with Medicare payment incentives in the areas of treatment planning and follow-up care planning for Medicare beneficiaries with cancer, including the identification of gaps in current quality measures;
12. Improve post-acute care through continuing care hospitals that offer inpatient rehabilitation, long-term care hospital, and home health or skilled nursing care during an inpatient stay and the 30 days immediately following discharge;
13. Fund home health providers who offer chronic care management services to Medicare beneficiaries in cooperation with interdisciplinary teams.

In selecting models for testing, the Secretary shall also consider the extent to which models meet the following criteria:

1. Foster care coordination for high-cost, chronically ill Medicare beneficiaries who are at highest risk for hospitalization or readmission;
2. Place the patient, including family members and other informal caregivers, at the center of the care team;
3. Include, but are not limited to, in-person contact with beneficiaries;
4. Utilize technology, such as electronic health records and patient-based remote monitoring systems, to coordinate care over time;

5. Maintain a close relationship between care coordinators and primary care practitioners;
6. Rely on a team-based approach to interventions such as comprehensive care assessments, care planning, and self-management coaching.

To be approved for expansion, models would be required to demonstrate that they meet patient-centered criteria as determined by the Secretary, such as the use of patient and caregiver assessments or the use of individualized care plans.

Within 18 months of enactment, the Center would be required to post on the CMS website a report on the Center's initial consideration of the models listed above, as well as a detailed plan for the continuing work of the Center.

The Chairman's Mark would appropriate $10 billion from the Part A and Part B Trust Funds to the Center over 10 years. The costs of otherwise uncovered benefits delivered under this authority would be counted against the Center's overall funding level. In addition, the Center would be required to directly allocate a portion of such funding for the Center's evaluation activities.

*Bundled Payment National Pilot Project*
Section Summary: The Secretary would be required to develop, test and evaluate alternative payment methodologies through a national, voluntary pilot program that is designed to provide incentives for providers to coordinate patient care across the continuum and to be jointly accountable for the entire episode of care starting in 2013. If evaluations find that the pilot program achieves goals of improving patient outcomes, reducing costs and improving efficiency, then the Secretary would be required to submit an implementation plan to Congress on making the pilot a permanent part of the Medicare program.

Prior to the start of the pilot program, the Secretary would be required to determine which patient assessment instrument (such as the Continuity Assessment Record and Evaluation, or CARE tool), should be used to evaluate a patient's clinical condition for the purposes of determining the most clinically-appropriate site for post-acute care. The Secretary would be required to work with the Agency for Healthcare Research and Quality (AHRQ) and the qualified consensus-based entity as defined in MIPPA to develop episode of care quality measures and quality measures in compliance with the quality measurement and endorsement procedures laid out in Quality Infrastructure section of this legislation that are applicable to all post acute care (PAC) settings. Finally, the Secretary would be required to determine which Medicare statutory provisions and related regulations would be appropriate to waive in order to conduct the pilot program. The waived requirements might include the three-day inpatient hospital admission prior to Medicare's coverage of a skilled nursing facility admission, the 60 percent compliance threshold necessary to qualify as an inpatient rehabilitation facility, or the 25 average length of stay necessary to qualify as a long term care hospital. The Secretary would be able to waive other requirements such as the anti-kickback or the civil monetary penalty statute after consultation with the Inspector General.

The Secretary would select eight conditions to be included in the pilot program by considering the following factors: (1) a mix of chronic and acute conditions; (2) a mix of surgical and medical conditions; (3) conditions for which there is evidence of opportunity for providers to improve quality of care while reducing total expenditures; (3) conditions with significant variation in readmissions and post acute care spending; (4) conditions

with high-volume or high post acute care spending; and (5) conditions that are deemed most amenable to bundling across spectrum of care given current practice patterns. The pilot program may cover the following services: acute care inpatient hospitalizations; physician services delivered inside and outside of the acute care hospital setting; outpatient hospital services, including emergency department visits; services associated with acute care hospital readmissions; PAC services including home health, skilled nursing, inpatient rehabilitation, long term care hospital; and other services that the Secretary determines appropriate.

