Medicare Program Changes in H.R. 3200, America's Affordable Health Choices Act of 2009

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Summary

Containing scores of provisions affecting Medicare payments, payment rules and covered benefits, H.R. 3200 treats the Medicare program as both a funding source for health insurance reform and a tool to shape future changes in the way that health services are paid for and delivered. Preliminary estimates from CBO on the introduced bill indicate that, absent interaction effects, net reductions in Medicare direct spending may approach $50.5 billion from 2010-2014 and $210.6 billion from 2010-2019. Major savings are expected from constraining Medicare's annual payment increases, linking payments for Medicare Advantage plans to fee-for-service payments, and requiring drug manufacturers to provide drug rebates for certain low income Medicare beneficiaries. These savings are offset by increased physician payments necessary to reform the sustainable growth rate formula among other physician payment changes.

With respect to reshaping health care delivery, H.R. 3200 would provide financial incentives to acute care and critical access hospitals to reduce potentially preventable readmissions and to improve care coordination starting in FY2012. These policies would be extended to post acute care providers starting in FY2015. Another provision would require the Secretary to develop a detailed plan to bundle payments for post acute care services within 3 years of enactment. Also, by January 1, 2011, the existing physician-hospital bundled payment demonstration would be converted to a pilot program and expanded to include post acute services.

H.R. 3200 would alter Medicare payments to a range of providers, physicians, practitioners and suppliers. Certain provisions address more systemic issues, such as increasing physician payments for preventive services. Others provisions are time-limited extensions of existing payment policies, such as 2-year extensions to Section 508 hospital reclassifications, the physician geographic floor, and rural ambulance add-ons. H.R. 3200 would also change the regulation of providers. For instance, Medicare providers would be subject to enhanced screening and oversight in areas designated as high risk for fraud and abuse. Additionally, the Stark whole hospital and rural exceptions for physician-owned hospitals would be eliminated except for those existing physician-owned hospitals that qualify for an exception.

Finally, provisions in H.R. 3200 would improve Medicare benefits provided to individuals. For instance, the Medicare Part D coverage gap for prescription drugs (the donut hole) would be eliminated; certain low income subsidies would be amended by changing Medicare's asset test.

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Introduction

On July 14, 2009, H.R. 3200, the Affordable Health Care Act of 2009 was introduced into the three Committees in the House of Representatives with jurisdiction over health policy (Committees on Education and Labor, Ways and Means, and Energy and Commerce).[1] The proposed legislation with different amendments has been passed out of the full Committees of Education and Labor (on July 17, 2009), Ways and Means (on July 16, 2009) and the Energy and Commerce Committee (on July 31, 2009). Containing scores of provisions affecting Medicare payments, payment rules and covered benefits, H.R. 3200 treats the Medicare program as both a funding source for health reform and a tool to shape future changes in the way that health services are delivered. Preliminary estimates from the Congressional Budget Office (CBO) on the bill initially introduced to the Committees indicates that, absent interaction effects, net reductions in Medicare direct spending may approach $50.5 billion from 2010-2014 and $210.6 billion from 2010-2019.

The proposed legislation includes 3 divisions; Division B contains the changes to the Medicare and Medicaid programs. This report will discuss all of the proposed changes included in Titles I, and VI and selected provisions in Titles II, III, and IX of Division B in H.R. 3200 concerning payment and program modifications to Medicare's fee-for-service program, its prescription drug benefit, and the Medicare Advantage (MA) program; efforts to reform Medicare's payment methods, program integrity changes to address fraud waste and abuse, and other miscellaneous Medicare changes. Provisions that would modify Medicare's graduate medical education payments to teaching hospitals, its preventive care benefits, its quality measurement efforts, and other public health initiatives are not covered.[2] The body of this report will include a discussion of the financial impact on the Medicare program by H.R. 3200 that the CBO established (the CBO score), then provide an overview of Medicare changes by provider type and program, followed by a brief discussion of the program integrity changes.[3] **Appendix: Selected Medicare Provisions in Division B of H.R. 3200** provides a brief current law description, explanation of the proposed change, and where possible, the CBO score for most of the Medicare provisions in H.R. 3200.

Congressional Budget Office (CBO) Score

On July 17, 2009, the CBO and the staff of the Joint Committee on Taxation completed a preliminary analysis of H.R. 3200, as introduced on July 14, 2009.[4] As explicitly stated by CBO, its estimates were based on specifications provided by Committee staff rather than by detailed analysis of legislative language. The estimates do not include certain administrative costs that would be incurred by the government to implement the changes or H.R. 3200's impact on other

[1] H.R. 3200 has also been referred to House Budget and House Oversight and Government Reform Committees.

[2] Those provisions are discussed in CRS Report R40745, *Public Health, Workforce, Quality, and Other Provisions in H.R. 3200*, coordinated by C. Stephen Redhead and CRS Report R40741, *End-of-Life Care Provisions in H.R. 3200*, by Kirsten J. Colello.

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

[4] The analysis does not reflect any changes made after that date. Changes that were made after July 14, 2009 discussed in this report will be explicitly noted as such.

federal programs.[5] Also, additional provisions added by the Energy and Commerce Committee were not scored.

CBO estimates that the provisions in H.R. 3200 that would affect the Medicare, Medicaid, Children's Health Insurance and other federal programs would reduce direct spending by $219 billion over the FY2010-FY2019 period.[6] Of this total, Medicare (absent interaction affects) accounts for $210.7 billion of the reduction. Spending reductions are offset by spending increases. Medicare reductions in direct spending over the 10-year period are estimated to be $495.8 billion, offset by Medicare payment increases of $285.1 billion. As noted by CBO, the provisions that would result in the largest savings are:

- Permanent reductions in the annual updates to Medicare's fee-for-service payment rates (other than physicians' services) would account for an estimated budgetary savings of $196 billion over 10 years.[7]
- Using per-capita spending in fee-for-service Medicare to set rates for MA plans would account for an estimated $156 billion (before interactions) over 10 years; and
- Changing the drug rebate program and expanding drug coverage in Medicare's prescription drug program (Medicare Part D) would account for an estimated $30 billion in savings over the period.

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

Payment Rate Changes Affecting Medicare Fee-for-Service Providers

Medicare is a federal program that pays for covered health services for most persons 65 years of age and older and for most permanently disabled individuals under the age of 65. It consists of

[5] The CBO score can be found at http://www.cbo.gov/ftpdocs/104xx/doc10464/hr3200.pdf

[6] The estimated overall effect of the proposed legislation is a net increase in the federal budget deficit of $239 billion over the FY2010-FY2019 period. The projected 10-year cost of increasing insurance coverage of $1,042 billion is offset by the net spending decrease of $219 billion and by revenue provisions that are estimated to raise $583 over the same period.

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

[8] See http://corker.senate.gov/public/index.cfm?FuseAction=Files.View&FileStore_id=ad911e30-d2e2-43ae-9261-ae1ebf6626b3 accessed 9/9/2009 for a copy of the letter.

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

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

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

In June of each year, MedPAC issues another report to Congress examining more systemic issues affecting the Medicare program and making recommendations to increase Medicare's value, to promote its efficiency or payment accuracy, or to realign Medicare's payment incentives.[14] Most recently, for example, MedPAC has stated that Medicare's payment systems do not provide incentives to produce appropriate, high-quality care at an efficient price. Rather, Medicare's incentives, particularly in its fee-for-service program, reward excessive care and do not encourage

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

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

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

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

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

service coordination or quality care.[15] Often considered as part of regulatory and legislative changes to the program, MedPAC's recommendations concerning Medicare are not binding and are not automatically implemented. To differing extents, their analyses and recommendations have shaped provisions in H.R. 3200; where possible, that influence will be noted, particularly in the appendix to this report.

Hospitals and Other Part A Providers

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

Acute Care Hospitals

Generally, the provisions of H.R. 3200 affecting Medicare's payments to acute care hospitals would constrain payment increases to these hospitals, restructure payments to address treatment inefficiencies, and then reshape Medicare's disproportionate share hospital (DSH) hospital subsidies. Also, the exception which permits physicians with ownership interests in a hospital to refer Medicare and Medicaid patients to that hospital would be eliminated for new physician-owed hospitals or those that did not meet certain criteria.

Specifically, H.R. 3200 would adjust Medicare's annual payment updates to Part A providers to account for economy-wide productivity increases for cost savings estimated to be $132.9 billion (of the $196 billion total savings attributed to limits all Medicare's fee-for-service payment updates mentioned earlier) over 10 years. Under current law, the market basket component of the physician update or the Medicare economic index (MEI) is adjusted to exclude productivity gains. This provision uses the same measure of productivity improvement, the 10-year moving average of all-factory productivity, that is included in the MEI. Savings from extending this policy to acute care hospitals was not separately identified.

Under Medicare's current inpatient prospective payment system (IPPS), acute care hospitals receive a full payment for patient admissions even if the readmission is preventable and related to the initial admission, the result of inadequate discharge planning at the treating hospital, or results from inadequate post-discharge care coordination. MedPAC estimated that readmissions resulted in $15 billion in additional Medicare expenditures in FY2007; however, this estimate includes readmissions that may not have been related to the initial diagnosis, those that may not have been preventable, where patients experienced complications or those caused by factors beyond the hospitals' control. As explained in the appendix, this provision would reduce payments for acute care hospitals with excessive readmission rates relative to their expected readmission rate. CBO has estimated this provision as saving $19.1 billion over a 10-year period.[16]

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

[16] See Option 31, Reduce Medicare Payments to Hospitals with High Readmission Rates, in CBO's *Budget Options*, (continued...)

Since 1986, an increasing number of hospitals have received additional Medicare payments because they serve a disproportionate share of low-income patients. The justification for this subsidy has changed over time. Originally, the DSH adjustment was intended to compensate hospitals for their higher Medicare costs associated with the provision of services to a large proportion of low-income patients. Now, the adjustment is considered as a way to protect access to care for Medicare beneficiaries. H.R. 3200 would reduce hospitals' DSH payments starting in FY2017 contingent upon a reduction in the number of uninsured individuals of eight percentage points from 2012-2014. A hospital with higher levels of uncompensated care would receive additional payments. CBO has estimated that this policy would save $10.2 billion from FY2017 to FY2019.

Skilled Nursing Facilities (SNFs)

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

In the final rule published on Friday, July 31, 2009, CMS describes its proposal to recalibrate the case mix indexes to better account for the resources used in the care of the medically complex and to improve upon its payment refinements made in 2006. According to CMS, the total impact of these changes for FY 2010, accounting for a MB increase of 2.2 percentage points, would be a decrease in Medicare payments to SNFs of 1.1% (or $360 million) below FY 2009 payments. Some individual providers could experience larger decreases in payments than others due to case-mix utilization. The proposed PPS and Consolidated Billing SNF payment regulation for FY 2010, describes how the Secretary would recalibrate the case-mix indexes (CMIs) for 2010 to more accurately match the service needs of beneficiaries.

Although MedPAC finds that Medicare payments to SNFs overall are adequate, it has raised concerns about the efficiency of the payment categories pertaining to nontherapy ancillary (NTA) services (e.g., prescription drugs, medical equipment and supplies, IV therapy) and therapy services. To better account for SNF stays with exceptionally high ancillary care needs, MedPAC recommends, in a June 2009 letter to the Secretary[17] and its *March 2009 Report*,[18] that the

(...continued)

Volume I, Health Care, December, 2008, pp. 64-65 for additional information.

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

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

Secretary revise the PPS by separating payments for NTA from the bundled PPS rate and by establishing an outlier policy for stays with exceptionally high NTA costs. In addition, MedPAC explains that the current reimbursement system for therapy costs encourages the under provision of therapy services to patients. To improve payments for therapy, MedPAC recommends that the Secretary recalibrate the payment category for therapy costs so as to better match such payments to the actual amount of therapy services needed by patients. MedPAC also recommends that the market basket update for 2010 be eliminated.

The provisions contained in H.R. 3200 are consistent with MedPAC's recommendations. Specifically, the bill would eliminate the SNF MB update for 2010 and make all subsequent MB annual updates subject to a productivity adjustment. Under the bill, the rate of growth in payments to SNFs would likely slow but it would never fall below zero. H.R. 3200 would also require that changes be made to the SNF payment categories pertaining to NTA and therapy services, as are recommended by MedPAC. H.R. 3200 also contains provisions that would pay reduced Medicare payments to SNFs on claims associated with certain persons who are readmitted to a hospital from a SNF within 30 days of an initial hospital discharge. Finally, certain Medicare-certified SNFs would also be part of the Post-Acute Care Demonstration expansion to test bundled payments for hospitals and post-acute care providers.

Home Health Agencies (HHAs)

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

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

In CY 2008, CMS made refinements to the home health (HH) PPS to try to improve payment efficiencies. Specifically, this regulation established changes to the home health agency (HHA) case-mix index to account for the relative resource utilization of different patients. These changes modified the coding or classification of different units of service that do not reflect real changes in case-mix. As a result, the national prospective 60-day episode payment rate was adjusted downward by 2.75% for CY 2008, by 2.75% for each year of CY 2009 and CY 2010, and by 2.71% for CY 2011.

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

H.R. 3200 would slow payment growth to HHAs, as is consistent with MedPAC's recommendations. Specifically, the bill would eliminate the MB update for 2010 and make all subsequent MB annual updates subject to a productivity adjustment. Under the bill, the rate of growth in payments to HHAs would likely slow but it would never fall below zero. H.R. 3200 would also require that the case-mix adjustments planned by the Secretary for CY 2010 and CY 2011 be fully implemented in 2010, resulting in a total downward adjustment of payments by 5.46% in 2010. Finally, H.R. 3200 would grant the Secretary the authority to adjust HHA payments by a uniform percentage, as long as payments would not fall below the amount paid in the previous year.

Physicians and Other Part B Providers

The bill would make several changes to how Medicare payments to physician are determined and to physician reporting and feedback programs. These modifications include refinements to the calculation of the payments, the introduction of new bonus payments, and adjustments to existing programs for physicians. First and foremost, the method for determining the annual updates to the Medicare physician fee schedule (the sustainable growth rate system, or SGR) would be modified by resetting the baseline and making adjustment to how future updates would be calculated. CBO estimates that these actions would require additional outlays of $228.5 billion over the period from 2010-2019.

In addition, the bill as introduced would make a number of changes to how Medicare physician payments are calculated under the fee schedule and modify reporting and bonus programs for physicians. The Secretary (through CMS) would have additional flexibility to be able to review and adjust potentially misvalued codes under the physician fee schedule, make adjustments to Medicare payment localities in California to address imbalances created by uneven economic growth, extend the floor for the index representing geographic variation in physician work used in determining payments, create a new 5% bonus payment for physicians who practice in areas where total Medicare per capita spending falls in the lowest 5% of all counties or equivalent areas, extend the payment for the technical component of certain pathology services, and modify the payment for imaging services to more closely reflect the actual use of the equipment. The bill would also modify the physician quality reporting initiative program (PQRI) to include a feedback program, integrate PQRI and extend the years of the bonus payments. In addition, amendments approved by the Energy and Commerce Committee would modify the existing resource-based feedback program for physicians by specifying in more detail the types of information that would be reported under the program and how CMS could use the information. CBO's initial estimates are that the savings more than offset the costs of these modifications (by $200 million), but this estimate excludes the effect of the Energy and Commerce amendments.

Payment and Administrative Changes Affecting the Medicare Advantage Program

H.R. 3200 would reduce the maximum amount Medicare would pay private health plans in some areas of the country[19], in addition to other payment and administrative changes. Payments to

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

private plans are determined by comparing a plan's cost of providing required Medicare benefits (*bid*) to the maximum amount Medicare will pay for those benefits in each area (*benchmark*). Historically, Congress has increased the benchmark amounts, in part, to encourage plan participation in all areas of the country. As a result, the benchmark amounts in some areas are higher than the average cost of original fee-for-service (FFS) Medicare. Benchmarks exceed average spending in original Medicare by an estimated 17% in 2009. As a result, Medicare is projected to pay private plans an average of 14% more per beneficiary in 2009 than it does for beneficiaries in the original Medicare program. [20] Starting in 2011, H.R. 3200 would phase-in MA benchmarks equal to per capita FFS spending in each county. Starting in 2013, MA benchmarks would be equal to per capita FFS spending in each county. This may result in reductions in access to private plan options, or the supplemental benefits and reduced cost-sharing that some private plans provide. It is estimated that this provision would save $48.1 billion over the FY2010-2014 period and $156.3 billion over the FY2010-2019 period. This is one of the provisions that would result in the largest savings in H.R. 3200.