The episode of care established in the pilot program would start three days prior to a qualifying admission to the hospital and span the length of the hospital stay and 30 days following the patient discharge, unless the Secretary determines another timeframe is more appropriate for purposes of the pilot. The Secretary would develop policies to ensure the traditional fee-for-service program provides payment for PAC services in the appropriate setting for those patients who require continued PAC services after the 30th day following the discharge.

With respect to payments for the participating providers in the pilot program, the Secretary would test alternative payment methodologies, which would include bundled payments or arrangements in which providers continue to receive reimbursement under current payment systems, but are held jointly accountable for the quality and cost of care provided to Medicare patients. Payments would be adjusted for patient severity of illness and other patient characteristics, including having a major diagnosis of substance abuse or mental illness, resources needed to provide care as well as adjustments for differences in hospital average hourly wages, physician work, practice expense, malpractice expense, and geographic adjustment factors. The pilot program‘s payment methodology would also take into account the provision of services such as care coordination, medication reconciliation, discharge planning and transitional care services and other patient-centered activities as defined appropriate by the Secretary.

The pilot program‘s bundled payment would be made to a Medicare provider or other entity comprised of multiple providers to cover the costs of acute care inpatient and outpatient hospital services, physician services and post-acute care. The comprehensive bundled payment would include the costs of any rehospitalizations that occur during the covered period. The bundled payment for each of the eight selected conditions would be based on the average hospital, physician, and post-acute care payments made over the hospitalization period for patient.

Any Medicare provider, including hospitals, physician groups, or post-acute entities interested in assuming responsibility for the bundled payment would be able to apply to participate in the pilot program. Any entity assuming responsibility for the bundled Medicare payment would be required to have an arrangement with an acute hospital for initiation of bundled services. All services provided under the bundle would be required to be provided or directed by Medicare-participating providers. Eligible entities would receive the bundled payment for each patient served, regardless of whether patient receives certain levels of physician or post acute care.

In those instances a condition selected for the pilot program is also subject to Medicare‘s readmissions policy, hospitals participating in the pilot would be exempt from readmissions penalty for that condition. The bundled payment to a pilot participant would cover any preventable readmissions within the covered period. In the case where a patient with a selected condition is readmitted for a preventable readmission at a

different hospital than the initial hospitalization, the Secretary would reimburse the subsequent hospital its base operating and capital MS-DRG payment amounts and the physicians at the subsequent hospital the amount that would otherwise be made if this policy did not apply. The Secretary would then adjust the bundled payment to recoup these same amounts. This payment correction would not apply to patient readmissions associated with trauma-related, and burn-related diagnoses, and other areas as outlined in the readmissions policy in another section of this legislation and as determined by the Secretary.

The Secretary would be directed to establish quality measures related to care provided across all providers participating in the pilot. These quality measures would be risk-adjusted and would include: episode of care measures; measures of improved functional status; other patient outcomes deemed appropriate by the Secretary; rates of readmission; rates of preventable readmissions as defined in the readmissions policy; rates of return to the community; rates of admission to the ER after hospitalization (as distinctly separate from readmission rates); efficiency measures; measures of patient-centeredness of care; patient perception of care measures; measures to monitor and detect the under provision of necessary care; and other measures deemed appropriate by the Secretary.

The Secretary would be given the authority to delete, revise, and add quality measures as deemed appropriate related to the care being provided to patients within the pilot program. All providers who participate in pilot would be required to report to the Secretary on quality measures during each year of the program. At the discretion of the Secretary, to the extent practicable, these measures would be required to be reported through an electronic health record in a manner prescribed by the Secretary.
The Secretary would be required to conduct an independent evaluation of the pilot program and submit reports to Congress no later than two and three years after date of the implementation of the pilot program. The evaluation would include an examination of the extent of performance improvement related to quality measures, health outcomes, access to care and financial outcomes.

The Secretary would consult with representatives of small and rural hospitals, including critical access hospitals (CAHs), to determine appropriate and effective methods for hospitals to participate in the pilot program or in a similar pilot program. The Secretary would consider innovative methods of implementing bundling in these hospitals, including the challenges associated with the small volume of services provided to Medicare beneficiaries by these hospitals and potential lack of access to certain post-acute services in some communities. Not later than two years after the date of enactment of this Act, the Secretary would submit to Congress a report on the results of this consultation including recommendations with the respect to the appropriate application of bundling to small and rural hospitals, including CAHs.

If the Secretary finds that the pilot program results in significant improvements in quality and outcomes and reductions in cost, then the Secretary would be required to submit an implementation plan to Congress in FY2016 with recommendations regarding making the pilot a permanent part of the Medicare program in FY2018. If the Secretary finds that the pilot program did not result in significant improvements in quality and outcomes or reductions in cost, the Secretary would be required to submit a report to Congress in FY2016 providing recommendations on how the pilot could have been improved to address these shortcomings. In the event the Secretary determines that the pilot program results in significant improvements in quality and outcomes and reductions in

cost, the Secretary may extend the pilot program for those who participated in the pilot for a duration deemed appropriate by the Secretary. This extension will allow current participants to remain in the program absent any further action by Congress to further expand the program.

*Reducing Avoidable Hospital Readmissions*
Section Summary: CMS would calculate national and hospital-specific data on the readmission rates of Medicare participating subsection (d) hospitals and for hospitals paid under section 1814 (b)(3) for eight conditions that the Secretary selects based on spending and readmission rates. Starting in FY 2012, the Secretary would share these data with hospitals, and the data would be publicly reported on the Hospital Compare website. Starting in FY 2013, hospitals with readmission rates above a certain threshold would have payments for the original hospitalization reduced by 20 percent if a patient with a selected condition is re-hospitalized with a preventable readmission within seven days and by ten percent if a patient with a selected condition is re-hospitalized with a preventable readmission within 15 days.

Preventable readmissions would be defined as all readmissions that could have been reasonably prevented, as determined by the Secretary. Certain readmissions that would be excluded from the definition as follows: (1) readmissions associated with metastatic malignancies, trauma, and burns; (2) planned readmissions; (3) readmissions for patients with discharge status of —left against medical advice; and (4) patients who are transferred to another short-term acute care hospital.

According to a methodology that would be determined by the Secretary, which may include using condition-specific measures endorsed by the National Quality Forum, CMS would calculate a national preventable readmissions benchmark by condition. Each condition would be based on a weighted average of all DRGs related to each condition. CMS would also calculate a hospital-specific preventable readmissions rate by calculating preventable readmissions rates for each of the above conditions that a hospital treats. Calculations would be risk adjusted for patient‘s severity of illness, other patient characteristics, including having a major diagnosis of substance abuse or mental illness, and differences in case types.

Hospitals with readmissions above the 75th percentile (based on 30 day rates) for selected conditions would be subject to readmissions payment policy related to the selected conditions. Calculation of percentiles would be based on prior year‘s performance. For example, if a hospital is subject to the policy in 2009, and then in 2010 is under the 75th percentile, it would not be subject to the policy in 2011. A hospital above the 75th percentile would incur the 20 percent penalty for the original admission only after it is determined that a preventable readmission occurred within seven days of discharge from the original admission. A ten percent penalty for the original admission would be imposed only after it is determined that a preventable readmission occurred within 15 days of discharge from the original admission. CMS would be required to implement these edits through its claims processing systems so that a readmission to a hospital different than the hospital of the original admission would result in the application of the policy to the original hospital.

Three years after implementation of the readmissions policy, the Secretary would have the authority to expand the policy to other conditions. Additional conditions would be selected based on: (1) high spending on readmissions or high rates of readmissions; and (2) other criteria as determined by the Secretary.

*Primary Care/General Surgery Bonus*
Section Summary: The Chairman's Mark would establish a new ten percent bonus on select evaluation & management codes under the Medicare fee schedule for five years, beginning January 1, 2011. The groups of codes to which this bonus would apply would be office visits, home visits, nursing facility visits, and domiciliary, rest home (e.g. boarding home), or custodial care services.

The bonus would be available to primary care practitioners who: (1) have a specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine (or are an advanced practice nurse or physician assistant); and (2) furnish 60 percent of their services in the select codes. Services provided to both established patients and new patients would qualify. Qualifying practitioners providing care in a HPSA would also receive the 10 percent bonus on hospital visit codes that are typical of primary care medicine (as determined by the Secretary), though only ten percent of these visits would count toward the 60 percent threshold.

In addition, general surgeons providing care in a HPSA would also be eligible for a ten percent bonus on major procedure codes for five years, beginning January 1, 2011. Half (50 percent) of the cost of the bonuses would be offset through an across-the-board reduction to all other codes, except for physicians who primarily provide services in a HPSA zip code.