Starting in 2011, MA plans that provide quality health care in qualifying areas would receive an increase in their benchmarks. Currently, MA plans are required to have quality improvement programs before January 1, 2010, however, payments to MA plans are not contingent on the quality of care provided to Medicare beneficiaries. This provision is estimated to cost $2.9 billion over the 2010-2014 period and $9.6 billion over the FY2010-2019 period.

H.R. 3200 would extend the Secretary's authority to adjust payments to plans for differences in the way diagnosis coding of patients differs between MA plans and original Medicare. In general, MA plan payments are risk-adjusted to account for the variation in the cost of providing care. Risk adjustment is designed to compensate plans for the increased cost of treating older and sicker beneficiaries, and thus discourage plans from preferential enrollment of healthier individuals. The Medicare risk adjustment models take into account the variation in expected medical expenditures of the Medicare population associated with demographic characteristics (age, sex, current Medicaid eligibility, original Medicare eligibility due to a disability), as well as medical diagnoses. The Deficit Reduction Act of 2005 (P.L. 109-171, DRA) required the Secretary, when risk adjusting payments to MA plans during 2008, 2009, and 2010, to adjust for patterns of diagnosis coding differences between MA plans and providers under parts A and B of Medicare, to the extent that the Secretary identified such differences based on an analysis of data submitted for 2004 and subsequent years. It is estimated that this provision would save $2.9 billion over the 2010-2014 period and $15.5 billion over the 2010-2019 period.

H.R. 3200 makes additional changes to the Medicare Advantage program which would result in costs or savings of less than $0.5 billion over the 10-year period (2010-2019), as estimated by CBO. Each of these provisions is explained in detail in the appendix to this report.

Changes Affecting Medicare's Prescription Drug Benefit

In January 2009, the Medicare prescription drug program began its fourth year of operation. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173)

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

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

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

H.R. 3200 would make several changes to the Medicare Part D program to expand coverage and reduce costs to the program. Specifically, the bill would gradually phase out the coverage gap and completely eliminate it by 2022. During the coverage gap, consistent with a voluntary agreement with the pharmaceutical industry, Part D enrollees would be provided discounts of 50% for brand name drugs. However, the full drug price (the amount paid by the beneficiary plus the discount) would be used to calculate a beneficiary's out-of-pocket costs, thus enabling beneficiaries to reach the catastrophic level more quickly, at which time most of the drug costs would be paid for by Medicare. The bill would also establish a new prescription drug rebate program under which drug manufacturers would provide Medicare with rebates for the cost of drugs dispensed to dual eligible beneficiaries. CBO estimates that the combined savings from the discounts and the rebates would more than offset the cost of reducing the coverage gap and reduce Medicare expenditures approximately $30 billion for the 10 year period FY2010-2019. As CBO scored $0 savings for 2019 for these provisions, it is unknown whether savings would continue or costs would increase beyond this date. Additionally, because enrollees pay for about 25% of the cost of coverage through their premiums and the value of the prescription drug benefit would increase as the doughnut hole is phased out, CBO estimates that premiums would increase faster than they would under current law. However, CBO also estimates that, on average, the reduction in beneficiary cost sharing would outweigh the increase in premiums. The Energy and Commerce Committee version of H.R. 3200 would also require the Secretary to negotiate prices with manufacturers. While some believe that the government would have greater leverage in negotiations and would be better able to obtain lower prices than the plan sponsors, a CBO scoring on similar legislation introduced in the prior Congress concluded that this requirement would have a negligible effect on federal expenditures.

The bill also contains several provisions that would make it easier for beneficiaries to apply and qualify for the low-income subsidy and would help to improve access to LIS plans. For example, self-certification of income and assets would be allowed when applying for the subsidy, the asset test for the low-income subsidy would be raised, and cost sharing would be eliminated for individuals receiving care under a home and community based waiver who would otherwise require care in a facility for the mentally retarded. Additionally, HHS would be given the authority to auto-enroll subsidy-eligible individuals into plans using an "intelligent assignment"

process instead of the random process currently used. The new process would be designed to better insure that beneficiaries are enrolled in plans that are low cost and that cover the drugs the beneficiaries are currently taking. The bill would also change the methodology used to determine which plans are eligible to enroll low-income beneficiaries. This change may enable more plans to qualify as low-income plans and help reduce the number of low-income beneficiaries who need to change plans from year to year. CBO has scored the changes to the low-income subsidy program at a cost of $11.9 billion over 10 years.

H.R. 3200 also includes a number of provisions aimed at expanding consumer protections for Part D enrollees. For example, beneficiaries would be allowed to change drug plans outside of the annual open enrollment period if their current plan makes a change to its formulary that reduces coverage of needed drugs or increases cost-sharing. Additionally, the bill would enhance oversight to better ensure that low-income beneficiaries receive retroactive reimbursement payments owed to them by their drug plans (for cost sharing expenditures made by the beneficiary after the date the beneficiary became eligible for the subsidy).

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

As noted by MedPAC, the Medicare program must overcome limitations with its existing fee-for-service payment systems, by addressing its strong incentives to increase service volume and broadening the scope of Medicare's payment to encompass services provided by different entities during a patient's episode of care.[21] The wide geographic variation in Medicare's spending per beneficiary that is not explained by measurable differences in health status adds layers of complexity to any contemplated payment or health delivery reform proposal.

Certain provisions included in H.R. 3200 to establish pilot program to bundle payments for physician and hospital as well as post acute care services represent a starting point with these payment reforms. Other pilot programs will establish accountable care organizations and medical homes in an effort to provide incentives to better manage the quality and cost-efficiency of health care delivered to a population of chronically sick patients over an extended period of time. These pilot programs would build on existing demonstration programs; unlike the existing efforts, if assessed as successfully accomplishing care coordination while maintaining budget neutrality, the pilot programs could be implemented on a permanent basis without further Congressional action.

Changes to Address Fraud, Waste, and Abuse

H.R. 3200 includes over 30 provisions aimed at reducing fraud, waste, and abuse in the Medicare program. These provisions target the areas of fraud enforcement, program integrity, Medicare's enrollment and billing procedures, and funding for anti-fraud activities. Certain provisions would also apply to providers and suppliers participating in the Medicaid and CHIP programs.

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

In the area of enforcement, the legislation introduces new Civil Monetary Penalties (CMPs) for certain types of infractions, including falsifying information on provider enrollment applications and delaying investigations and audits by the Office of the Inspector General (OIG). The legislation would also give CMS the authority to impose additional penalties on MA plans for violating CMS marketing requirements and misrepresenting or falsifying information. In the area of program integrity, the bill would authorize the Secretary to subject high-risk providers to enhanced screening and oversight procedures, including moratoriums on enrolling new providers and requiring providers and suppliers to adopt internal compliance programs. Finally, H.R. 3200 increases funding for the Health Care Fraud and Abuse Control Program (HCFAC) by $100 million annually. The *aggregate* CBO score for all fraud, waste, and abuse provisions is -$0.4 billion for FY2010-FY2014 and -$1.3 billion for FY2010-FY2019.

Concluding Observations

Under H.R. 3200, Medicare serves as both a funding source for health insurance reform and a tool to shape future changes in the way that health services are paid for and delivered. Policy makers are debating whether Medicare savings should be used to offset broader reform efforts or whether these funds are more appropriately directed at strengthening the program's future financial standing. Industry representatives are debating the extent to which the Medicare program can be viewed as a funding source without compromising beneficiaries' access to quality care. Proponents of health insurance reform argue that the Medicare program and care provided to beneficiaries would be strengthened by certain of the payment reforms included in the bill and not harmed by the payment reductions. How (and whether) these different discussions will be resolved remains an open question.

Appendix. Selected Medicare Provisions in Division B of H.R. 3200

This appendix contains the majority of provisions in H.R. 3200 affecting the Medicare program with a brief current law, simplified provision description and, where possible, the associated CBO score. The section number and title of Medicare provisions that have been omitted from the appendix will be included in footnotes to the immediately preceding provision. Those provisions in H.R. 3200 that were included in the bill as passed by the Energy and Commerce Committee are explicitly noted as such.

Sec. 1101. Skilled Nursing Facility Payment Update. Skilled nursing facilities (SNFs) are paid through a prospective payment system (PPS) which is composed of a daily ("per-diem") urban or rural base payment amount that is then adjusted for case mix and area wages. Each year, the SNF payment rate is increased by an update factor that is determined, in part, by the projected increase in the SNF market basket (MB) index. Without changes to current law, the SNF MB update for FY 2010 is 2.2%. The provision would eliminate the MB update for FY 2010. For each subsequent fiscal year, the rate would be increased by the skilled nursing facility MB percentage change for the fiscal year involved. This provision would not apply to payments for days before January 1, 2010. *The CBO score (with interaction with Section 1103) is -$0.8 billion for FY2010-FY2014 and -$26.0 billion for FY2010-FY2019.*

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

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

The update factors for certain providers would include a productivity adjustment which would equal the percentage change in 10-year moving average of annual economy-wide private nonfarm business multi-factor productivity. The adjustment would be included for IPPS hospitals, SNFs,

IRFs. and hospice care for fiscal years beginning in 2010. To the extent that the base rate for LTCHs would be subject to an annual update, the update factor would be subject to a productivity adjustment starting for rate year 2010. To the extent that the base rate for IPFs would be subject to an annual update, the update factor would be subject to a productivity adjustment starting for rate year 2011.

The component of the IPPS update that is reduced when the acute care hospital does not submit quality data would not be reduced below zero. Similarly, the component of the IPPS update that is reduced for the acute care hospital is not a meaningful electronic health record (EHR) user would not be reduced below zero. The update reduction for those IPPS hospitals that are not meaningful EHR users would apply only with respect to the fiscal year involved and would not include the productivity adjustment; the Secretary would not be able to take into account the reduction in computing the applicable MB increase in subsequent years. T*he CBO score (with interaction with Sections 1101 and 1102) is -$23.2 billion for FY2010-FY2014 and -$101.6 billion for FY2010-FY2019.*

Sec. 1111. Payments to Skilled Nursing Facilities. SNFs are paid through a PPS which is composed of a daily ("per-diem") urban or rural base payment amount that is then adjusted for case mix and area wages. The base payment is adjusted for treatment type and care needs of the beneficiary based on 53 payment-adjusted resource utilization groups (RUGs). In January 2006, CMS implemented a refined SNF PPS (using FY 2001 claims data), including a parity adjustment to ensure that estimated total payments under the 53-group RUG model would maintain parity to the formerly used 44-group RUG model in a budget neutral manner. CMS also applied an adjustment to account for the variability in the use of nontherapy ancillary (NTA) services (e.g., prescription drugs, medical equipment and supplies, IV therapy). After noting that actual utilization patterns differed from CMS projections, CMS used actual CY 2006 claims data to update its calibrations and its parity adjustment so as to re-establish budget neutrality and its NTA adjustment component.

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

The provision would require the Secretary to adjust the case mix indexes for FY2010, using FY2006 claims data, by the appropriate recalibration factor, as proposed in the SNF proposed rule issued by the Secretary on May 12, 2009. It would also require the Secretary to increase payments for non-therapy ancillary services by 10% and decrease payments for the therapy case mix component of such rates by 5.5%. Such payment changes would be required to apply for days on or after January 1, 2010, and until the Secretary implements an alternative case mix classification system for the SNF PPS.

The Secretary would also be required to ensure the accuracy of payments for NTA services furnished during a fiscal year beginning with FY 2011, within certain specifications. Beginning with October 1, 2010, The Secretary would be required to provide for an addition or adjustment

to the outlier payment amounts and to reduce estimated payments that would otherwise be made under the PPS with respect to a FY by 2 percent. The total amount of additional payments or payment adjustments for these outliers with respect to a FY could not exceed 2 percent of total payments projected or estimated based on the SNF PPS. *The CBO Score is -$2.5 billion for FY 2010-FY2014 and -$6 billion for FY2010-FY2019.*

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

The provision would require the Secretary to submit no later than July 1, 2016 a Medicare DSH report including recommendations on the appropriate targeting of DSH funds that would be consistent with its original intent and consider any reduction in the number of uninsured individuals as well as hospitals' remaining uncompensated care costs. If H.R. 3200 decreases the national rate of uninsurance among the under 65-population by 8 or more percentage points from 2012 to 2014, the Medicare DSH adjustment would be reduced starting in FY2017. Additional payments (not to exceed 50% of the aggregate DSH reduction) would be made based on the estimated amount of uncompensated care, excluding bad debt, provided by a hospital; hospitals with higher levels of uncompensated care would receive higher uncompensated care payments. *The CBO score is $0.0 for FY2010-FY2014 and -10.2 billion for FY2010-FY2019.*

Sec. 1121. Sustainable Growth Rate Reform. Each year since 2003, Congress has passed laws that have overridden the reductions in Medicare physician payments that would have been required under existing law (the sustainable growth rate, or SGR, system). These reductions were a consequence of actual Medicare Part B expenditures exceeding projected targets. Most recently, Section 101 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA , P.L. 110-173) increased the update to the conversion factor for Medicare physician payment by 0.5% compared with 2007 rates for the first six months of 2008 and the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) extended the 0.5% increase through the end of 2008 and set the update to the conversion factor to 1.1% for 2009. Without further legislation, the update formula will require a reduction in physician fees beginning January 1, 2010 estimated at 21% by the CBO and by additional amounts annually for at least several years thereafter.

This bill would (1) reset the baseline for calculating future expenditure targets ─ meaning that past overages would not be required to be recouped, and (2) create a new method for calculating future updates. Instead of grouping all physician expenditures together in the calculation of the annual update to the fee schedule under the SGR system, the bill would establish separate target growth rates for (a) evaluation and management services and (b) for all other services.

Each category would have a separate target growth rate. The target growth rate for a year, beginning with 2010, would be computed and applied separately for each service category as defined above and would be computed using the same method for computing the target growth rate except that the update to the conversion factor for evaluation and management services as well as Medicare covered preventive services would be allowed to increase by the percentage growth rate of GDP per capita plus 2 percentage points, while the increase for all other

physicians' services would be allowed to grow at the percentage rate of increase in GDP per capita plus 1 percentage point. *CBO scores this provision as requiring an additional $73.7 billion in outlays over the next five years (2010-2014) and $228.5 billion over the next ten (2010-2019).*

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

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

Under this proposal, the Secretary would periodically identify and make appropriate adjustments to the relative values for the services identified as being potentially misvalued. The Secretary would examine the following, as appropriate: (1) codes (and families of codes as appropriate) for which there has been the fastest growth; (2) codes (and families of codes as appropriate) that have experienced substantial changes in practice expenses; (3) codes for new technologies or services within an appropriate period (such as three years) after the relative values are initially established for such codes; (4) multiple codes that are frequently billed in conjunction with furnishing a single service; (5) codes with low relative values, particularly those that are often billed multiple times for a single treatment; (6) codes that have not been subject to review since the implementation of the RBRVS (the so-called 'Harvard-valued codes'); and (7) such other codes determined to be appropriate by the Secretary. *According to CBO, this provision would increase outlays by approximately $100 million over the next five years (2010-2014) and $200 million over the next ten (2010-2019).*

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

The bill would create a new incentive payment for physicians; providers delivering services in counties or equivalent areas in the United States that fall in the lowest 5% based on per capita spending for Medicare part A and part B services would receive an additional 5% payment for the Medicare Part B services. The Secretary would standardize per capita spending to eliminate the effect of geographic adjustments in payment rates. *CBO estimates that an additional $500 million in outlays would be required by this provision, with all the spending occurring from 2011 to 2013.*

Sec. 1124. Modifications to the Physician Quality Reporting Initiative (PQRI). The Tax Relief and Health Care Act of 2006 (TRHCA, P.L. 109-432) required the establishment of a

physician quality reporting system (the Physician Quality Reporting Initiative, PQRI) that would include an incentive payment to eligible professionals who satisfactorily report data on quality measures. MIPPA made this program permanent and extended the bonuses through 2010; the incentive payment was increased from 1.5% of total allowable charges under the physician fee schedule in 2007 and 2008 to 2% in 2009 and 2010.