*Redistribution of Unused GME slots to Increase Access to Primary Care and Generalist Physicians*
Section Summary: Similar to the proposal set forth in the MMA, the Chairman's Mark would establish a policy to redistribute currently unused residency training slots as a way to encourage increased training, particularly in the areas of primary care and general surgery. In this provision, the Centers for Medicare and Medicaid Services (CMS) would calculate the number of unused resident slots over the last three fiscal years. Unused slots would be defined as the difference between total available resident slots and a hospital's actual FTE of residents. Based on this calculation, 80 percent of unused slots would be included in a pool for redistribution. Rural teaching hospitals with less than 250 beds would be exempt from the redistribution of any of their unfilled positions. Certain other hospitals who participated in a voluntary reduction plan under Section 1886 (h)(6) would also be exempt from the redistribution policy if they demonstrate that they have a specified plan in place for filling the unused residency positions within two years of enactment of this legislation.

The Secretary would be required to increase the otherwise applicable resident limit for each qualifying hospital that submits a timely application by such number determined by the Secretary. The aggregate number of increases in resident limits would be equal to the estimated aggregate reduction in resident limits. A hospital that receives an increase in its otherwise applicable resident limit would be required to ensure that (1) the number of FTE residents in a primary care residency as determined by the Secretary is not less than the average number of FTE residents in a primary care residency during the three most recent cost reporting periods ending prior to the date of enactment; and (2) that not less than 75 percent of the positions attributable to such an increase are in a primary care or general surgery residency. A hospital that does not meet this requirement would have its otherwise applicable resident limit reduced by the amount of the increase authorized under this provision. Those positions would be subsequently distributed according to the priorities established in this provision.

When determining the increase in a hospital's otherwise applicable resident limit, the Secretary would take into account the demonstrated likelihood that: (1) a hospital would fill the positions within the first three cost reporting periods beginning on or after July 1, 2010; (2) a hospital would take part in an innovative delivery model that promotes quality and care coordination, such as payment bundling; and (3) a hospital would have an accredited rural training track residency program. The Secretary would distribute the increase in the otherwise applicable resident limit based on the following factors: (1) to hospitals located in states with resident to population ratios in the lowest quartile; (2) to hospitals located in a state that is among the top 25 states in terms of the ratio of the total population living in a health professional shortage area (HPSA) determined by the U.S. Department of Health and Human Services compared to total population of the state based on the most recent state population projections by the U.S. Census Bureau; and (3) to hospitals located in rural areas.

Hospitals would not be permitted to apply for more than 75 additional FTE residency positions under this provision, unless the number of residency positions exceed the number of approved applications for such positions. The increase in resident positions would be distributed no later than two years after the date of enactment.

The per resident amounts (PRAs) for the resident positions distributed under this provision would equal the hospitals PRAs for primary and non-primary care positions for the purposes of calculating direct graduate medical payments. The indirect medical education adjustment for the resident positions distributed under this provision would reduce the formula multiplier in the IME adjustment factor by 50 percent.

*Promoting Greater Flexibility for Residency Training Programs*
Section Summary: In order to promote training in outpatient settings and to ensure the availability of residency programs in rural and underserved areas, this policy would provide increased flexibility in laws and regulations governing graduate medical education funding in the Medicare program. Specifically, effective for cost reporting periods beginning on or after July 1, 2010, all time spent by a resident would count toward Medicare direct graduate education payment, without regard to the setting where the activities are performed, if the hospital continues, or in the case of a jointly operated residency program, the involved entities continue to incur the costs of the stipends and the fringe benefits of the resident during the time the resident spends in the setting.

Effective for discharges on or after July 1, 2010, all the time spent by a resident in patient care activities in a nonhospital setting would be counted towards Medicare indirect medical education payment if the hospital continues, or in the case of a jointly operating residency training program, the entities continue to incur the costs of the stipends and fringe benefits of the resident during the time spent in that setting.
An eligible training site would be an ambulatory or outpatient training site. A jointly operated residency training program means an approved medical residency training program that is jointly operated by one or more hospitals or by one or more eligible training sites under a written agreement which specifies a method for an equitable distribution of time spent by the resident in activities relating to patient care.
Each hospital or eligible training site participating in the operation of a jointly operated residency training program would submit the written agreement to the Secretary. In the case of a jointly operated residency training program, the direct graduate medical education and the indirect medical education payments would not exceed the aggregate

payments that would have been made to the hospitals and the eligible training sites if the training program had been independently operated.

*Rules for Counting Resident Time for Didactic and Scholarly Activities and Other Activities*
Section Summary: When calculating DGME payments, Medicare would count the time that residents in approved training programs spend in certain non-patient care activities in a nonhospital setting that is primarily engaged in furnishing patient care. Reimbursable non-patient care activities would include didactic conferences and seminars but would not include research that is not associated with the treatment or diagnosis of a particular patient. In addition, Medicare would count all the vacation, sick leave and other approved leave spent by resident in an approved training program as long as the leave time does not extend the program‘s duration.

When calculating IME payments, Medicare would adopt the same rules about counting residents‘ leave time. Medicare would also include all the time spent by residents in approved training programs on certain non-patient care activities (including didactic conferences but not certain research) that occurs in an acute care hospital or in a provider-based hospital outpatient department. These provisions would be effective as of dates determined appropriate by the Secretary.

*Preservation of Resident Cap Positions from Closed and Acquired Hospitals*
Section Summary: The Secretary would promulgate regulations to establish a process where the residency allotments in a hospital with an approved medical residency program that closes could be used to increase the otherwise applicable residency limit for other hospitals. The increase in residency positions would be distributed in the following priority order. First priority would be given to hospitals located in the same or contiguous core-based statistical area as the hospital that closed; second priority would be given to hospitals located in the same State as the hospital that closed; third priority would be given to hospitals located in the same region of the country as the hospital that closed; and fourth priority, to be used only if the residents are not distributed under the other priorities, would be the priorities established for the distribution of additional residency positions established previously in this legislation. The residency positions would be distributed to those hospitals that demonstrate a likelihood of filling the position within three years.

A special rule for acquired hospitals would be established. Specifically, when a hospital is acquired through any mechanism by another entity with approval of a bankruptcy court during a period determined by the Secretary, but not less than within three years, the applicable resident limit of the acquired hospital would be the limit of the acquired hospital as of the date immediately before the acquisition without regard to whether the acquiring entity accepts assignment of the Medicare provider number of the hospital that was acquired. The acquiring entity would be required to continue operation of the hospital that was acquired and to furnish services, medical residency programs, and the volume of patients similar to those of the hospital that was acquired during such period. These provisions would not affect any temporary adjustment to a hospital‘s FTE resident cap established under 42 CFR 413.79 as in effect on the date of enactment.
The provisions would not be implemented in a manner that would require reopening of any settled hospital cost report where there is not a jurisdictionally proper appeal pending on Medicare‘s IME and DGME payments as of the date of enactment.

*Proposal on Development of a National Workforce Strategy*

Section Summary: Several studies and policy experts have called for a renewed effort to develop a comprehensive and coordinated national strategy to address workforce shortages and encourage training in key focus areas that support delivery system reform goals, such as improving care coordination, health provider use of health information technology and increasing access to primary care services. Some recommendations have promoted, at minimum, a need to provide additional resources to support the workforce-related activities of CMS and HRSA and to encourage increased collaboration among these agencies. Others have called for the establishment of a national workforce commission that would be tasked with advising Congress and the Secretary on health care workforce policy and recommendations.

To achieve these goals, the Secretary would create a Workforce Advisory Committee. The Committee would be comprised of external stakeholders and representatives of health professionals, schools of higher education for health care professionals, public health experts, health insurers, business, labor, state or local workforce investment boards, and any other health professional organization or practice the Secretary determines appropriate.

These stakeholders would develop and present a national workforce strategy to the Secretary and the Congress that will set the nation on a path toward recruiting, training and retaining a health workforce that meets the nation‘s current and future health care needs. In developing this strategy, the Committee would consult closely with relevant Federal agencies such as HRSA and the Veterans Administration to avoid duplication of effort and to review government wide Federal workforce policies. The Committee would also consult with state and local entities. The Committee would present biannual reports to Congress, relevant Federal agencies, and the public outlining its findings and policy recommendations. Specifically, the committee will examine the current and projected health care workforce supply; the current and projected demand for health professionals; the health care workforce education training capacity; the implications of new and existing Federal policies which will affect the health care workforce; and finally the health care workforce needs of specific populations, including minorities, rural and urban populations, and medically underserved populations.