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

The bill would integrate physician quality reporting under the PQRI and EHR reporting relating to the meaningful use of EHR. The integration would consist of the following (1) the development of measures that would both demonstrate meaningful use of an electronic health record for purposes of EHR reporting and provide information on the clinical quality of the care furnished to an individual; (2) the collection of health data to identify deficiencies in the quality and coordination of care for Medicare beneficiaries; and (3) other activities as specified by the Secretary. The Secretary would develop such a plan no later than January 1, 2012. Incentive payments under the PQRI program would be extended through 2012; for each of the years 2009 through 2012, the bonus would be 2% of Part B payments. *According to the CBO, this provision would require an additional $600 million in 2012 and $1 billion in 2013.*

Sec. 1125. Adjustment to Medicare Payment Localities. The Medicare fee schedule pays providers differently according to the geographic location, known as a Medicare physician payment locality, in which the provider practices. By construction, the costs of providing physician services were relatively consistent within each payment locality at the time when they were defined; sub-regions of a state were designated as separate payment localities only if the data showed a marked difference between the costs in that area compared with the rest of the state. Economic conditions have affected parts of the country differently in the years since the payment localities were created. If localities were to be created based on data from recent years using the original methodology, the resulting number and composition of the payment localities might not be the same as the ones that currently exist.

The bill would alter the payment localities in the state of California used as the basis for the geographic adjustment of Medicare physician payments. Under the proposal, payments to California physicians would transition from a system based on the current localities to one based on Metropolitan Statistical Areas (MSAs) for services furnished on or after January 1, 2011. The provision includes a hold harmless condition that would require that no geographic adjustments be reduced during the first 5 years of the transition from the former county-based payment localities to the MSA-based fee schedule areas. The new fee schedule areas would be subject to periodic review and adjustments. *CBO estimates that these changes would require an additional $200 million over the next five years (2010-2014) and $300 over the next ten (2010-2019).*

Sec. 1126. Resource-Based Feedback Program For Physicians In Medicare. Both MedPAC and GAO have suggested that CMS provide information to physicians on their resource use with the expectation that physicians who are outliers would alter their practice patterns as a result. Providing this information to physicians would enable them to assess their practice styles, evaluate whether they tend to use more resources than their peers or what evidence-based research (if available) recommends, and to revise practice styles as appropriate.

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

The proposal would modify the existing physician feedback program. The feedback reports would include measures of the utilization of services under the Medicare program based on claims data and would include quality data under the existing physician quality reporting initiative (PQRI) as well as other information determined to be appropriate. These reports would be provided confidentially to physicians and other practitioners (those who furnish services for which payment is made under Medicare and for which such payment would be made if furnished by a physician).

The feedback reports would include information allowing the comparison of a physician's resource use pattern to the use patterns of peers. These reports could include resource use data on a per capita basis, a per episode basis, or both. The reports would include information regarding nationwide groups of similarly situated physicians (taking into consideration specialty, practice setting, and such other criteria as the Secretary finds appropriate) and comparing the pattern of services of each physician in the group to the group average pattern of services

During 2011, the Secretary would evaluate the efficacy of the feedback methods with regard to changing practice patterns to improve quality and decrease costs. Taking into account the cost of each method, the Secretary would expand the program by developing a plan to disseminate feedback reports in a significant manner in the regions and cities of the country with the highest utilization of services under Medicare. The Secretary would establish a process by which a physician could opt not to receive feedback reports under this program. *This provision was not included in the draft of the legislation that CBO scored in its July 17, 2009 letter to the Congress.*

Sec. 1131. Incorporating Productivity Improvements into Market Basket Updates That Do Not Already Incorporate Such Improvements. Payments for certain durable medical equipment (DME) in specific areas may be established by competitive bidding, but generally, Medicare pays for certain medical services and supplies using different prospective payment systems or fee schedules. Each year, the Medicare program, often directed by Congress, addresses the issue of whether or how much to increase payments. Under this provision, starting in CY2010, Medicare's annual updates for hospital outpatient department services, ambulance services, ambulatory surgical center services, clinical laboratory services would be subject to the productivity adjustment established earlier in the legislation The productivity adjustment would apply to DME payments starting June 2013. *The CBO score is -$8.4 billion for FY2010-FY2014 and -$40.1 billion for FY2010-FY2019.*

Sec. 1141. Rental and Purchase of Power-driven Wheelchairs. Medicare pays for new or replacement power-driven wheelchairs in one of two ways: either Medicare will pay the supplier a monthly rental amount during the beneficiary's period of medical need (not to exceed 13 continuous months), or, payment is made on a lump-sum basis at the time the supplier furnishes the chair. Power wheelchairs are classified into 3 broad groups based on their reported performance in categories such as speed, range of travel and the height of the vertical obstruction

they can climb. This provision would restrict the 'lump-sum' payment provision for new and replacement power-driven wheelchairs to those recognized by the Secretary as classified within group 3 or higher. The provision would be effective for chairs furnished on or after January 1, 2010, but would not apply to areas where the payments for Medicare DMEPOS are based on the competitive bids of suppliers and bids had been submitted before October 1, 2010. *The CBO score is -$0.6 billion for FY2010-FY2014 and -$0.8 billion for FY2010-FY2019.*

Sec. 1141A. Election to Take Ownership, or to Decline Ownership, of a Certain Item of Complex Durable Medical Equipment After the 13-Month Capped Rental Period Ends. [*Committee on Energy and Commerce Amendment*] Pressure reducing support surfaces are used for the care or prevention of pressure ulcers or bedsores and are a covered Medicare Part B DME benefit. For beneficiaries that fulfill coverage criteria for a pressure reducing support surface, Medicare will pay the supplier a monthly rental amount during the beneficiary's period of medical need (though payments are not to exceed 13 continuous months). On the first day after the 13th continuous month of rental payments, the supplier of the item is required to transfer title to the item to the beneficiary. After the supplier transfers title to the beneficiary, Medicare pays for maintenance and servicing for parts and labor not otherwise covered under a manufacturer's warranty if the Secretary determines that payments are reasonable and necessary. Payment amounts for such maintenance and services are determined by the Secretary. Support surfaces come in different categories. A group 3 support surface is a complete bed system known as air-fluidized beds. It simulates the movement of fluid by circulating filtered air through silicone-coated ceramic beads.

This provision would eliminate the automatic transfer of title of group 3 support surfaces to beneficiaries after 13 months of continuous use. Effective upon enactment, this provision would require DME suppliers, during the 10th continuous month of rental, to offer the beneficiary the option to accept or reject the transfer of title to a group 3 support surface after the 13th month of rental. The beneficiary would be deemed to reject the title, unless it was accepted within one month of the offer. If the individual accepted the title, it would be transferred on the first day that begins after the 13th month of continuous rental; reasonable and necessary maintenance and servicing not otherwise covered by a manufacturer's warranty would be covered by Medicare, as under current law. If the beneficiary did not accept the title, payments for maintenance and servicing would be as follows: no maintenance and serving payment during the first 6 months following the 13 continuous months of rental payments; during the first month of each succeeding 6 month period, a maintenance and servicing payment could be made, (for parts and labor not covered by the supplier's or manufacturer's warranty as determined by the Secretary, to be appropriate for group 3 support surfaces) and in an amount equal to the lower of (a) a reasonable and necessary maintenance and servicing fee or fees established by the Secretary, or (b) 10% of the total purchase price, as specified.

If on the effective date of this legislation, the individual's rental period has exceeded 10 continuous months, but has not reached the first day after the 13th month of continuous rental, the supplier would be required to offer the beneficiary the option to reject or accept title to the group three support surface. The supplier would be required to do so within 1 month of the effective date. The beneficiary has one month to accept or reject the title. The beneficiary is deemed to reject the title unless it is accepts the title. Maintenance and servicing of the equipment would be as described above. *This provision was not included in the draft of the legislation that CBO scored in its July 17, 2009 letter to the Congress.*

Sec. 1142. Extension of Payment Rule for Brachytherapy. As required by MMA, Medicare's outpatient prospective payment system make separate payments for specified brachytherapy sources. As mandated by TRHCA, this separate payment will be made using hospitals' charges adjusted to their costs until January 1, 2008. MMSEA extended cost reimbursement for brachytherapy services until July 1, 2008. MMSEA also specified that therapeutic radiopharmaceuticals will be paid using this methodology for services provided on or after January 1, 2008, and before July 1, 2008. MIPPA extended cost reimbursement for brachytherapy and therapeutic radiopharmaceuticals until January 1, 2010. The provision would extend cost reimbursement for brachytherapy and therapeutic radiopharmaceuticals until January 1, 2012. *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

Sec. 1143. Home Infusion Therapy Report to Congress. Infusion therapy involves the administration of medication through a needle or a catheter. If a physician determines that it is medically appropriate for a particular patient, some infusion therapies may be provided in a patient's home. Infusion drugs administered in a patient's home are covered under the Medicare Part D drug benefit. Medicare Part D does not, however, cover supplies, equipment or professional services associated with home infusion therapy. The provision would require MedPAC to analyze the scope of infusion therapy services provided under specified programs, the benefits and costs of providing coverage under Medicare, and analysis of how payment for such services could be structured. MedPAC is to submit a report to Congress not later than 12 months after the date of enactment. *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

Sec. 1144. Require Ambulatory Surgical Centers (ASCs) to Submit Cost Data and Other Data. Ambulatory surgery centers (ASCs) must meet certain health, safety, and other specified standards in order to participate in Medicare. ASCs have never been required to submit cost reports. In March 2009, MedPAC recommended that Congress require ASCs to submit cost data and quality data that would allow for an effective evaluation of the adequacy of Medicare's payment rates. The provision would require ASCs to submit information on their facility costs as a condition for agreeing to participate in Medicare beginning 18 months after the date the Secretary develops the cost reporting form. No later than 3 years from enactment, an ASC cost reporting form would be developed taking into account the hospital cost reporting requirements. The ASC cost reports would be periodically audited. The requirements would apply to agreements applicable to cost reporting periods. Starting 2012, ASCs would be required to report quality data, including data on health care associated infections. *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

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

Sec. 1146. Medicare Improvement Fund. Section 188 of MIPPA established the Medicare Improvement Fund (MIF), available to the Secretary to make improvements under the original fee-for-service program under Parts A and B for Medicare beneficiaries. The American Recovery and Reinvestment Act of 2009 (ARRA) modified the availability so that $22.29 billion are to be available to the Secretary for this purpose for services furnished during FY2014. For fiscal year 2020 and in each subsequent fiscal year, the amount in the fund would be the Secretary's estimate, as of July 1 of the fiscal year, of the aggregate savings in Medicare expenditures due to payment reductions resulting from restrictions imposed on various Medicare providers as an incentive for the adoption and meaningful use of certified EHR technology. The proposal in this bill would modify the amount of monies in the fund so that $8 billion would be available for the period beginning with fiscal year 2011 and ending with fiscal year 2019. *CBO scores this provision as saving $16.7 billion in 2014 and $5.6 billion in 2015, when interacted with Section 1158, which requires the Secretary to use funds from the MIF to address geographic inequities.*

Sec. 1147. Payment for Imaging Services. Under the Medicare fee schedule, some services have separate payments for the technical component and the professional component. Medicare pays for each of these components separately when the technical component is furnished by one provider and the professional component by another. When both components are furnished by one provider, Medicare makes a single global payment that is equal to the sum of the payment for each of the components. Imaging procedures generally have two parts: the actual taking of the image (the technical component), and the interpretation of the image (the professional component).

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

The bill proposes to increase the utilization rate for calculating the payment for advanced diagnostic imaging equipment from 50% to 75%; this would result in a decrease in the payment. In addition, for single session imaging involving continuous body parts, the proposal would reduce the technical component fees for additional imaging services to 50% to reflect efficiency. These modifications would apply to services furnished on or after January 1, 2011. *CBO estimates that this provision would save an estimated $1.3 billion over the next five years (2010-2014) and $4.3 billion over the next ten (2010-2019).*

Sec. 1148. Durable Medical Equipment Program Improvements. This provision modified requirements for surety bonds, oxygen equipment and accreditation. *The CBO score for Section 1148 is $0.0 billion for FY2010-FY2014 and -$0.1 billion for FY2010-FY2019.*

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

orthotics, and supplies, (2) has been issued a provider number for at least 5 years, and (3) has not received an adverse action.

***Oxygen Equipment*:** Medicare makes rental payments for oxygen equipment. The monthly payments are made for the period of medical need, not to 36-months. The statute requires suppliers to continue furnishing the equipment during any period of medical need for the remainder of the reasonable useful lifetime of the equipment, which is defined by the Secretary as 5 years (or 60 months). This provision would modify the time period during which the supplier would be required to furnish medically necessary oxygen and oxygen equipment. As of the 27th month of the 36 month rental period, the supplier furnishing the equipment would be required to continue furnishing the equipment (either directly or through arrangements with other suppliers) during any subsequent period of medical need for the remainder of the reasonable useful lifetime of the equipment regardless of the location of the individual, unless another supplier accepted the responsibility to furnish equipment during the remainder of the period. This provision would apply to equipment furnished to individuals for whom the 27th month of a continuous period of use occurred on or after July 1, 2010. This provision would also allow a beneficiary to begin a new 36 month rental period if the supplier who had been furnishing oxygen and oxygen equipment to the beneficiary was declared bankrupt and its assets were liquidated and at the time of the declaration and liquidation more than 24 months of rental payments had been made.

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

Section 1149. MedPAC Study and Report on Bone Mass Measurement. The Medicare Payment Advisory Commission would conduct a study regarding bone mass measurement, including computed tomography, duel-energy x-ray absorptriometry, and vertebral fracture assessment. The study would focus on the following: (1) an assessment of the adequacy of Medicare payment rates for such services, taking into account costs of acquiring the necessary equipment, professional work time, and practice expense costs; (2) the impact of Medicare payment changes since 2006 on beneficiary access to bone mass measurement benefits in general and in rural and minority communities specifically; (3) a review of the clinically appropriate and recommended use among Medicare beneficiaries and how usage rates among such beneficiaries compares to such recommendations; and (4) in conjunction with the findings under (3), recommendations, if necessary, regarding methods for reaching appropriate use of bone mass measurement studies among Medicare beneficiaries. Not later than 9 months after enactment, the Commission would submit a report to the Congress containing a description of the results of the aforementioned study and the conclusions and recommendations, if any, regarding each of the issues described above. *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

Sec. 1149A. Exclusion of Customary Prompt Pay Discounts Extended to Wholesalers from Manufacturer's Average Sales Price for Payments for Drugs and Biologicals Under

Medicare Part B. [*Committee on Energy and Commerce Amendment*] Medicare Part B pays for a small number of drugs in limited circumstances including drugs administered to patients in physician offices and outpatient departments. MMA established a Part B drug reimbursement methodology based on the Average Sales Price (ASP) of drugs; since January 2005, Medicare has paid for most physician administered drugs based on 106% of the volume-weighted ASP for each drug code. MMA defines ASP as the average manufacturer's sales of a drug to all purchasers in the United States in a given quarter. The ASP is net of any price concessions provided by the manufacturer to the purchaser (e.g. the wholesaler, group purchasing organization or provider) such as prompt pay discounts, volume discounts, and rebates other than those obtained through the Medicaid drug rebate program. Some physician groups are concerned that the prompt pay discounts provided to wholesalers or group purchasing organizations are not passed on to physicians, but are still included in the determination of the ASP, thereby lowering Medicare payment to physicians for the cost of the drugs. This provision would exclude customary prompt pay discounts extended to wholesalers from the calculation of ASP in cases where the discounts do not exceed 2% of the wholesale acquisition cost[22] for drugs and biologicals that are sold on or after January 1, 20011 and before January 1, 2016. *This provision was not included in the draft of the legislation that CBO scored in its July 17, 2009 letter to the Congress.*

Sec. 1149B. Timely Access to Post-Mastectomy Items. [*Committee on Energy and Commerce Amendment*] A breast prosthesis is covered by Medicare Part B for a patient who has *had* a mastectomy. An external breast prosthesis garment, with mastectomy form is covered for use in the postoperative period prior to a permanent breast prosthesis or as an alternative to a mastectomy bra and breast prosthesis. The breast prosthesis and garment are not covered by Medicare prior to the mastectomy or breast cancer surgery as there is no medical need for the items.