In addition, the committee would report on specific high-priority topics including efforts to integrate the health care workforce into a reformed delivery system, the implications for the health care workforce as a result of greater utilization of health information technology, nursing workforce capacity, mental and behavioral health care workforce capacity, and the geographic distribution of health care providers.

*Demonstration Project to Address Health Professions Workforce Needs*
Section Summary: The Chairman's Mark establishes demonstration grants to address needs in the health professions workforce. It would establish a demonstration grant program through competitive grants to provide aid and supportive services to low-income individuals with the opportunity to obtain education and training for occupations in the health care field that pay well and are expected to experience labor shortages or be in high demand. These grants would be made by the Secretary of Health and Human Services, in consultation with the Secretary of Labor, to states, Indian tribes, tribal organizations, institutions of higher education, local workforce investment boards under the Workforce Investment Act, or community-based organizations. At least three grants must be awarded to an Indian tribe, Tribal organization, or Tribal College or University. Grantees must consult with the state agency administering the Temporary Assistance for Needy Families (TANF) block grant, and, if the grantee is not a local workforce investment board, consult with local and state workforce investment boards.

The demonstration grant is to serve low-income persons, including recipients of assistance under state Temporary Assistance for Needy Families (TANF) programs. The demonstration program shall provide eligible individuals, if appropriate, with financial aid; child care, case management; and supportive services. Financial aid received shall not be considered income, and shall be disregarded in determining eligibility for TANF, Medicaid, the Supplemental Nutrition Assistance Program (SNAP), Low Income Home Energy Assistance Program, and any program administered by the Department of Housing and Urban Development.

Grantees must submit interim reports and a final report to the Secretary of HHS on their activities, which will assess the projects' effectiveness in improving outcomes for participants and address health professions workforce needs in the project areas. The Secretary of HHS must evaluate the demonstration project. The evaluation will identify successful activities for creating and sustaining a health professions workforce that has accessible entry meets, meets high standards for education, training, certification and professional development; and provides increased wages, health care coverage, and other benefits for the workers. The Secretary of HHS shall submit interim and final reports on the demonstration to Congress.

The Chairman's Mark also establishes a demonstration program to competitively award grants to up to six states for three years to develop core training competencies and certification programs for personal and home care aides.

In selecting states to participate, the Secretary will establish criteria to ensure geographic and demographic diversity. In addition, a state must offer medical assistance for personal care services under its Medicaid state plan, not reduce the number of hours of training from pre-demonstration levels or below levels required by state or federal law; and recruit a minimum number of health and long term care providers to participate in the project. Participating states must demonstrate that their existing training standards are different from other states and different from the competencies described in the demonstration.

The demonstration will determine the efficacy of developing core training competencies in the following areas: the role of the personal or home care aid; consumer rights, ethics, and confidentiality; communication, cultural, and linguistic competence and sensitivity, problem solving, behavior management, and relationship skills; personal care skills; health care support; nutritional support; infection control; safety and emergency training;

training specific to an individual consumer‘s needs; and self-care. The project will also evaluate the methods used to implement these competencies including: length of training; appropriate student to trainer ratio; time spent in the classroom compared to on-site; trainer qualifications; content for hands-on training and written certification exam; and continuing education requirements.

The Secretary of Health and Human Services will develop an experimental or control group testing protocol, in consultation with an independent evaluation contactor, to evaluate the impact of core training competencies on: job satisfaction; mastery of job skills; beneficiary and family satisfaction with services; and on existing training infrastructure and resources of the States. The evaluation must also address whether a minimum number of hours of initial training should be required for personal or home care aides. The Secretary will make an interim report to Congress within two years after enactment and a final report within a year of completion of the demonstration project. The Chairman‘s Mark appropriates $85 million per year for five years (FY2010-FY2014) for these demonstrations, with no more than $5 million per year for three years (FY 2010-FY2012) allowed for the personal and home care aid demonstration.

## SUBTITLE B – IMPROVING MEDICARE FOR PATIENTS AND PROVIDERS

*Sustainable Growth Rate*
Section Summary: The annual update to the conversion factor used in the determination of the Medicare fee schedule would be a 0.5 percent increase in 2010. The conversion factor for 2011 and subsequent years would be computed as if the increase in 2010 had never applied.

*Extension of Floor on Medicare Work Geographic Adjustment*
Section Summary: The Chairman‘s Mark would extend the 1.00 floor for the geographic index for physician work for an additional two years through December, 2012.

*Misvalued Relative Value Units (RVUs)*
Section Summary: The Secretary would be required 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. For purposes of identifying potentially misvalued services, the Secretary shall examine codes for which there has been the fastest growth; codes that have experienced substantial changes in practice expenses; codes for new technologies or services after the relative values are initially established for such codes; multiple codes that are frequently billed in conjunction with furnishing a single service; codes with low relative values, particularly those that are often billed multiple times for a single treatment; codes which have not been subject to review since the implementation of the RBRVS; and such other codes determined to be appropriate by the Secretary. Adjustments to misvalued procedures would be subject to budget neutrality requirements.

*MedPAC Study on Adequacy of Medicare Payments for Health Care Providers Serving Rural Areas*
Section Summary: The Chairman‘s Mark would require MedPAC to review payment adequacy for rural health care providers serving the Medicare program and provide a report to Congress by January 1, 2011.
*Improving the Coverage Gap in Medicare Part D*

Section Summary: The Chairman's Mark would establish a discount program for beneficiaries who enroll in Part D and have drug spending that falls into the coverage gap.

## SUBTITLE E – ENSURING MEDICARE SUSTAINABILITY

*Medicare Commission*
Section Summary: The Chairman's Mark would establish an independent Medicare Commission that would develop and submit proposals to Congress aimed at extending the solvency of Medicare, slowing Medicare cost-growth, and improving the quality of care delivered to Medicare beneficiaries. The Commission would be composed of 15 members, who would be appointed by the President and confirmed by the Senate. The Senate Majority Leader, the Speaker of the House, the Senate Minority Leader, and the House Minority Leader would each present three recommendations for appointees to the President; however, these recommendations in no way would limit the President's ultimate responsibility to present Congress with qualified nominees. Qualifications for members of the Commission would be similar to the qualifications required for members of the Medicare Payment Advisory Commission (MedPAC). Members of the Commission would serve six-year, staggered terms and would continue to serve until replaced.

MedPAC would continue to exist in its current form as an advisory body to Congress. The Commission would be tasked with presenting proposals to Congress that would reduce Medicare spending by targeted amounts compared to the trajectory of Medicare spending under current law. The scope of proposals presented to Congress should (1) to the extent feasible, target reductions to sources of excess cost growth; (2) to the extent feasible, improve the health care delivery system, including the promotion of integrated care, care coordination, prevention and wellness and quality improvement; (3) to the extent feasible, protect beneficiary access to care, including in rural and frontier areas; (4) to the extent feasible, consider the effects of benefit changes on beneficiaries; (5) to the extent feasible, consider the effects of proposals on any provider who has, or is projected to have, negative profit margins; and (6) not impact providers scheduled to receive a reduction to their inflationary payment updates in excess of a reduction due to productivity in a year in which the Commission's proposals would take effect. The Commission would be prohibited from presenting proposals that would ration care, increase revenues, or otherwise change Medicare cost-sharing, benefits, or eligibility standards.

Beginning with the 2013 report of the Medicare Trustees, the Chairman's Mark would require the CMS Office of the Actuary (OACT) to project whether the Medicare per-capita growth rate in 2015 will exceed the average of the growth rates in the Consumer Price Index (CPI) and the Consumer Price Index for medical care (CPI-M) projected for 2015. The Medicare per-capita growth rate would be calculated as the five-year moving average of Medicare spending (Parts A, B, and D) per unduplicated enrollee, ending with the projection for the year in which the Commission's proposals would apply. This projection would be made without regard to the physician fee schedule update, and would take into account any delivery system reforms or other payment changes that have been enacted, are scheduled to be enacted, or published as a final rule but have not been implemented at the time of the analysis.