Upon enactment, the provision would specify that payment for post-mastectomy external breast prosthesis garments would be made regardless of whether the items are supplied to the beneficiary prior to or after the mastectomy procedure or other breast cancer surgical procedure. The Secretary would be required to develop policies to ensure appropriate beneficiary access and utilization safeguards. *This provision was not included in the draft of the legislation that CBO scored in its July 17, 2009 letter to the Congress.*

Sec. 1149C. Moratorium on Medicare Reductions in Payment Rates for Certain Interventional Pain Management Procedures Covered Under the ASC Fee Schedule. [*Committee on Energy and Commerce Amendment*] CMS implemented a new payment system for ASCs starting on January 1, 2008. The new payment system which will be phased in over a 4-year period uses the ambulatory payment classification groups that are the basis for Medicare's OPPS used to pay for hospital outpatient department services. Under the new payment system, Medicare's payments for certain services will increase and those for other services will decrease.

This provision would establish that Medicare payments for interventional pain management services provided in ASCs starting January 1, 2010 and before January 1, 2012 would not be less than the payment rate in effect as of January 1, 2007 under the prior payment system. The interventional pain services included under this provision would be epidural injections, facet joint

[22] The term `wholesale acquisition cost' means, with respect to a drug or biological, the manufacturer's list price for the drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates or reductions in price, for the most recent month for which the information is available, as reported in wholesale price guides or other publications of drug or biological pricing data.

injections, and sacroiliac joint injections. *This provision was not included in the draft of the legislation that CBO scored in its July 17, 2009 letter to the Congress.*

Sec. 1149D. Medicare Coverage Of Services Of Qualified Respiratory Therapists Performed Under The General Supervision Of A Physician. [*Committee on Energy and Commerce Amendment*] Under current law, respiratory therapists can not be reimbursed independently under the Medicare fee schedule, as they are not included in the definition of physicians and other providers. Thus, services provided by respiratory therapists outside of hospital settings are generally covered as services "incident to a physician's professional service." Under this provision, the physician must directly supervise the service (meaning the physician must be physically present) when the physician is not the one providing the service.

The provision would amend the definition of "medical and other health services" and add a new subparagraph addressing respiratory therapy and respiratory therapists. For purposes of the Medicare program, respiratory therapy services would include those services that are performed by a respiratory therapist under the general (not direct) supervision of a physician for the diagnosis and treatment of respiratory illnesses (and would be physicians' services if furnished by a physician). These services would be reimbursed under the Medicare fee schedule, but only if no facility or other provider charges are paid with respect to the furnishing of such services. The term 'respiratory therapist' would mean an individual who (1) is credentialed by a national credentialing board recognized by the Secretary, (2) is licensed to practice respiratory therapy in the State in which the respiratory therapy services are performed, or in the case of an individual in a State which does not provide for such licensure, is legally authorized to perform respiratory therapy services (in the State in which the individual performed such services) under State law or the State regulatory mechanism provided by State law, (3) is a registered respiratory therapist; and (4) holds a bachelor's degree.

Payment for these respiratory services furnished by a respiratory therapist would be the amount equal to 80 percent of the lesser of the actual charge for the services or 85 percent of the Medicare fee schedule amount provided for the same services if furnished by a physician. This change applies to services furnished on or after January 1, 2010. *This provision was not included in the draft of the legislation that CBO scored in its July 17, 2009 letter to the Congress.*

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

According to MedPAC's analysis of 2005 Medicare data, 6.2% of hospitalizations of Medicare beneficiaries resulted in readmission within 7 days and 17.6% of hospitalizations resulted in

readmission within 30 days. The 17.6% of hospital readmission accounts for $15 billion in Medicare spending. These readmission rates reflect the total number of readmissions, including those that may not have been related to the initial diagnosis and may not have been preventable. MedPAC, CMS, and others have expressed concern that providers do not have financial incentives to reduce potentially preventable readmissions. In addition, MedPAC, in its June 2008 report, recommended that Medicare's payments to hospitals with relatively high readmission rates for select conditions be reduced.

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

The adjustment factor for a hospital in a fiscal year would be the greater of (1) a floor adjustment factor equal to a reduced percentage of the discharge payment or (2) the excess readmissions ratio for the applicable fiscal year. The floor adjustment factor would be 0.99 of the discharge payments in FY2012, 0.98 of the discharge in FY 2013, 0.97 in FY 2014; or 0.95 in subsequent fiscal years. The excess readmissions ratio would equal 1 minus the ratio of the aggregate payments for excess readmissions for the hospital divided by the aggregate payments for all discharges. (Each component of this formula is specified in the provision.) Beginning with discharges for FY2014, the Secretary would be able to provide additional incentives for hospitals to reduce their potentially preventable readmission rates (by ranking hospitals by readmission ratios from lower to higher readmissions and establishing a benchmark that is lower than the 50^{th} percentile).

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

Starting in FY2012, the Secretary would select 3 applicable conditions that have been endorsed by the consensus based entity as of the date of enactment. Beginning with FY2013, the Secretary would be required to expand the list of applicable conditions to include 4 conditions identified by the MedPAC in its June 2007 *Report to Congress*. The Secretary would also be able to extend it to other conditions including an appropriate all-condition measure of readmissions. In expanding the list of conditions, the Secretary would be required to seek the endorsement by a consensus-based entity, but would be able to apply such conditions with such endorsement.

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

Starting in FY2011, targeted hospitals that received $10 million or more in DSH payments in their most recently settled cost report could receive increased payments for transitional care activities, such as care coordination services; hiring translators and interpreters; increasing

discharge planning services among other actions. The payment increase would be subject to aggregate and hospital-specific caps. In the aggregate, payment increases would not exceed 5% of the estimated savings attributed to the hospital readmission policy in a fiscal year. A specific hospital would not receive more than the estimated difference attributed to the excess readmissions policy. The Secretary would make these additional payments on a lump sum basis, a periodic basis, a claim by claim basis or in any other form deemed appropriate. Not later than 3 years after funds are first made available, GAO would be required to submit a report on the use of such funds.

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

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

Application to Post Acute Care Providers. The proposal would also reduce Medicare payments on claims from post-acute care providers (SNFs, IRFs, HHA, and LTCHs) for patients readmitted to an applicable hospital or a CAH within 30 days of an initial discharge from a hospital or a CAH. Payments to post-acute providers would be reduced by 0.996 for the fiscal year or rate year 2012; 0.993 for the fiscal or rate year 2013; and 0.99 for fiscal or rate year 2014. This policy would apply to the discharges or services starting October 1, 2011 or July 1, 2012 depending upon the providers Medicare rate setting schedule.

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

Physicians. The Secretary would be required to conduct a study to determine how this readmissions policy could be applied to physicians and issue a public report no later than 1 year after enactment. Such approaches would be required to be considered: (1) creating a code (or codes) and budget neutral payment amount(s) under the fee schedule for services furnished by an appropriate physicians who sees an individual within the first week after discharge from a hospital or CAH.; (2) developing measures of readmissions rates for individuals treated by physicians; (3) applying a payment reduction for physicians who treat the patient during the

initial admissions that results in a readmission; and (4) methods for attributing payments or payment reductions to the appropriate physician or physicians.

Funding. In addition to funds otherwise available, $25 million for each fiscal year beginning with 2010 would be appropriated to the CMS Program Management Account; the amounts appropriated for a fiscal year would be available until expended. *The CBO score is -$3.8 billion for FY2010-FY2014 and -$19.1 billion for FY2010-FY2019.*

Sec. 1152. Post Acute Care Services Payment Reform Plan and Bundling Pilot Program. Medicare pays for most post-acute care (PAC) services, including skilled nursing facilities (SNF), long-term care hospitals (LTCH), inpatient rehabilitation facilities (IRF), and home health, under prospective payment systems (PPS) established for each type of provider. Payments across PAC settings may differ considerably even though the clinical characteristics of the patient and the services delivered may be very similar. The Deficit Reduction Act of 2005 (P.L. 109-171) required the Centers for Medicare and Medicaid Services (CMS) to develop a Post Acute Care Payment Reform Demonstration (PAC demonstration) to standardize patient assessment information from PAC settings and to use these data to guide payment policy in the Medicare program. This demonstration began in 2008 and a report is expected to be submitted to Congress by the Secretary in 2011. CMS has also established a 3-year Acute Care Episode (ACE) Demonstration to test the effects of using a bundled payment for hospital and physician services for a set of 9 orthopedic and 28 cardiovascular conditions. There are 5 participants in the ACE demonstration which began early in 2009.

The provision would require the Secretary to develop a detailed plan for bundling payments for Medicare's PAC services (SNFs, IRFs, LTCHs, hospital based outpatient rehabilitation facilities, and home health agencies services) provided after discharge from a hospital and as determined appropriate by the Secretary. This provision would also require the Secretary, by no later than January 1, 2011 to convert the acute care episode demonstration into a pilot program and expand it to include post acute services and such other services the Secretary determines to be appropriate, Under this pilot program, the Secretary could apply bundled payments to: (i) hospitals and physicians; (ii) hospitals and post-acute-care providers; (iii) hospitals, physicians, and post-acute care providers; or (iv) combinations of post-acute providers. Bundled payments would be applied in manner as to include collaborative care networks and continuing care hospitals, as defined by the legislation. The Secretary would also be required to provide a study of and development of a plan, that could be implemented by the Secretary in a demonstration, to test additional ways to increase bundling of payments for physicians in connection with an episode of care. *The CBO score is $0.0 for FY 2010-FY2014 and $0.0 for FY2010-FY2019.*

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

Starting in 2007, HHAs were required to submit to the Secretary health care quality data. A HHA that does not submit the required quality data now receives an update of the MB minus two percentage points. This reduction only applies to the fiscal year in question. The provision would

eliminate the MB update for home health payments for 2010. Home health agencies would still be subject to the requirement to submit required quality data in subsequent years. *The CBO score is -$2.8 billion for FY 2010-FY2014 and -$7.7 billion for FY2010-FY2019.*

Sec. 1154. Payment Adjustments for Home Health Care. HHAs are paid under a PPS. Payment is based on 60-day episodes of care for beneficiaries, subject to several adjustments, with unlimited episodes of care in a year. In calendar year (CY) 2008, CMS made refinements to the PPS that resulted in payment reductions established in 42 CFR §484.220 as described in the *Federal Register* issued on August 29, 2007 (72 FR 49879). This regulation established changes to the HHA case-mix index to account for the relative resource utilization of different patients. These changes modified the coding or classification of different units of service that do not reflect real changes in case-mix. As a result, the national prospective 60-day episode payment rate was adjusted downward by 2.75% for CY2008; by 2.75% for each calendar year 2009 and 2010, and by 2.71% for CY2011.

The provision would accelerate the case-mix adjustments described in 42 CFR § 484.220 by implementing both the planned CY2011 adjustment of 2.71% and the planned CY2010 of 2.75% at the same time in CY2010, for a total CY2010 downward adjustment of 5.46%. These adjustment amounts would not be limited if more recent data were to indicate that a greater adjustment would be appropriate. Starting in 2011, PPS amounts would be adjusted by a uniform percentage determined appropriate by the Secretary and based on analysis of certain factors. After 2011, such amounts would be required to be equal to the amount paid for the previous year updated by the HH MB. If the Secretary is not able to compute the changed prospective payment amounts for 2011 on a timely basis, then the Secretary would be required to pay 95% of what the prospective payment amount would have been had this provision not applied and to compare, before July 1, 2011, amounts paid to amounts that would have been paid had the Secretary been able to compute the adjustment on a timely basis. For 2012, the Secretary would be required to decrease or increase the prospective payment amount (or at the Secretary's discretion, over a period of several years beginning with 2012), by the amount (if any) by which the amount applied is greater or less, respectively, than the amount that should have been applied. *The CBO score is -$9.6 billion for FY 2010-FY2014 and -$34.2 billion for FY2010-FY2019.*

Sec. 1155. Incorporating Productivity Improvements Into Market Basket Update For Home Health Services. Home health agencies (HHAs) are paid under a prospective payment system (PPS). The base payment amount, or national standardized 60-day episode rate, is increased annually by an update factor that is determined, in part, by the projected increase in the home health MB index. This index measures changes in the costs of goods and services purchased by HHAs. HHAs are required to submit to the Secretary health care quality data. A HHA that does not submit the required quality data will receive an update of the MB minus two percentage points. The provision would make annual updates by the HH MB, beginning with 2010, subject to a productivity adjustment as long as the annual update would not be less than zero. The productivity adjustment would equal the 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity. *The CBO score is -$2.1 billion for FY 2010-FY2014 and -$14.9 billion for FY2010-FY2019.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

payment year. These adjustments for services furnished before January 1, 2014 could not exceed the amounts in the Medicare Improvement Fund as amended in this legislation. No more than half of that $8 billion would be available in any one payment year. *The CBO score is $8.0 billion for FY2010-FY2014 and $8.0 billion for FY2010-FY2019.*

Sec. 1161. Phase-in of Payment Based on Fee-for-Service Costs. Medicare Advantage (MA) is an alternative way for Medicare beneficiaries to receive covered benefits. Under MA, private health plans are paid a per-person amount to provide all Medicare-covered benefits (except hospice) to beneficiaries who enroll in their plan. Payments to MA plans are determined by comparing plan *bids* to a *benchmark*. Each bid represents the plan's estimated revenue requirement for providing required Medicare services to an average Medicare beneficiary. The benchmark is the maximum amount Medicare will pay a plan. If the plan bid is below the benchmark, the plan payment is the bid plus 75% of the difference between the bid and the benchmark. If the bid is above the benchmark, the plan payment is equal to the benchmark and each plan enrollee must pay a premium equal to the difference between the bid and the benchmark. MA benchmarks are based, in part, on historical Medicare private plan payment rates. BBA 97 increased payments to private plans above rates of per capita FFS costs in some areas. Subsequent legislation also increased payment rates to private plans. The historical payment rates were used as the basis for the benchmark amounts. As a result, current MA benchmarks exceed per capita FFS costs in some areas. This provision would phase-in MA benchmarks equal to per capita FFS spending in each county starting in 2011. Starting 2013, MA benchmarks would be equal to per capita FFS spending in each county. Benchmarks could not be less than per capita FFS spending. The provision would not apply to Programs of All-Inclusive Care for the Elderly (PACE). *The CBO score is -$48.1 billion for FY2010-FY2014 and -$156.3 billion for FY2010-FY2019.*

Sec. 1162. Quality Bonus Payments. Though all MA organizations are required to have a quality improvement program by January 1, 2010, payments to MA plans are not contingent on the quality of care provided to plan enrollees. (A description of how plans are paid is included under Section 1161 above.) Under this provision, starting in 2011, MA plans could receive an increase in their benchmark if they were a qualifying plan in a qualifying county. The benchmark increases would equal 2.6% in 2011, 5.3% in 2012 and 8.0% in subsequent years. A qualifying plan would have had a quality ranking (based on the quality ranking system established by CMS in 2007) of 4 stars or higher during a specified previous year. A qualifying county would be one, for a year, (a) that was within the lowest quarter of counties with respect to per capita spending in original Medicare, and (b) within which, 50 percent of individuals were enrolled in MA and of the residents enrolled, at least 50 percent were enrolled in a plan with a quality ranking of 4 stars or higher. A plan could lose its quality bonus payment for non-compliance with MA rules. *The CBO score is $2.9 billion for FY2010-FY2014 and $9.6 billion for FY2010-FY2019.*

Sec. 1163. Extension of Secretarial Coding Intensity Adjustment Authority. Medicare payments to MA plans are risk-adjusted to account for the variation in the cost of providing care. DRA required the Secretary to adjust for patterns of diagnosis coding differences between MA plans and providers under parts A and B of Medicare for plan payments in 2008, 2009, and 2010, to the extent that the Secretary identified such differences. The Secretary did not make adjustments in 2008 and 2009, due to ongoing analyses, but is to adjust rates in 2010. The provision would extend the requirement that MA plan payments be adjusted for differences in coding patterns beyond 2010. The provision would require the Secretary to conduct analyses of coding differences periodically and incorporate the findings on a timely basis. *The CBO score is -$2.9 billion for FY2010-FY2014 and -$15.5 billion for FY2010-FY2019.*

Sec. 1164. Simplification of Annual Beneficiary Election Periods. Medicare beneficiaries may enroll in or change their enrollment in MA from November 15 to December 31 each year (the annual, coordinated election period). Changes go into effect January 1st of the next year. During the first three months of the year, beneficiaries can enroll in an MA plan, and individuals enrolled in an MA plan can either switch to a different MA plan or return to original Medicare. This period is known as the continuous open enrollment and disenrollment period. The provision would move the annual, coordinated election period to 15 days earlier in the year -- November 1st to December 15th, rather than from November 15th to December 30th. The provision would eliminate the continuous open enrollment and disenrollment period (during the first three months of the year.) *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

Sec. 1165. Extension of Reasonable Cost Contracts. Reasonable cost plans are MA plans that are reimbursed by Medicare for the actual cost of providing services to enrollees. Cost plans were created in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA, P.L. 97-248). BBA 97 included a provision to phase-out the reasonable cost contracts, however, the phase-out has been delayed over the years through congressional action. These plans are allowed to operate indefinitely, unless two other plans of the same type (i.e., either 2 local or 2 regional plans) offered by different organizations operate for the entire year in the cost contract's service area. After January 1, 2010, the Secretary may not extend or renew a reasonable cost contract for a service area if (1) during the entire previous year there were either two or more MA regional plans or two or more MA local plans in the service area offered by different MA organizations; and (2) these regional or local plans meet minimum enrollment requirements. This provision would extend for two years—from January 1, 2010, to January 1, 2012—the length of time reasonable cost plans could continue operating regardless of any other MA plans serving the area. The provision would modify the minimum enrollment requirement used as one of the criteria the Secretary considers when determining whether to renew or extend a reasonable cost plan. The enrollment criteria would apply to the portion of the MA regional or local plan's service area for the year that it was within the service area of the reasonable cost contract (and not the total service area of the MA regional or local plan). *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

Sec. 1166. Limitation of Waiver Authority for Employer Group Plans. The Secretary has the authority to waive or modify requirements that hinder the design of, the offering of, or the enrollment in employer or union sponsored MA plans. Such plans can be offered either under contracts between the union or employer group and a MA organization, or directly by the employer or union group. For employers or unions that sponsor an MA plan directly (and not through a contract with a private MA organization), the Secretary would only have authority to waive or modify MA requirements for the plan if 90% of eligible individuals enrolled in the plan live in a county in which the MA organization offers an MA local plan. This provision would apply to plan years on or after January 1, 2011, and would not apply to plans in effect as of December 31, 2010. *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

Sec. 1167. Improving Risk Adjustment for MA Payments. In general, Medicare payments to MA plans are risk adjusted to account for the variation in the cost of providing care. Risk adjustment is designed to compensate plans for the increased cost of treating older and sicker beneficiaries, and thus discourage plans from preferential enrollment of healthier individuals. The Medicare risk adjustment models take into account the variation in expected medical expenditures associated with demographic characteristics (age, sex, current Medicaid eligibility, original Medicare eligibility due to a disability), as well as medical diagnoses, and differences in coding

practices between MA and providers under Medicare Part A and B. The provision would require the Secretary to evaluate and report on the adequacy of MA risk adjustments at predicting costs for beneficiaries with chronic or co-morbid conditions, beneficiaries dually-eligible for Medicare and Medicaid, and non-Medicaid eligible low-income beneficiaries. The report would also address the need and feasibility of including further gradations of diseases or conditions and multiple years of beneficiary data. Taking this report into account, not later than January 1, 2012, the Secretary would be required to implement necessary improvements to the MA risk adjustment system. *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

Sec. 1168. Elimination of the MA Regional Plan Stabilization Fund. MMA created the MA Regional Program and established the MA Regional Plan Stabilization Fund to encourage plans to enter into and/or remain in the MA Regional Program. The fund was originally set at $10 billion with additional money added to the fund from savings in the bidding process. Funds were to be available from 2007 through the end of 2013. Subsequent legislation decreased the amount of funds available and delayed their availability. Most recently, MIPPA reduced the initial funding of the program to one dollar. Money from the regional plan bidding process continues to flow into the Fund, but availability is delayed until 2014. The provision would eliminate the Fund and transfer amounts in the Fund to the Part B Trust Fund. *The CBO score is -$0.2 billion for FY2010-FY2014 and -$0.2 billion for FY2010-FY2019.*

Sec. 1169. Study Regarding the Effects of Calculating Medicare Advantage Payment Rates on a Regional Average of Medicare Fee for Service Rates. [*Committee on Energy and Commerce Amendment*] The provision would require the CMS to conduct a study to determine the potential effects of calculating MA rates on a more aggregated geographic basis, rather than using county boundaries. The study would consider whether the alternatives would result in (a) improvements in quality of care, (b) greater equity among providers, and (c) more predictable benchmark amounts. CMS would be required to consult with certain experts and stakeholders. CMS would be required to submit a report to Congress, including recommendations, no later than one year after the date of enactment. *This provision was not included in the draft of the legislation that CBO scored in its July 17, 2009 letter to the Congress.*

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

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

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

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

Sec. 1175. Authority to Deny Plan Bids. By the first Monday in June, each local MA plan must submit to the Secretary an aggregate monthly bid amount (which includes separate bids for required services, any offered supplemental benefits, and any offered drug benefits) for each MA plan it intends to offer in the upcoming calendar year. The Secretary has the authority to evaluate and negotiate the plan's bid amounts and its proposed benefit packages. Beginning January 2011, the Secretary would not be required to accept any or every bid submitted by a MA or PDP plan. *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

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

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

for Sections 1176 and 1177 is +$0.2 billion for FY2010-FY2014 and $0.1 billion for FY2010-FY2019.

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

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

The Secretary would be required to provide an analysis of the SNPs that were approved by CMS as of January 1, 2004. The analysis of these grandfathered SNPs would include the impact of such plans on cost, quality of care, patient satisfaction, and other subjects as specified by the Secretary. By December 31, 2011, the Secretary would be required to submit a report to Congress including recommendations on how the appropriate treatment of these plans. *The CBO score for Sections 1176 and 1177 is +$0.2 billion for FY2010-FY2014 and $0.1 billion for FY2010-FY2019.*

Sec. 1181. Elimination of Coverage Gap. Medicare law sets out a defined standard benefit structure under the Part D prescription drug benefit that includes a gap in coverage (the *doughnut hole*) during which enrollees, who are not eligible for the low-income subsidy, are responsible for paying 100% of the cost of their drugs. Prior to the implementation of the Medicare Part D outpatient prescription drug benefit in 2006, Medicaid was the primary payer for drugs for dual-eligible beneficiaries. Drug manufacturers who wish to have their drugs available for Medicaid enrollees must provide state Medicaid programs with rebates on drugs paid on behalf of Medicaid beneficiaries. This provision would gradually phase out the coverage gap until it is completely eliminated in 2022. Drug manufacturers would be required to provide the Secretary rebates for drugs dispensed to full-benefit dual eligible Part D plan enrollees, and the funds would be used to pay for all or part of the elimination of the coverage gap. *The CBO score (with interaction with Section 1182) is –$22.1 billion for FY 2010-FY2014 and -$29.7 billion for FY2010-FY 2019. In a separate analysis,[23] CBO also estimates that beneficiary premiums would increase faster than they would under current law; however, on average, the reduction in beneficiary cost sharing would outweigh the increase in premiums.*

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

Sec. 1182. Discounts for Certain Part D Drugs in Original Coverage Gap. This provision incorporates a voluntary PhRMA agreement to provide discounts of 50% for brand-name drugs used by Part D enrollees in the Part D coverage gap. Manufacturers of prescription drugs would enter into agreements with Medicare Part D drug plan sponsors to provide discounts on drugs provided to plan enrollees in the coverage gap period. The amount of the discount, in addition to the amount actually paid by the enrollee, would count toward costs incurred by the plan enrollee. Plan enrollees receiving the low income subsidy would not be eligible for the discount. This provision would be applicable to drugs dispensed after December 31, 2010. The *CBO score (with interaction with Section 1182) is –$22.1 billion for FY 2010-FY2014 and -$29.7 billion for FY2010-FY 2019.*

Sec. 1183. Repeal of Provision Relating To Submission Of Claims By Pharmacies Located In Or Contracting With Long-Term Care Facilities. Section 172 of MIPPA provided for a new set of requirements for contracts between Part D drug plan sponsors and pharmacies located in or contracting with long-term care facilities for plan years beginning on or after January 1, 2010. Each contract entered into with a PDP sponsor or MA-PD plan is required to provide that a pharmacy located in or having a contract with a long-term care facility would have between 30 and 90 days to submit claims for reimbursement. H.R. 3200 would repeal Section 172 of MIPPA and eliminate these deadlines for long-term care pharmacists to file Part D claims to allow more time for coordination with state Medicaid programs. *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

Sec. 1184. Including Costs Incurred By AIDS Drug Assistance Programs And Indian Health Service In Providing Prescription Drugs Toward The Annual Out Of Pocket Threshold Under Part D. Under a standard Medicare Part D plan design, beneficiaries must incur a certain level of out-of-pocket costs ($4,350 in 2009) before catastrophic protection begins. These include costs that are incurred for the deductible, cost-sharing, or benefits not paid because they fall in the coverage gap. Costs are counted as incurred, and thus treated as true out-of-pocket (TrOOP) costs only if they are paid by the individual (or by another family member on behalf of the individual), paid on behalf of a low-income individual under the subsidy provisions, or paid under a State Pharmaceutical Assistance Program. Additional payments that do not count toward TrOOP include Part D premiums and coverage by other insurance, including group health plans, workers' compensation, Part D plans' supplemental or enhanced benefits, or other third parties. This provision would allow costs paid by the Indian Health Service or under an AIDS Drug Assistance Program to count toward the out-of-pocket threshold for costs incurred on or after January 1, 2011. *The CBO score is +$0.3 billion for FY 2010-FY2014 and+$0.8 billion for FY2010-FY 2019.*

Sec. 1185. Permitting Mid-Year Changes In Enrollment For Formulary Changes That Adversely Impact An Enrollee. Part D plans are permitted to operate formularies—lists of drugs that a plan chooses to cover and the terms under which they are covered. By law, Part D plans may not change the therapeutic categories and classes in a formulary other than at the beginning of each plan year except as the Secretary may permit to take into account new therapeutic uses and newly approved covered part D drugs. If a plan removes a covered part D drug from a formulary or makes any change in the preferred or tiered cost-sharing status of a drug, appropriate notice must be provided to the Secretary, affected enrollees, physicians, pharmacies, and pharmacists. This provision would establish a special enrollment period that would enable Part D enrollees to change plans outside of the open enrollment period if their plan makes changes to its formulary that increases cost-sharing or otherwise reduces coverage. The provision would apply

to contract years beginning on or after January 1, 2011. *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

Sec. 1186. Negotiation of Lower Covered Part D Drug Prices on Behalf of Medicare Beneficiaries. [*Energy and Commerce Amendment*] Part D plan sponsors (or the pharmacy benefit managers they have contracted with) negotiate prices with drug manufacturers, wholesalers, and pharmacies and are required to provide enrollees with access to these negotiated prices for covered Part D drugs. The law specifically states that the Secretary may not interfere with the negotiations between drug manufacturers and pharmacies and PDP sponsors. Further, the Secretary may not require a particular formulary or institute a price structure for the reimbursement of covered Part D drugs. This is known as the "non-interference provision" (SSA § 1860D-11(i)). Section 1186 would strike SSA § 1860D-11(i), and in its place, add language that would require the Secretary to negotiate prescription drug prices (including discounts, rebates and other price concessions) that may be charged to PDP sponsors and MA organizations, but would still allow prescription drug plans to obtain discounts or price reductions below those negotiated by the Secretary. The provision would also maintain the prohibition against the establishment of a formulary by the Secretary; however, there would no longer be an explicit prohibition of the institution of a price structure. The provision would take effect on the date of enactment and would first apply to negotiations and prices for plan years beginning on January 1, 2011. *This provision was not included in the draft of the legislation that CBO scored in its July 17, 2009 letter to Congress. However, CBO scored similar legislation in the 110th (H.R. 4) and concluded that it would have a negligible effect on federal spending.*[24]

Sec. 1187 State Certification Prior to Waiver of Licensure Requirements Under Medicare Prescription Drug Program. *[Energy and Commerce Amendment]* Medicare Part D participants must obtain coverage through a Part D sponsor—a private insurer or other entity that has contracted with Medicare to provide prescription drug benefits. According to Section 1860D-12 of the SSA, a sponsor of a prescription drug plan is required to be organized and licensed under state law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each state it offers a prescription drug plan. Under certain circumstances, a sponsor may apply to CMS for a waiver of this requirement. The National Association of Insurance Commissioners (NAIC) has noted instances in which PDP sponsors have been granted waivers from state licensure requirements but did not have fully completed applications for licensure pending at the time the waiver had been granted.

The provision would amend Section 1860D-12 of the SSA to require that CMS may only grant a waiver of licensure for a particular state if it has received a certification from the State Insurance Commissioner that the prescription drug plan has a substantially complete application pending in that state. Additionally, the waiver could be revoked if the State Insurance Commissioner submits a certification to CMS that the sponsor committed fraud with respect to the waiver, did not make a good faith effort to satisfy state licensing requirements, or was determined by the state to be ineligible for licensure. The requirements would be effective for plan years beginning January 1, 2010. *This provision was not included in the draft of the legislation that CBO scored in its July 17, 2009 letter to the Congress.*

[24] Letter to the Honorable John D. Dingell, from Donald B. Marron, Acting Director, Congressional Budget Office, January 10, 2007, http://www.cbo.gov/ftpdocs/77xx/doc7722/hr4.pdf .

Sec. 1191. Telehealth Expansion and Enhancements. Medicare covers certain services including professional consultations, office and other outpatient visits, individual psychotherapy, pharmacological management, psychiatric diagnostic interview examinations, neurobehavioral status exams, and end stage renal disease related services delivered via an eligible telecommunications system. An interactive telecommunications system is required as a condition of payment. The originating site (the location of the beneficiary receiving the telehealth service) can be a physician or practitioner's office, a critical access hospital, a rural health clinic, a federally qualified health center, a hospital-based renal dialysis center, a skilled nursing facility, a community mental health center or a hospital. The originating site must be in a rural health professional shortage area or in a county that is not in a metropolitan statistical area or at an entity that participates in a specified federal telemedicine demonstration project.