If the projected excess cost growth is estimated to be greater than the average of CPI and CPI-M, the Commission would be required to submit a proposal to Congress by

January 1, 2014 that would reduce excess cost growth by 0.5 percentage points in 2015, as estimated by OACT. If excess cost growth is projected to be less than 0.5 percentage points (or the equivalent reduction in future years), then the Commission would be required to submit a proposal that eliminates excess cost growth, as certified by OACT. The Chairman‘s Mark would also require that the Commission‘s proposals are certified by OACT to not increase spending within the following ten-year budget window.
If the Commission fails to submit a proposal by the January 1st deadline that meets the requirements described above, the Secretary of HHS would be required to submit a proposal to Congress that would achieve the same reduction in excess cost growth (as certified by OACT) by no later than January 5, 2014. The Secretary‘s proposal would be subject to the same scope and requirements as the Commission.

The Commission would be required to submit a draft of its proposal to MedPAC and CBO by September 1, 2013. Once the proposal is submitted to Congress, MedPAC would be required to review and present its analysis of the Commission‘s (or Secretary‘s) proposal no later than February 1, 2014. By April 1, 2014, the Senate Finance Committee, along with the relevant House Committees, would be required to report out either the Commission‘s (or Secretary‘s) proposal or an amended proposal that achieves the same level of reductions in excess cost growth. Policy changes extraneous to Medicare would be prohibited and would be stricken from the proposal. If a committee fails to report a legislative package achieving the targeted level of Medicare savings by April 1st, the Commission‘s (or Secretary‘s) package would be automatically discharged from that committee.

The Chairman‘s Mark would require the package be brought to the floor within 15 days of being reported or discharged from a committee. In the Senate, the package would be subject to 30 hours of debate. Only budget-neutral and germane amendments would be considered in order. Once passed by both chambers, the conference report would be subject to 10 hours of debate in the Senate. If a package that meets the level of Medicare savings described above is not enacted into law by August 15, 2014, the Chairman‘s Mark would require the Commission‘s (or Secretary‘s) original proposal to go into effect automatically.

Changes implemented as a result of this provision would not be subject to administrative or judicial review.

*Patient-Centered Outcomes Research Institute (the “Institute”)*
Section Summary: The Chairman‘s Mark would authorize the establishment of a private, non-profit corporation that would be known as the —Patient-Centered Outcomes Research Institute. The purpose of the Institute would be to assist patients, clinicians, purchasers, and policy makers in making informed health decisions by advancing the quality and relevance of clinical evidence through research and evidence synthesis. The research would focus on the manner in which diseases, disorders, and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed, and would consider variations in patient subpopulations. Research conducted would compare the clinical effectiveness, risk and benefits of two or more medical treatments, services or items. The Mark would define treatment, services and items as: health care interventions, protocols for treatment, care management and delivery, procedures, medical devices, diagnostics tools, pharmaceuticals (including drugs and biological), and any strategies or items used in the treatment, management, and diagnosis of, or prevention of illness or injury, in patients.

The Institute would also disseminate their research findings. The Institute would be subject to the provisions specified below and, to the extent consistent with the Chairman‘s Mark, to the District of Columbia Non-Profit Corporation Act.

*Sense of the Senate Regarding Medical Malpractice*
Section Summary: The Chairman‘s Mark would express the Sense of the Senate that health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance. The Mark would further express the Sense of the Senate that states should be encouraged to develop and test alternatives to the current civil litigation system as a way of improving patient safety, reducing medical errors, encouraging the efficient resolution of disputes, increasing the availability of prompt and fair resolution of disputes, and improving access to liability insurance, while preserving an individual‘s right to seek redress in court. The Mark would express the Sense of the Senate that Congress should consider establishing a state demonstration program to evaluate alternatives to the current civil litigation system.

*Imaging Self-referral Sunshine*
Section Summary: The in-office ancillary exception would include a requirement that with respect to magnetic resonance imaging, computed tomography, positron emission tomography, and any other designated health services as determined by the Secretary, the referring physician must inform the individual at the time of the referral that the individual may obtain the services from a person other than the referring physician, a physician who is a member of the same group practice as the referring physician, or an individual who is directly supervised by the physician or by another physician in the group practice. The individual must be provided with a written list of suppliers who furnish services in the area in which the individual resides. This new requirement would apply to services furnished after January 1, 2010.