Under this provision, a renal dialysis facility would be included as a covered originating site for telehealth services effective for services starting January 1, 2011. The Secretary would appoint a Telehealth Advisory Committee to make policy recommendations regarding telehealth services including the appropriate addition or deletion of covered services and procedure codes for authorized payments. In making determinations with respect to covered services, the Secretary would be required to take into account the recommendations of the Committee. If the Secretary does not implement a recommendation, the Secretary would publish a statement providing the reason for such decision in the *Federal Register. The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

Sec. 1192. Extension of Outpatient Hold Harmless Provision. Small rural hospitals (with no more than 100 beds) that are not sole community hospitals (SCHs) can receive additional Medicare payments if their outpatient payments under the prospective payment system are less than under the prior reimbursement system. For calendar year (CY) 2006, these hospitals received 95% of the difference between payments under the prospective payment system and those that would have been made under the prior reimbursement system. The hospitals received 90% of the difference in CY2007 and 85% of the difference in CY2008. The payment is set at 85% for CY2009. Sole community hospitals with not more than 100 beds receive 85% of the payment difference for covered HOPD services furnished on or after January 1, 2009, and before January 1, 2010. Under this provision, small rural hospitals and sole community hospitals with not more than 100 beds would receive 85% of the payment difference for covered HOPD services furnished until January 1, 2012. *The CBO score is +$0.4 billion for FY2010-FY2014 and +$0.4 billion for FY2010-FY2019.*

Sec. 1193. Extension of Section 508 Hospital Reclassifications. Section 508 of MMA provided $900 million for a one-time, 3-year geographic reclassification of certain hospitals that were otherwise unable to qualify for administrative reclassification to areas with higher wage index values. These reclassifications were extended from March 31, 2006 to September 30, 2007 by the Tax Relief and Health Care Act of 2006 (P.L. 109-432). MMSEA extended the reclassifications to September 30, 2008. MIPPA extended the reclassifications until September 30, 2009. These extensions are exempt from any budget neutrality requirements. Under this provision, Section 508 reclassifications would be extended until September 30, 2011. *The CBO score is +$0.5 billion for FY2010-FY2014 and +$0.5 billion for FY2010-FY2019.*

Sec. 1194. Extension of Geographic Floor for Work. The Medicare fee schedule is adjusted geographically for three factors to reflect differences in the cost of resources needed to produce physician services: physician work, practice expense, and medical malpractice insurance. The geographic adjustments are indices that reflect how each area compares to the national average in

a "market basket" of goods. A geographic practice cost index (GPCI) with a value of 1.00 represents an average across all areas. A series of bills set a temporary floor value of 1.00 on the physician work index beginning January 2004; most recently, Section 134 of the MIPPA extended the application of this floor when calculating Medicare physician reimbursement through December, 2009. The other geographic indices (for practice expense and medical malpractice) were not modified by these Acts. The proposal would extend the 1.00 floor for the geographic index for physician work for an additional 3 years through December, 2012. *CBO estimates that this provision would increase outlays by $1.3 billion with all the outlays occurring in the next three years (2010-2012).*

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

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

The provision would maintain the 3% higher payments for ground transports originating in rural areas or rural census tracts until December 31, 2012. The MIPPA provision maintaining the designation of certain areas as rural for the purposes of Medicare's payments for air ambulance services would be maintained until December 31, 2011. *The CBO score is +$0.1 billion for FY2010-FY2014 and +$0.1 billion for FY2010-FY2019.*

Sec. 1197. Ensuring Proportional Representation of Interests in Rural Areas on MedPAC. ***[Energy and Commerce Amendment]*** BBA 97 established MedPAC to advise Congress on issues impacting the Medicare program. The Commission is composed of 17 members appointed for three-year terms by GAO. A mix of health care providers, health researchers, insurance organization officials, employers, representatives from prescription drug benefit programs, and consumers, among others are represented on MedPAC. This provision would establish that the proportion of MedPAC commissioners who would represent the interests of health care providers and beneficiaries located in rural areas would be no less than the proportion of total number of Medicare beneficiaries who live in rural areas. This provision would apply to appointments to MedPAC made after enactment. *This provision was not included in the draft of the legislation that CBO scored in its July 17, 2009 letter to the Congress.*

Sec. 1201. Improving Assets Tests for Medicare Savings Program and Low-income Subsidy Program. Federal assistance is provided to certain low-income persons to help them meet Medicare Part D premium and cost-sharing charges. To qualify for the Part D low-income subsidy, Medicare beneficiaries must have resources no greater than the income and resource limits established by MMA. In general, beneficiaries may qualify for a subsidy if they have an annual income below 150% of the FPL and if their resources do not exceed a certain limit (in 2009, $12,510 for individuals or $25,010 if married). Under this provision, the asset test used to determine eligibility for the low income subsidy and Medicare Savings programs would be increased. In 2012, the level would be $17,000 for an individual and $34,000 for a couple and would be indexed annually by the CPI. *The CBO score (the combined score for Sections 1201-1207) is +$3.3 billion for FY2010-2014 and +$11.9 billion for FY2010-2019.*

Sec. 1202. Elimination of Part D Cost-sharing for Certain Non-institutionalized Full-benefit Dual Eligible Individuals. Cost-sharing subsides for LIS enrollees are linked to the standard Part D prescription drug coverage. Full-subsidy eligibles have no deductible, minimal cost sharing during the initial coverage period and coverage gap, and no cost-sharing over the catastrophic threshold. Full-benefit dual eligibles who are residents of medical institutions or nursing facilities have no cost-sharing. This provision would eliminate cost sharing for people receiving care under a home and community based waiver who would otherwise require institutional care in a facility for the mentally retarded for drugs dispensed on or after January 1, 2011. *The CBO score (the combined score for Sections 1201-1207) is +$3.3 billion for FY2010-2014 and +$11.9 billion for FY2010-2019.*

Sec. 1203. Eliminating Barriers to Enrollment. Under the Medicare Part D low-income subsidy program, dual eligibles, those receiving assistance through Medicare Savings Programs, and recipients of SSI are deemed subsidy-eligible individuals for up to one year; other persons, or their personal representatives, have to apply for assistance either at state Medicaid offices or Social Security offices. Applicants are required to provide information from financial institutions as requested to support information in the application, and to certify as to the accuracy of the information provided. Under this provision, individuals applying for the low-income subsidy under the prescription drug program would be permitted to qualify on the basis of self-certification of income and resources beginning January 1, 2010. *The CBO score (the combined score for Sections 1201-1207) is +$3.3 billion for FY2010-2014 and +$11.9 billion for FY2010-2019.*

Sec. 1204. Enhanced Oversight Relating to Reimbursements for Retroactive Low Income Subsidy Enrollment. Individuals who qualify for Medicaid, a Medicare Savings Program, or SSI are automatically deemed eligible for the low-income subsidy, while other individuals with limited income and resources may apply for the low-income subsidy and have their eligibility determined by either the SSA or their state Medicaid agency. As eligibility is effective the month the application was submitted, LIS status is often applied retroactively. If a beneficiary is already enrolled in a Part D plan, the Part D sponsor must take steps to ensure that the beneficiary has been reimbursed for any premiums or cost-sharing the member had paid that should have been covered by the subsidy. This provision would enhance oversight to make sure that low-income beneficiaries who are owed retroactive reimbursement payments from their drug plans receive them. The reimbursement would be made automatically by the Part D sponsor upon appropriate notice that the beneficiary is eligible for assistance and no further information would need to be submitted to the plan by the beneficiary. *The CBO score (the combined score for Sections 1201-1207) is +$3.3 billion for FY2010-2014 and +$11.9 billion for FY2010-2019.*

Sec. 1205. Intelligent Assignment in Enrollment. Generally, there is a two-step process for low-income persons to gain Part D coverage. First, a determination must be made that they qualify for the assistance; second, they must enroll, or be enrolled, in a specific Part D plan. Full-benefit dual-eligible individuals who have not elected a Part D plan are auto-enrolled into one by CMS using a random assignment process. Because of the random nature of the process, some dual eligibles may be enrolled in plans that may not best meet their needs; for example, necessary drugs may not be covered by the new plan. Under this provision, for contract years beginning with 2012, the Secretary would be given the option to use an "intelligent assignment" process as an alternative to the random assignment process which would take into account the quality, cost, and formularies of plans. *The CBO score (the combined score for Sections 1201-1207) is +$3.3 billion for FY2010-2014 and +$11.9 billion for FY2010-2019.*

Sec. 1206. Special Enrollment Period and Automatic Enrollment Process for Certain Subsidy Eligible Individuals. In general, a Medicare beneficiary who does not enroll in Part D during his or her initial enrollment period may enroll only during the annual open enrollment period, which occurs from November 15 to December 31 each year. Beneficiaries already enrolled in a Part D plan may change their plans during the annual open enrollment period. There are a few additional, limited occasions when an individual may enroll in or disenroll from a Part D plan or switch from one Part D plan to another, called special enrollment periods. The provision would establish a new special enrollment period for persons deemed to be low-income subsidy eligible individuals for subsidy determination made for months beginning with January 2011. HHS would be given the authority to enroll subsidy-eligible beneficiaries into plans using a process that accounts for the quality, cost and/or formulary of plans, while also giving beneficiaries the option of choosing another plan. *The CBO score (the combined score for Sections 1201-1207) is +$3.3 billion for FY2010-2014 and +$11.9 billion for FY2010-2019.*

Sec. 1207. Application of MA Premiums Prior to Rebate in Calculation of Low Income Subsidy Benchmark. The federal government pays up to 100% of the Part D premiums for LIS beneficiaries who are enrolled in "benchmark" plans. A Part D plan qualifies as a benchmark plan if it offers basic Part D coverage with premiums equal to or lower than the regional low-income premium subsidy amount. MA plans offering prescription drug coverage submit a separate bid for the Part D portion. Payment for the portion of the premium attributable to basic prescription drug benefits is calculated in the same way as that for stand-alone PDPs, however the MA plan may choose to apply some of its Part C rebate payments to lower the Part D premium. MedPAC has noted that the number of plans that qualify as low-income benchmark plans has been decreasing in recent years, resulting in fewer options for LIS enrollees. For the 2009 plan year, approximately 2.3 million LIS enrollees were affected by the decrease in the number of qualifying plans and needed to enroll, or be enrolled, in new plans. This provision would exclude the Medicare Advantage rebate amounts from the MA-PDP premium bids when calculating the low-income regional benchmark for subsidy determinations made for months beginning with January 2011. *The CBO score (the combined score for Sections 1201-1207) is +$3.3 billion for FY2010-2014 and +$11.9 billion for FY2010-2019.*[25]

Sec. 1231. Extension Of Therapy Caps Exceptions Process. Current law places two annual per beneficiary payment limits for all outpatient therapy services provided by non-hospital providers. For 2009, the annual limit on the allowed amount for outpatient physical therapy and speech-

[25] Sections 1221, 1222, 1223, and 1224 in Subtitle B: Reducing Health Disparities are discussed in CRS Report R40745, *Public Health, Workforce, Quality, and Other Provisions in H.R. 3200*, coordinated by C. Stephen Redhead.

language pathology combined is $1,840, and there is a separate limit for occupational therapy of $1,840. The Secretary was required to implement an exceptions process for 2006, 2007, and the first half of 2008 for cases in which the provision of additional therapy services was determined to be medically necessary. Section 141 of MIPPA extended the exceptions process for therapy caps through December 31, 2009. The provision would extend the exceptions process for therapy caps for 2 years, through December 31, 2011. *CBO estimates that this provision would increase outlays by $1.8 billion.*

Sec. 1232. Extended Months of Coverage of Immunosuppressive Drugs for Kidney Transplant Patients and Other Renal Dialysis Provisions. Medicare coverage for beneficiaries with end-stage renal disease (ESRD) generally begins in the fourth month of dialysis treatments or the month of a kidney transplant. After receiving a kidney transplant, individuals are prescribed immunosuppressive drugs to reduce the risk of their immune system rejecting the new organ. If a beneficiary already had Medicare because of age or disability before the onset of end-stage renal disease, or if an individual became eligible for Medicare because of age or disability after receiving a transplant paid for by Medicare, Medicare will continue to pay for immunosuppressive drugs with no time limit. However, if a beneficiary qualifies for Medicare only because of kidney failure, Medicare, together with coverage of the immunosuppressive drugs, ends 36 months after the month of the successful transplant.

This provision would eliminate the current 36-month limitation on Medicare coverage of immunosuppressive drugs for kidney transplant patients who would otherwise lose this coverage on or after January 1, 2012. It would also make technical changes to the Medicare ESRD bundled payment system. *The CBO score is +$0.1 billion for FY 2010-2014 and +$0.4 billion for FY 2010-2019.*[26]

Sec. 1234. Part B Special Enrollment Period and Waiver of Limited Enrollment Penalty for Tricare Beneficiaries. Starting in 2001, military retirees and their eligible dependents become eligible for Tricare for Life at the same time they become eligible for Medicare. Tricare for Life essentially functions as a Medicare supplement and provides coverage for authorized services not covered by Medicare. Enrollment in Medicare Part B is required for access to Tricare for Life. Prior to the legislation creating Tricare for Life, many retirees had not enrolled in Part B, believing that they would always have access to military medical facilities. With the establishment of Tricare for Life and the concomitant need to enroll in Medicare Part B, there was concern over the potential imposition of significant penalties for late enrollment in Part B. Subsequent legislation–Section 625 of MMA–waived the Part B enrollment penalty for eligible retirees who enrolled in Part B prior to December 31, 2004. This provision would create a special 12-month enrollment period in which military retirees (or their eligible dependents) who have not yet enrolled in Medicare Part B can enroll in Part B, thus becoming eligible for Tricare for Life, without incurring a late enrollment penalty. This provision would also require the Secretary of HHS to establish a method for providing rebates for late enrollment penalties that were charged to certain disabled and end-stage renal disease (ESRD) beneficiaries who enrolled during or after January 2005 and before the month of enactment of this Act. *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

[26] Section 1233. Advance Care Planning Consultation is discussed in CRS Report R40741, *End-of-Life Care Provisions in H.R. 3200*, by Kirsten J. Colello.

Sec. 1235. Exception for Use of More Recent Tax Year in Case of Gains From Sale of Primary Residence in Computing Part B Income-Related Premium. Medicare beneficiaries have out-of-pocket cost-sharing requirements that differ according to the services they receive. Physician and outpatient services provided under Part B are financed through a combination of beneficiary premiums, deductibles, and federal general revenues. In general, Part B beneficiary premiums equal 25% of estimated program costs for the aged, with federal general revenues accounting for the remaining 75%. Beginning in 2007, higher-income enrollees pay a higher percentage of Part B costs. The provision would exclude income from the gains attributable to the sale of a primary residence from the beneficiary's modified adjusted gross income in determining the Part B income-related premium. This modification would apply to premiums and payments for years beginning with 2011. *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

Sec. 1236. Demonstration Program on Use of Patient Decisions Aids. Current law does not explicitly address patient decision aids, which are information tools to help patients understand health care options, and make informed choices that take into account their lifestyle, preferences, and beliefs. This provision would require the Secretary to conduct a Medicare demonstration program to determine if using patient decision aids would improve beneficiaries' understanding of their medical treatment options. The program would enroll not more than 30 eligible providers, with preference given to providers that have documented experience, and the necessary information technology infrastructure and training, in using patient decision aids. Eligible providers would be required to provide follow-up counseling visits after beneficiaries have viewed decision aids, to address questions about subsequent medical care and the beneficiary's preferences. The Secretary would have to provide for the development of a code(s) and reimbursement for the follow-up counseling. Eligible providers would be responsible for the costs of selecting, purchasing, and delivering patient decision aids, and reporting data on quality and outcome measures. *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

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

This provision would add a new section 1866D to the Social Security Act (SSA) to establish the accountable care organization pilot program to test different payment incentive models. Specific payment incentive models to be tested include: the performance target model, the partial capitation model, and other payment models. A qualifying accountable care organization (qualifying ACO) would be a group of physicians or other physician organizational models which is organized, at least in part, for the purpose of providing physician services and meet other specified standards. A qualifying ACO could include a hospital or any other provider or supplier (furnishing Medicare covered services) that is affiliated with the ACO under an arrangement structured so that the provider or supplier participates in the pilot program and shares in any incentive payments. The pilot program would begin no later than January 1, 2012. An agreement with a qualifying ACO under this pilot would cover a multi-year period of between 3 and 5 years.

The Secretary would evaluate the payment incentive model for each qualifying ACO to assess the pilot's impact on beneficiaries, providers of services, suppliers and the program. The evaluation would be publicly available within 60 days of the date of completion of such report. The OIG would be responsible for monitoring of the operation of ACOs under the pilot program with

regard to violations of the Stark self referral prohibition (Section 1877 of the SSA). No later than 2 years after the date the first pilot agreement is established, and every 2 years thereafter for 6 years, the Secretary would report to Congress on the use of authorities under the pilot program and its impact on expenditures, access, and quality. The Secretary would be able issue regulations to implement on a permanent basis 1 or more models of the pilot program that are beneficial to Medicare. However, to do so, the Chief Actuary of the CMS would be required to certify that the expansion of the program's components would result in estimated spending that would be less than what spending would otherwise be estimated to be in the absence of such expansion.

The program management account of CMS would be appropriated $25 million for FY2010 through FY2014 and $20 million in FY2015 for the purposes of administering and carrying out the pilot program, but not for payments for Medicare covered items and services or for incentive payments. *The CBO score is -$0.2 billion for FY2010-FY2014 and -$2.0 billion for FY2010-FY2019.*

Sec. 1302. Medical Home Pilot Program. TRHCA, as modified by MIPPA, requires the Secretary to establish a 3-year demonstration in up to 8 states with urban, rural and underserved areas, to redesign the health care delivery system to provide targeted, accessible, continuous, and coordinated family-centered care to high need Medicare populations with chronic or prolonged illnesses requiring regular medical monitoring, advising or treatment.

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

The independent patient-centered medical home pilot program would begin within 6 months of enactment. The Secretary would be required to pay independent patient-centered medical homes a monthly fee, paid prospectively, for each targeted high need beneficiary who consents to receive services. This pilot program would have to be designed to include the participation of physicians in practices with fewer than 10 full-time equivalent physicians, as well as physicians in larger practices, particularly in underserved and rural areas, as well as federally qualified community health centers, and rural health centers. A physician in a group practice that participates in the Accountable Care Organization pilot program established in section 1866D of the SSA would not be eligible to participate in this pilot program, unless this program is ultimately made permanent.

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

The Secretary would be required to start the CBMH pilot program within 2 years of enactment. Demonstration sites under the pilot program would operate for up to 5 years after the initial implementation phase. The Secretary would be required to establish a methodology for payment

for medical home services furnished under the CBMH model, to include two separate prospective monthly payments for each high need beneficiary: one to a community-based or State-based organization, and one to the primary or principal care practice.

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

$6 million for each of fiscal years 2010 through 2014 would be transferred from the Federal Supplementary Medical Insurance Trust Fund (Part B Trust Fund) to the CMS Program Management Account to carry out this section. $200 million for each of fiscal years 2010 through 2014 for payments for independent patient-centered medical home services, and $125 million for each of fiscal years 2012 through 2016 for CBMH services would be available for CMS from the Part B Trust Fund. In addition to funds otherwise available, $2.5 million for each of fiscal years 2010 through 2012 would be available to CMS from the Part B Trust Fund for initial implementation costs. Any amounts made available under this subsection for a fiscal year would be available until expended. The authority for the Medicare Medical Home Demonstration project would be repealed. The $100 million established by the TRHCA for the existing Medicare Medical Home Demonstration would be made available to the independent patient-centered medical home pilot program. *The CBO score is $1.5 billion for FY2010-FY2014 and $1.8 billion for FY2010-FY2019.*

Sec. 1303. Independence at Home Pilot Program. ***[Energy and Commerce Amendment]*** The Secretary would be required to conduct a Medicare pilot program, beginning no later than January 1, 2012, to test a payment incentive and service delivery model that uses physician and nurse practitioner directed home-based primary care teams designed to reduce expenditures and improve health outcomes in the provision of items and services to certain high-cost, chronically ill Medicare beneficiaries. The Secretary would enter into agreements with qualifying Independence at Home Medical Practices (practice) which are legal entities comprised of an individual physician or nurse practitioner or group of physicians and nurse practitioners. The Secretary would design the pilot program to include the participation of physician and nurse practitioner practices with fewer than 10 full-time equivalent physicians, as well as physicians in larger practices, particularly in underserved rural areas. A home-based primary care team could be led by a nurse practitioner or physician assistant, if it complies with the requirements of this provision and acts consistently with State law.

Practices would be expected to spend at least 5% less than a target spending level or a target rate of growth. A practice could receive 80% of savings in excess of 5% if Medicare expenditures for applicable beneficiaries are at least 5% greater than would result from normal variation in expenditures Medicare services covered by Parts A and B (and Part D to the extent the Secretary decides to include such costs). Practices could receive interim payments for geriatric assessments and monthly care coordination services. However, those payments, or a fraction of them, may be recouped by the Secretary in the event that the practice does not achieve the required savings. To participate, a practice would be required to demonstrate to the Secretary that it is able to assume financial risk for the 5% savings requirement. The Secretary must limit payments for shared savings to each practice so that aggregate expenditures for applicable beneficiaries, including shared savings payments, would not exceed the amount that would have been expended if the pilot program had not been implemented.

Agreements with practices under the program could cover a 3-year period. The Secretary would also be required to submit to Congress a report on the pilot's best practices no more than 2 years after the date the first agreement is entered into and every second year thereafter during the pilot program. Subject to the evaluation, the Secretary may enter into additional agreements with practices to further test and refine models. If determined to be beneficial by the Secretary and certified by the Chief Actuary of the CMS as resulting in lower estimated Medicare spending, the Secretary may issue regulations to permanently implement the Independence at Home Practice Model. The provision would appropriate to the CMS Program Management Account $5 million for each of fiscal years 2010 through 2014 to administer the pilot program. *This provision was not included in the draft of the legislation that CBO scored in its July 17, 2009 letter to the Congress.*

Sec. 1304. Payment Incentive for Selected Primary Care Services. Section 1833(m) of the Social Security Act provides bonus payments (10% of what would otherwise be paid under the fee schedule) for physicians who furnish medical care services in geographic areas that are designated by the Health Resources and Services Administration (HRSA) as primary medical care health professional shortage areas (HPSAs) under section 332 (a)(1)(A) of the Public Health Service (PHS) Act. In addition, for claims with dates of service on or after July 1, 2004, psychiatrists furnishing services in mental health HPSAs are also eligible to receive bonus payments.

The provision would establish payment incentives for primary care services furnished on or after January 1, 2011 by a primary care practitioner. The amount of the payment incentive would be 5% (or 10% if the practitioner provides the services predominately in an area that is designated as a primary care health professional shortage area) and would be paid from the Part B Trust Fund. The primary care services incentive payments would not be taken into account in determining the additional payments for physicians in health professions shortage areas or in physician scarcity areas. *CBO estimates that this provision would require an additional $2.5 billion over the next five years (2010-2014) and $6.4 billion over the next ten (2010-2019).*

Sec. 1305. Increased Reimbursement Rate for Certified Nurse-Midwives. In general, Medicare pays 80% of the reasonable charges (the lesser of the actual charge for the services or the amount determined by the fee schedule) for provider services covered under Medicare Part B. However, Medicare payments for services performed by certified nurse–midwives to Medicare beneficiaries are currently limited to no more than 65% of the fee schedule amount for the same service performed by a physician. The proposal would remove the 65% restriction for Medicare payments to certified nurse-midwives. The modification would apply to services furnished on or after January 1, 2011. *According to the CBO, this provision would require about $100 million in additional outlays over the 5-year as well as the 10-year window.*[27]

Sec. 1308. Excluding Clinical Social Worker Services From Coverage Under the Medicare Skilled Nursing Facility Prospective Payment System and Consolidated Payment. The majority of services provided to beneficiaries in a Medicare covered SNF stay are included in the bundled prospective payment made to the SNF. Certain services have been specifically excluded from SNF consolidated billing. In these instances, Medicare will pay the entity providing the service directly. Currently, the items and services provided by a clinical social worker are

[27] Sections 1306 and 1307 concerning coverage and waiver of cost sharing for certain preventive services are discussed in *CRS Report R,40745 Public Health, Workforce, and Quality Provisions in the House Health Reform Legislation (H.R. 3200).*

included in the SNF consolidated billing. The provision would exclude items and services provided by clinical social workers to Medicare beneficiaries in a SNF from SNF consolidated billing and would establish a separate Medicare payment on or after July 1, 2011. *The CBO score is $0.0 billion for FY 2010-FY2014 and $0.0 billion for FY2010-FY2019.*

Sec. 1309. Coverage of Marriage and Family Therapist Services and Mental Health Counselor Services. Section 1861(s)(2) of the SSA defines "medical and other health services" as including medical supplies, hospital services, diagnostic services, outpatient physical therapy services, rural health clinic services, home dialysis services and supplies, antigens and physician assistant and nurse practitioner services. Marriage and family therapists and mental health counselors are not included under current law.

The provision would add two subcategories of medical and health services: marriage and family therapists, and mental health counselors. Required qualifications for a marriage and family therapist, and mental health counselor would be established. Medicare would pay 80% of the lesser of the actual charge for services or 75% of the amount that would be paid for a psychologist's services. The Secretary would be required to consider confidentiality issues while developing criteria to allow direct payment of the therapist and medical information sharing with the patient's primary care physician or nurse practitioner. Services provided by marriage and family therapists and mental health counselors would be excluded from consolidated billing by SNFs; marriage and family therapists and mental health counselors would be providers in rural health clinics and federally qualified health centers. Marriage and family therapists and mental health counselors would be one of the practitioner categories who can file claims for services provided. *The CBO score is $0.2 billion for FY2010-FY2014 and $0.5 billion for FY2010-FY2019.*

Sec. 1310. Extension of Physician Fee Schedule Mental Health Add-on. By law, every five years CMS examines Medicare billing codes under the physician fee schedule to determine whether they are overvalued or undervalued. Subsequent to the most recent evaluation, Medicare increased the rates for the codes used by physicians to bill for "evaluation and management" (E/M) services (face-to-face visits with patients), effective January 1, 2007. To maintain budget neutrality, rates for certain other codes, including some used to bill for psychotherapy services, were reduced. MIPPA increased Medicare payments under the fee-schedule for psychotherapy services by 5% beginning on July 1, 2008 and ending on December 31, 2009. The provision would extend the increase payments for psychotherapy services for an additional two years (ending December 31, 2011). *The CBO score is $0.1 billion for FY2010-FY2014 and $0.1 billion for FY2010-FY2019.*[28]

Sec. 1601. Increased Funding and Flexibility to Fight Fraud and Abuse. The Health Care Fraud and Abuse Control (HCFAC) account funds activities to fight health care fraud. The HCFAC program along with the Medicare Integrity Program (MIP) were both established by the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191) which sought to increase and stabilize federal funding for health care anti-fraud activities. Specifically, HCFAC funds are directed to the enforcement and prosecution of health care fraud whereas MIP funding supports the program integrity activities undertaken by CMS contractors. This provision would

[28] Sections 1311 and 1312 concerning access to vaccines and certified diabetes educators; section 1401 establishing comparative effectiveness research; most of the sections concerning quality in Title IV, and all of the sections in Title V concerning graduate medical education are discussed in CRS Report R40745, *Public Health, Workforce, Quality, and Other Provisions in H.R. 3200*, coordinated by C. Stephen Redhead.

increase funding for HCFAC and MIP by $100 million annually beginning with FY2011. Total mandatory and discretionary funding for health care fraud activities in FY2009 amounted to $1.4 billion.[29] *Non-scorable savings attributed to the increased HCFAC spending is $0.4 billion from FY2010-FY2014 and $1.3 billion from FY2010-FY2019.*[30]

Sec. 1611. Enhanced Penalties for False Statements on Provider or Supplier Enrollment Applications. In Medicare, providers and suppliers are required to submit an application to enroll in the Medicare program in order to receive payment. To participate in Medicaid, providers and suppliers are required to sign written agreements with their State Medicaid Agency. Beginning January 2010, this provision would provide that a person who knowingly makes or causes to be made any false statement, omission, or misrepresentation on an application, agreement, bid, or contract to participate in a federal health program be subject to a civil monetary penalty (CMP) of $50,000. Entities such as Medicaid managed care organizations, Medicare Advantage (MA) organizations, and Part D Prescription Drug Plans (PDPs) would also be subject to this provision. *The aggregate CBO score for Sections 1611 through 1653 is $-0.4 billion for FY2010-FY2014 and -1.3 billion for FY2010-FY2019.*

Sec. 1612. Enhanced Penalties for Submission of False Statements Material to a False Claim. The CMP authority in the SSA requires the imposition of CMPs on any person, including an organization, agency, or other entity, who engages in various types of improper conduct with respect to federal health care programs, including presenting false or fraudulent claims to a federal agency. Beginning January 2010, persons who knowingly make, use, or cause to be made or used any false statement or record material to a false claim would be subject to a CMP of $50,000 for each violation. *The aggregate CBO score for Sections 1611 through 1653 is $-0.4 billion for FY2010-FY2014 and -1.3 billion for FY2010-FY2019.*

Sec. 1613. Enhanced Penalties for Delaying Investigations. Beginning January 2010, this provision would provide that persons who fail to grant timely access, upon reasonable request, to the Office of the Inspector General (OIG) for the purpose of audits, investigations, evaluations be subject to CMPs of $15,000 per day. The provision would also modify the contractual requirements for MA plans to allow the Secretary to conduct timely audits and inspections of MA plans. *The aggregate CBO score for Sections 1611 through 1653 is $-0.4 billion for FY2010-FY2014 and -1.3 billion for FY2010-FY2019.*

Sec. 1614. Enhanced Hospice Program Safeguards. Medicare statute mandates the establishment of health and safety standards that providers must meet in order to participate in the Medicare and Medicaid programs (i.e. hospitals, hospices, nursing homes, and home health agencies). These standards are often referred to as Conditions of Participation (CoPs). Generally, state agencies, under contract with CMS, survey providers to determine compliance with CoPs. This provision would require the Secretary to develop and implement intermediate sanctions for hospices that fail to meet federal health and safety standards. The sanctions may include CMPs of up to $10,000 for each day of non-compliance, payment suspension or denial, the appointment of temporary managers, correction plans, and staff training. If after a period of sanctions, the deficiencies have not been corrected, the Secretary would be required to terminate the providers'

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

[30] Scorekeeping rules establish that decreases in mandatory spending will not be scored as a result of an increase in direct spending for administration or program management activities. See Budget Option 115 in CBO's *Budget Options: Volume I: Health Care*, December 2008 pp. 209-210.

participation in federal health programs. *The aggregate CBO score for Sections 1611 through 1653 is $-0.4 billion for FY2010-FY2014 and -1.3 billion for FY2010-FY2019.*

Sec. 1615. Enhanced Penalties for Individuals Excluded from Program Participation. Beginning January 2010, this provision would provide that a person who orders or prescribes an item or service, including home health care, lab tests, prescription drugs, durable medical equipment (DME), ambulance services, or physical or occupational therapy when they have been excluded from participation in a federal health care program, and the person knows or should know that a claim for such item or service will be presented to such a program, is subject to a CMP of $50,000 for each order or prescription.[31] *The aggregate CBO score for Sections 1611 through 1653 is $-0.4 billion for FY2010-FY2014 and -1.3 billion for FY2010-FY2019.*

Sec. 1616. Enhanced Penalties for Provision of False Information by Medicare Advantage and Part D Plans. The Secretary has the authority to impose intermediate sanctions and CMPs ranging from $25,000 to $100,000 on MA plans that violate the terms of their contract. Among the types of violations are failing to provide medically necessary care, imposing excess beneficiary premiums, expelling or refusing to re-enroll beneficiaries, or misrepresenting or falsifying information. Beginning January 2010, this provision would add an additional penalty for MA and Part D plans to include an assessment of up to three times the amount claimed by the plan based on the misrepresentation or falsified information. *The aggregate CBO score for Sections 1611 through 1653 is $-0.4 billion for FY2010-FY2014 and -1.3 billion for FY2010-FY2019.*

Sec. 1617. Enhanced Penalties for Medicare Advantage and Part D Marketing Violations. The Secretary has the authority to impose intermediate sanctions and CMPs ranging from $25,000 to $100,000 on MA plans that violate the terms of their contract. This provision would increase the number of violations that would be subject to the imposition of sanctions and CMPs by the Secretary. Beginning January 2010, employees, agents, or participating providers of MA plans that: 1) enroll beneficiaries in a MA or Part D plan without their consent, 2) transfer an individual from one plan to another for the purpose of earning a commission, 3) or fail to comply with CMS marketing requirements could be subject to sanctions imposed by the Secretary. *The aggregate CBO score for Sections 1611 through 1653 is $-0.4 billion for FY2010-FY2014 and -1.3 billion for FY2010-FY2019.*

Sec. 1618. Enhanced Penalties for Obstruction of Program Audits. The OIG has permissive authority (i.e. discretion) to exclude an entity or individual from a federal health program for a conviction related to the obstruction of a health care fraud investigation. Beginning January 2010, this provision would expand the OIG's permissive exclusion authority to include a conviction related to the obstruction of an audit related to health care fraud. *The aggregate CBO score for Sections 1611 through 1653 is $-0.4 billion for FY2010-FY2014 and -1.3 billion for FY2010-FY2019.*

Sec. 1619. Exclusion of Certain Individuals and Entities from Participation in Medicare and State Health Care Programs. Medicare statute provides that the Secretary (and through delegation, OIG) has the authority to exclude individuals and entities from participation in federal

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

health care programs under a variety of circumstances. This provision would clarify the effect of an exclusion of an individual or entity on payment made under a federal health care program. Subject to exceptions, payment cannot be made from any federal health care program with respect to an item or service furnished (1) by an excluded individual or entity, or (2) at the medical direction, or on the prescription of an authorized individual (e.g., a physician) when the person submitting a claim for the item or service knew or had reason to know of an individual's exclusion. *The aggregate CBO score for Sections 1611 through 1653 is $-0.4 billion for FY2010-FY2014 and -1.3 billion for FY2010-FY2019.*

Sec. 1631. Enhanced CMS Program Protection Authority. Beginning January 2011, this provision would authorize the Secretary to subject Medicare, Medicaid, and CHIP providers and suppliers to enhanced screening, oversight, or a moratorium on enrollment in instances where there is a significant risk of fraud. Determinations of what constitutes a significant risk of fraud would be made by the Secretary. The Secretary would be required to establish procedures for screening and enhanced oversight (i.e. site visits, enhanced claims review). In instances of serious ongoing fraud, the Secretary would have the authority to impose a moratorium on enrolling providers within a certain category of providers or specific geographic area. *The aggregate CBO score for Sections 1611 through 1653 is $-0.4 billion for FY2010-FY2014 and -1.3 billion for FY2010-FY2019.*

Sec. 1632. Enhanced Medicare, Medicaid, and CHIP Program Disclosure Requirements Relating to Previous Affiliations. In order to receive payment from Medicare, providers must enroll in the Medicare program. CMS regulations mandate that Medicare enrollment applications contain information to uniquely identify the provider (i.e. proof of business name, social security number, or Tax ID number) and include documentation necessary to verify licensure. State Medicaid agencies determine whether a provider or supplier is eligible to participate in the Medicaid program by providing for written agreements with providers and suppliers. Beginning January 2011, this provision would require that providers or suppliers enrolling or re-enrolling in Medicare, Medicaid, or CHIP be required to disclose information on their affiliations with certain providers or suppliers. The Secretary would have the authority to deny enrollment in instances when an affiliation poses a risk of fraud. *The aggregate CBO score for Sections 1611 through 1653 is $-0.4 billion for FY2010-FY2014 and -1.3 billion for FY2010-FY2019.*

Sec. 1633. Required Inclusion of Payment Modifier for Certain Evaluation and Management Services. Evaluation and management services include certain primary care services, hospital inpatient medical services, preventive medicine visits, and others. This provision would require the Secretary to establish a payment modifier for evaluation and management services that result in the ordering of additional services (i.e. lab tests, prescription drugs, DME, or other services) determined by the Secretary to be at high risk of fraud. *The aggregate CBO score for Sections 1611 through 1653 is $-0.4 billion for FY2010-FY2014 and -1.3 billion for FY2010-FY2019.*

Sec. 1634. Evaluations and Reports Required Under Medicare Integrity Program. The MIP program requires the Secretary to enter into contracts with private entities to conduct a variety of program integrity activities for the Medicare program including auditing providers, reviewing claims for medical necessity, and identifying and investigating alleged fraud. Beginning in 2011, this provision would require MIP contractors to submit annual reports to the Secretary on their activities. *The aggregate CBO score for Sections 1611 through 1653 is $-0.4 billion for FY2010-FY2014 and -1.3 billion for FY2010-FY2019.*

Sec. 1635. Require Providers and Suppliers to Adopt Programs to Reduce Waste, Fraud, and Abuse. This provision would require Medicare providers and suppliers to establish compliance programs to reduce fraud. The Secretary, in consultation with the OIG, would be required to establish the core components for these programs. Providers and suppliers that do not meet requirements for establishing these programs would be subject to certain sanctions, including a CMP of up to $50,000 or disenrollment. The Secretary would be authorized to conduct a pilot program for certain high-risk providers prior to implementing these compliance requirements across all providers. *The aggregate CBO score for Sections 1611 through 1653 is $-0.4 billion for FY2010-FY2014 and -1.3 billion for FY2010-FY2019.*

Sec. 1636. Maximum Period for Submission of Medicare Claims Reduced to Not More Than 12 Months. Medicare statute requires that payments be made only to Medicare eligible providers and only if a written request for payment is filed within three calendar years after the year in which the services were provided. The Secretary is authorized to reduce this period to no less than one year if necessary. Beginning January 2011, the provision would reduce the time period for filing a written request for payment from three calendar years to one calendar year. *The aggregate CBO score for Sections 1611 through 1653 is $-0.4 billion for FY2010-FY2014 and -1.3 billion for FY2010-FY2019.*

Sec. 1637. Physicians Who Order DME or Home Health Services Required to be Medicare Enrolled Physicians or Eligible Professionals. In order to receive payment from Medicare, physicians are required to certify that specified services (i.e. inpatient psychiatric services, post-hospital extended care services, and home health services) meet certain conditions. For example, physicians must certify that home health care services are necessary because the patient is confined to his/her home and needs skilled nursing care. In the case of DME, payment may only be made if the physician has communicated to the supplier a written order for the item. Beginning January 2010, this provision would require that physicians who order DME or home health services be a Medicare eligible professional or enrolled in the Medicare program. *The aggregate CBO score for Sections 1611 through 1653 is $-0.4 billion for FY2010-FY2014 and -1.3 billion for FY2010-FY2019.*

Sec. 1638. Requirement for Physicians to Provide Documentation on Referrals to Programs at High Risk of Waste and Abuse. Beginning January 2010, the Secretary would have the authority to disenroll, for no more than one year, a Medicare enrolled physician or supplier that fails to maintain and provide access to written orders or requests for payment for DME, home health services, or referrals for other items and services to the Secretary. The provision would also extend the OIG's permissive exclusion authority to include individuals or entities that order, refer, or certify the need for health care services that fail to provide adequate documentation to the Secretary. *The aggregate CBO score for Sections 1611 through 1653 is $-0.4 billion for FY2010-FY2014 and -1.3 billion for FY2010-FY2019.*

Sec. 1639. Face to Face Encounter with Patient Required Before Physicians May Certify Eligibility for Home Health Services or DME under Medicare. In order to receive payment from Medicare, physicians are required to certify that specified services (i.e. inpatient psychiatric services, post-hospital extended care services, and home health services) meet certain conditions. For example, physicians must certify that home health care services are necessary because the patient is confined to his/her home and needs skilled nursing care. In the case of DME, payment may only be made if the physician has communicated to the supplier a written order for the item. Beginning January 2010, this provision would require that physicians have a face-to-face encounter (including through telehealth) with the individual prior to issuing a certification or re-

certification. The provision would also apply to physicians making home health certifications in Medicare, Medicaid, and CHIP. *The aggregate CBO score for Sections 1611 through 1653 is $-0.4 billion for FY2010-FY2014 and -1.3 billion for FY2010-FY2019.*

Sec. 1640. Extension of Testimonial Subpoena Authority to Program Exclusion Investigations. The Secretary has the authority to exclude individuals and entities from participation in federal health care programs under a variety of circumstances. Beginning January 2010, this provision would apply the Secretary's testimonial subpoena authority to program exclusion investigations. Thus, the Secretary would be able to issue subpoenas and require the attendance and testimony of witnesses and the production of any other evidence relating to matters under investigation or in question by the Secretary. *The aggregate CBO score for Sections 1611 through 1653 is $-0.4 billion for FY2010-FY2014 and -1.3 billion for FY2010-FY2019.*

Sec. 1641. Required Repayments of Medicare and Medicaid Overpayments. This provision would require Medicare and Medicaid providers and suppliers, including Medicaid managed care plans, MA plans, and Part D plans, that know of an overpayment to report and return the overpayment within 60 days. *The aggregate CBO score for Sections 1611 through 1653 is $-0.4 billion for FY2010-FY2014 and -1.3 billion for FY2010-FY2019.*

Sec. 1642. Expanded Application of Hardship Waivers for OIG Exclusions to Beneficiaries of any Federal Health Care Program. The Secretary has the authority to exclude individuals and entities from participation in federal health care programs under a variety of circumstances. Exclusions from federal health programs are mandatory in some circumstances, and permissive in others. Generally, in the case of a mandatory exclusion, the minimum period of exclusion cannot be less than five years. However, if a federal health care program administrator determines that the exclusion would impose a hardship, the Secretary may, after consultation with the OIG, waive the exclusion under certain circumstances. This provision would clarify that the "hardship waiver" for exclusions applies to beneficiaries enrolled in a federal health care program. *The aggregate CBO score for Sections 1611 through 1653 is $-0.4 billion for FY2010-FY2014 and -1.3 billion for FY2010-FY2019.*

Sec. 1643. Access to Certain Information on Renal Dialysis Facilities. This provision would require End State Renal Disease Facilities to provide the Secretary with access to information relating to any ownership or compensation arrangement between the facility and the medical director of such facility or between the facility and any physician for the purposes of an audit or evaluation. *The aggregate CBO score for Sections 1611 through 1653 is $-0.4 billion for FY2010-FY2014 and -1.3 billion for FY2010-FY2019.*

Sec. 1644. Billing Agents, Clearinghouses, or Other Alternate Payees Required to Register Under Medicare. CMS has implemented regulations requiring Medicare providers and suppliers to submit an application to enroll in the Medicare program in order to receive billing privileges. The enrollment application requires that providers and suppliers include the names, addresses, and tax ID numbers for billing agencies on their applications. Beginning January 2012, this provision would require billing agencies, clearinghouses, or other payees that submit claims on behalf of a health care provider to register with the Secretary. *The aggregate CBO score for Sections 1611 through 1653 is $-0.4 billion for FY2010-FY2014 and -1.3 billion for FY2010-FY2019.*

Sec. 1645. Conforming CMPs to False Claims Act (FCA) Amendments. The federal False Claims Act (FCA), codified at 31 U.S.C. §§ 3729-3733, provides for the imposition of CMPs and

damages for the knowing submission of false claims to the United States government. The recently enacted Fraud Enforcement and Recovery Act of 2009 (FERA, P.L. 111-21), made several amendments to the FCA, which essentially expanded the types of conduct that could lead to FCA liability. The CMP authority in the SSA requires the imposition of CMPs on any person, including an organization, agency, or other entity, who engages in various types of improper conduct with respect to federal health care programs. Similar to the FERA amendments to the FCA, this provision would amend the CMP statute by expanding the types of conduct that could lead to CMPs. For example, the provision would remove the requirement that a claim be presented to a government officer, employee, agent, or agency in order to be liable for CMPs. In addition, the bill would create a new section 1128A(a)(12), which would impose CMPs on a person who conspires to commit a violation of the CMP statute. *The aggregate CBO score for Sections 1611 through 1653 is $-0.4 billion for FY2010-FY2014 and -1.3 billion for FY2010-FY2019.*

Sec. 1651. Access to Information Necessary to Identify Waste and Abuse. This provision would establish that the Attorney General have unrestricted access to all Medicare and Medicaid claims and payment databases. Access for the Attorney General would be facilitated by the OIG and in consultation with CMS or the owner of any such database. Access would be required to be carried out for the purposes of law enforcement activity and in a manner consistent with any applicable disclosure, privacy, and security laws, including HIPAA. *The aggregate CBO score for Sections 1611 through 1653 is $-0.4 billion for FY2010-FY2014 and -1.3 billion for FY2010-FY2019.*

Sec. 1652. Elimination of Duplication Between the Healthcare Integrity and Protection Databank and the National Practitioner Databank. Medicare statute requires the Secretary to develop and maintain a national health care fraud and abuse data collection program, the Health Care Integrity and Protection Data Bank (HIPDB), for the reporting of adverse actions taken against health care providers or suppliers. The Health Care Quality Improvement Act of 19.86 established the National Practitioner Data Bank (NPDB). The NPDB collects and releases data on the professional competence of physicians, dentists, and certain healthcare practitioners. This provision would require the Secretary to transfer information from the HIPDB to the NPDB. The transition would be funded from the fees collected to access the database and from the annual HCFAC appropriation. *The aggregate CBO score for Sections 1611 through 1653 is $-0.4 billion for FY2010-FY2014 and -1.3 billion for FY2010-FY2019.*

Sec. 1653. Compliance with HIPAA Privacy and Security Standards. The Privacy Act of 1974 generally prohibits disclosures of records contained in a system of records maintained by a federal agency without the written request or consent of the individual to whom the record pertains. HIPAA Privacy and Security Rules establish national standards for the privacy and security of protected health information. This provision would clarify that the privacy and security regulations promulgated under the HIPAA and the Privacy Act of 1974 apply to all fraud, waste, and abuse provisions in this bill.[32] *The aggregate CBO score for Sections 1611 through 1653 is $-0.4 billion for FY2010-FY2014 and -1.3 billion for FY2010-FY2019.*

Sec. 1801. Disclosures to Facilitate Identification of Individuals Likely to Be Ineligible for the Low-Income Assistance Under the Medicare Prescription Drug Program to Assist Social

[32] Title VII with provisions amending the Medicaid and CHIP programs are discussed in a forthcoming CRS report. Sections 1801 and 1802 in Title VII Revenue Related Provisions will not be not included in that report.

Security Administration's Outreach to Eligible Individuals. Under Medicare Part D, beneficiaries with incomes and assets below certain levels may be eligible for low-income subsidy benefits. Section 1144 of the SSA requires the Commissioner of Social Security to conduct outreach efforts to inform potential LIS beneficiaries about the additional premium and cost-sharing subsidies. The Social Security Administration, from its own records, and other available non-tax records is able to determine a potential pool of LIS beneficiaries, but such pool may be over-inclusive and include persons ineligible for the LIS benefits. It is believed that the IRS possesses additional income information, and, through imputation, some asset information, that could narrow the pool of potentially eligible LIS beneficiaries thereby reducing outreach costs. Under this provision IRS would be authorized to disclose to the Social Security Administration certain taxpayer return information to assist in identifying individuals likely to be eligible for the low-income subsidy and help focus outreach efforts. *This provision was not scored by CBO.*

Sec. 1901. Repeal of the Trigger Provision. The Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds are overseen by a board of trustees that reports annually to Congress on Medicare expenditures and revenues. As part of their analysis, as required MMA, the trustees must determine whether or not general revenue financing will exceed 45% of total Medicare outlays within the next seven years. MMA requires that if an excess general revenue funding determination is made for two successive years, the President must submit a legislative proposal to respond to the warning and Congress is required to consider the proposals on an expedited basis. On January 6, 2009, the House approved a rules package (H.Res. 5) that nullifies the trigger provision in the House for the 111th Congress. This provision would repeal the 45% trigger. *The CBO score is $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.*

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

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

FY2014. *The CBO score is $0.0 billion for FY2010-FY2014 and -$0.0 billion for FY2010-FY2019.*

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